Amendment Number 18 (19)

Contract #30-2022-007-DHB-#

Medicaid Direct Prepaid Inpatient Health Plan

This Amendment to the Contract #30-2022-007-DHB-# Medicaid Direct Prepaid Inpatient Health Plan Contract ("Contract"), as subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PIHP Plan Name ("Contractor" or "PIHP"), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to make clarifications, technical corrections and updates related to the following Sections:

I. Section II. Definitions and Abbreviations;
II. Section III. Contract Term, General Terms and Conditions, Protections, and Attachments;
III. Section IV. Scope of Services; and
IV. Section VI. Attachments.

The Parties agree as follows:

I. Modifications to Section II. Definitions and Abbreviations

Specific subsections are modified as stated herein.

a. *Section II. Definition and Abbreviations, A. Definitions*. The following defined terms are revised and restated as follows:

176. **Tailored Care Management Payments:** Per Member per month payments made to AMH+ practices, CMAs, and PIHPs for the provision of Tailored Care Management. Tailored Care Management Payments will be subject to rates set by the Department, which shall not be placed at risk.

b. *Section II. Definition and Abbreviations, A. Definitions* is revised to add the following newly defined terms:

229. **Children and Families Specialty Plan:** A statewide capitated Prepaid Health Plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of Chapter 108D, including the requirements pertaining to the Children and Families (CAF) specialty plan, but excluding the requirements only pertaining to BH I/DD Tailored Plans.
230. **Risk-bearing Subcontractor**: Assumes financial risk from the upstream health plan by agreeing to share in costs and outcomes under a subcontract agreement.

c. *Section II. Definitions and Abbreviations, B. Abbreviations and Acronyms* is revised to add the following newly defined acronym:

255. CFSP: Children and Families Specialty Plan

II. Modifications to Section III. Contract Term, General Terms and Conditions, Protections, and Attachments

Specific subsections are modified as stated herein.

a. *Section III. B. General Terms and Conditions, 11. CONTRACT ADMINISTRATORS, For the Department* is revised and restated in its entirety as follows:

For the Department

a. Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick Associate Director, Managed Care Contracting
Address Physical Address	1915 Health Services Way Raleigh, NC 27607
Address Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-410-5526
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

b. Contract Administrator regarding day-to-day activities herein:

Name & Title	Kelsi A. Knick Deputy Director of BH I/DD Tailored Plans
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7031
Email Address	kelsi.knick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

c. Department's federal, State and the Department Compliance Coordinator for all security matters:

Name & Title	Pyreddy Reddy, DHHS CISO
Address 1	1915 Health Services Way Raleigh, NC 27607
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

d. Department's HIPAA and Policy Coordinator for all federal, State, and Department privacy matters:

Name & Title	John Thompson Chief Compliance Officer
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7701
Email Address	John.e.thompson@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

II. Modifications to Section IV. Scope of Services

Specific subsections are modified as stated herein.

a. *Section IV. A. Administration and Management, 2. Entity Requirements* is revised to add the following:

d. Accreditation

i. In accordance with 42 C.F.R. § 438.322, the PIHP shall, effective January 1, 2026, notify the Department within thirty (30) Calendar Days of the date on which the PIHP is accredited by any private accrediting entity. The PIHP may submit a single notification of accreditation by a private

accrediting entity to the Department as to both the PIHP Contract and BH I/DD Tailored Plan Contract.

ii. In accordance with 42 C.F.R. § 438.322, the PIHP shall authorize any private independent accrediting entity that has accredited or accredits the PIHP to provide a copy of the most recent accreditation review to the Department and, as determined by the Department, to the EQRO, to include all of the following:
    1. Accreditation status;
    2. Survey type;
    3. Level (as applicable);
    4. Recommended actions or improvements;
    5. Corrective action plans;
    6. Summary(ies) of findings;
    7. Expiration date of the accreditation.

b. ***Section IV. A. Administration and Management, 2. Entity Requirements, b. PIHP Governance and Operations*** **is revised to add the following:**

iv. The PIHP shall be located in North Carolina unless prior written approval is provided by the Department. At no time shall the PIHP be located outside of the United States.

c. ***Section IV. B. Program Operations, 1. Services Lines, k.*** **is revised and restated in its entirety as follows:**

k. The PIHP shall digitally record and store and make available one hundred percent (100%) of incoming and outgoing Member Service Line, Provider Service Line and Behavioral Health Crisis Line calls for quality assurance purposes for a period of no less than twelve (12) months from the date of the call including Subcontractors.

d. ***Section IV. C. Compliance, 2. Program Integrity, c., ii. Prohibited Relationships*** **is revised to add the following:**

vii. The PIHP shall provide written disclosure of prohibited relationships.

e. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, c. Covered Medicaid Services, Section IV.F.1. Second Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services renamed,*** **revised and restated in its entirety as follows:**

Section IV.F.1. Third Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
1	Outpatient services	
2.1	Intensive outpatient services	Substance Use intensive outpatient program
2.5	Partial hospitalization services	Substance Use comprehensive outpatient treatment
3.3	Clinically managed population-specific high-intensity residential services	Clinically managed population-specific high-intensity residential services
3.5	Clinically managed high-intensity residential services	Clinically managed residential services (substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)

Section IV.F.1. Third Revised and Restated Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
4	Medically managed intensive inpatient services	Medically managed intensive inpatient services (Inpatient BH services)
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification)
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory withdrawal management, with extended on-site monitoring
3.2-WM	Clinically managed residential withdrawal management	Clinically managed residential withdrawal management services (social setting detoxification)
3.7-WM	Medically monitored inpatient withdrawal management	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal management	Medically managed intensive inpatient withdrawal management (Inpatient BH services)

f. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, d. Medical Necessity, vii.*** **is revised to add the following:**

4. The opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

g. ***Section IV. F. Benefits, 1. Behavioral Health and I/DD Benefits Package, e. Utilization Management, ii. UM Program Policy, 2.*** **is revised to add the following:**

l. Authorization of State Plan LTSS based on a Member's current needs assessment and consistent with the person-centered service plan.

h. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, b. Delivery of Tailored Care Management, ii. Provider-based Tailored Care Management, 4., iii.-iv*** **is revised and restated in its entirety as follows:**

iii. Contract Year 3: fifty-five percent (55%); and
iv. Contract Year 4: fifty-five percent (55%).

i. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, c. Eligibility for Tailored Care Management, i., 9.*** **is revised and restated in its entirety as follows:**

9. Reserved; and

j. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, l. Ongoing Care Management for Members Engaged in Tailored Care Management, ix., 2. ii.-iii.*** **is revised and restated in its entirety as follows:**

ii. Refer Members to the community-based organizations and social service agencies available on NCCARE360, realizing that there are instances where no community-based organization, social services agencies, or needed resources are available; and
iii. Track closed-loop referrals to ensure that follow-up is completed, and members' needs are met.

k. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, ii., 2.*** **is revised and restated in its entirety as follows:**

2. Reserved.

l. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, viii.*** **is revised and restated in its entirety as follows:**

viii. The PIHP shall hold each AMH+ and CMA accountable to all elements of the Tailored Care Management model contained in this Contract and associated guidance, by ensuring that all details are reflected in its contract with each AMH+ and CMA. Contract templates governing contracts between PIHPs and AMH+ practices and CMAs, including all sections and attachments of such contracts, shall be approved by the Department.

i. The PIHP may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based on Department review and approval.

m. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, xi.*** **is revised and restated in its entirety as follows:**

xi. The PIHP shall not require an AMH+ practice or CMA to undergo a pre-delegation audit for the purposes of NCQA accreditation in the first year of this Contract. The PIHP must ensure that in conducting oversight of AMH+ practices and CMAs it is monitoring Tailored Care Management-specific requirements contained in this Contract and the Tailored Care Management Provider Manual available at the following link, accurate as of the date of execution of this Contract: https://medicaid.ncdhhs.gov/tailored-care-management.

n. ***Section IV. G. Care Management and Care Coordination, 2. Tailored Care Management, u. Oversight of Tailored Care Management, xiii.-xvii.*** **is revised and restated in its entirety as follows:**

xiii. The PIHP shall not terminate its contract with an AMH+ or CMA under this provision until at least ninety (90) Calendar Days after PIHP launch. Notwithstanding the foregoing, the PIHP may immediately terminate the contract with an AMH+, CMA, or CIN or Other Partner if it determines, in its sole discretion, of fraud, waste, or abuse involving the subcontractor or such subcontractor's continued provision of services under this Agreement creates an imminent harm to members.

xiv. In the event of underperformance by an AMH+ or CMA relative to the requirements for Tailored Care Management contained in this Section:

1. The PIHP shall send a notice of underperformance to the AMH+ practice/CMA within fourteen (14) Calendar Days of identifying the underperformance, with a copy to the Department.
2. The PIHP shall provide the AMH+ or CMA with the opportunity to remediate any identified issues through a Corrective Action Plan (CAP), and a copy of the CAP shall be sent to the Department.
3. The PIHP shall ensure that a minimum of thirty (30) Calendar Days is provided for remediation of the identified underperformance addressed by the CAP, although the parties may establish longer remediation periods by mutual agreement.

xv. In the event of continued underperformance by an AMH+ or CMA that is not corrected after the time limit set forth on the CAP, and the PIHP terminates its contract with the AMH+ or CMA, then the PIHP shall notify the Department within seven (7) Calendar Days of initiating contract termination that it will no longer be contracting with the AMH+ or CMA for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.

xvi. In the event of underperformance by an AMH+ or CMA for Tailored Care Management, the PIHP shall ensure that there are no gaps in care management functions for Members assigned to the AMH+ practice or CMA.

xvii. As part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall have a documented process for how it will oversee AMH+ practices and CMAs that meet all the requirements above. This process must:

1. Describe how a CAP may be applied to an individual AMH+ practice or CMA.
2. Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ or CMA, in the event of continued underperformance.
3. Describe how, if the PIHP terminates its contract for Tailored Care Management with AMH+ practice or CMA, the PIHP would reassign members who were obtaining care management from that organization, taking member preferences into account and using the process described in *Section IV.G.2. Tailored Care Management*.
4. Describe how, if a certified AMH+ practice and/or CMA terminates its contract with the CIN or Other Partner, the AMH+ practice and/or CMA will be provided with options to continue serving as a Tailored Care Manager.

o. *Section IV. G. Care Management and Care Coordination, 8. Care Management and Care Coordination Policy, c., xx.* is revised and restated in its entirety as follows:

xx. Process for overseeing AMH+ and CMAs, as described in *Section IV.G.2. Tailored Care Management*. This process must:
1. Describe how a CAP may be applied to an individual AMH+ practice or CMA;
2. Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ or CMA, in the event of continued underperformance;
3. Describe how, if the PIHP terminates its contract for Tailored Care Management with AMH+ or CMA, the PIHP would reassign members who were obtaining care management through that organization, taking member preferences into account and using the process described in *Section IV.G.2. Tailored Care Management*; and
4. Describe how, if a certified AMH+ or CMA contracted by the PIHP to provide Tailored Care Management terminates its contract with a CIN or Other Partner, the PIHP will facilitate the transition to a new CIN or data partner in a manner that will minimize disruption of care.

p. *Section IV. G. Care Management and Care Coordination, 12. Additional Care Coordination Functions for Members Obtaining 1915(i) Services, b.* is revised and restated in its entirety as follows*:*

b. For all members obtaining 1915(i) services, regardless of whether they engage in Tailored Care Management, the PIHP shall ensure that care coordination includes:
   i. Conducting the independent assessment using a Department-designated tool to determine need for specific 1915(i) services. The PIHP shall comply with any additional guidance released by the Department on the Department-designated tool to conduct the independent assessment.
   ii. Guiding the development and submission of the Care Plan/ISP, based on assessed need and living arrangements:
      1. If applicable, the PIHP shall ensure that the member's care manager convenes a person-centered planning meeting and completes the Care Plan/ISP in line with federal requirements 42 C.F.R. § 441.725. This is done after the member is administered the independent assessment using a Department-designated tool for initial plans of care. For individuals receiving 1915(i) services, the annual person-centered Care Plan/ ISPs are due during the Member's month of birth.
      2. If applicable, the PIHP shall ensure that the member's AMH+ practice or CMA reviews and submits the Care Plan/ISP to the PIHP.
      3. The PIHP shall review Care Plan/ISP for compliance with 1915(i) SPA requirements, medical necessity, and the member's health and safety needs.
      4. For 1915(i) services requiring prior authorization review, the PIHP shall approve or deny the Care Plan/ISP within fourteen (14) Calendar Days of receiving a complete Care Plan/ ISP.
      5. In the case where services are immediately needed, the PIHP shall complete an interim person-centered care plan/ ISP within fourteen (14) Calendar Days of the Member's 1915(i) eligibility determination, so that services may be approved. Notwithstanding the existence of an interim person-centered Care Plan/ ISP, the Member's person-centered full, initial Care Plan/ ISP must be completed no later than forty-five (45) Calendar Days following the

determination of eligibility for 1915(i) services. Immediately needed 1915(i) services may include, but are not limited to, 1915(i) services that a member needs in order to:

a. Facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting;
b. Prevent imminent placement outside the person's current living arrangement;
c. Address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm; or
d. Prevent imminent loss of competitive integrated employment or an offer of such employment.

6. The PIHP shall ensure that 1915(i) services begin within forty-five (45) Calendar Days of Care Plan/ISP approval.

iii. Completing the independent assessment using a Department-designated tool prior to the development of the person-centered Care Plan/ ISP and updating the independent assessment at least annually or as significant changes occur with the Member as required by 42 C.F.R. § 441.720(b).

1. The PIHP shall update the independent assessment using a Department-designated tool by no later than thirty (30) Calendar Days prior to the expiration of the Member's eligibility for 1915(i) services to prevent gaps in service.
2. The PIHP shall ensure that a new person-centered Care Plan/ ISP is developed and signed by the Member/ Legally Responsible Person (if applicable) at least annually. Prior to the Member/ Legally Responsible Person (if applicable) signing the person-centered Care Plan/ ISP, the annual independent assessment and determination of eligibility for 1915(i) services must be completed.

iv. Explaining the service authorization process.
v. Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP, including providing a list of available providers and arranging provider interviews.
vi. Monitoring Care Plan/ISP goals at a minimum frequency based on the target date assigned to each goal.
vii. Maintaining close contact with the member/LRP (if applicable), providers and other members of the Care Plan/ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
viii. Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the member as required by 42 C.F.R. § 441.710(a)(1)(i).
ix. Reserved.
x. Providing timely notification to PIHP utilization management of updates to eligibility for 1915(i) services and timely processing of updates to the Care Plan/ISP.
xi. Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan (if applicable).
xii. Monitoring of service delivery to verify that:

1. At least one (1) 1915(i) service is utilized at a frequency determined by the Department in the 1915(i) SPA as required by 42 C.F.R. § 441.710(c).
2. Services are furnished in accordance with the Care Plan/ISP.
3. Member is offered a choice of 1915(i) service providers.
4. Member has access to services and supports that meet the member's needs.
5. Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-1915(i) service needs (medical care) are addressed and documented as appropriate.
6. 1915(i) services utilized do not exceed authorization.
7. Member is satisfied with the services being rendered.

q. ***Section IV. H. Providers, 1. Provider Network, b. Availability of Services (42 C.F.R. § 438.206), ii., 3.*** **is revised and restated as follows*:***

3. Ensuring that no incentive is given to providers, monetary or otherwise, for withholding, reducing, or limiting medically necessary services.

r. ***Section IV. H. Providers, 4. Provider Payments, o. ICF/IDD Provider Payments, ii.*** **is revised and restated as follows with no revisions to subsections 1-2:**

ii. Effective July 1, 2025, the PIHP shall increase reimbursement rates paid to ICFs appearing on the Department's ICF-IID fee schedule posted to the Department's Fee Schedule and Covered Codes website by a uniform dollar amount prescribed by the Department for services furnished by the ICF under revenue codes in the rate book on or after July 1, 2025 and during the rating period of July 1, 2025 through June 30, 2026. The PIHP shall apply the uniform dollar increase to ICF provider reimbursement rates consistent with the timeline requirements of *Section IV.J.1.d.iv.4)*. For any claims that the PIHP is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest consistent with the requirements of *Section IV.J.1.d.iv.*

s. ***Section IV. I. Quality and Value, 1. Quality Management and Quality Improvement, i., i.*** **is revised and restated as follows:**

i. Beginning in Contract Year 2, the Department may implement a quality withhold/incentive program based on a priority set of quality measures used to evaluate the administration of the Medicaid Direct Prepaid Inpatient Health Plan. A subset of the priority set may be included in the Withhold/Incentive Program. The Department reserves the right to add and remove measures from the priority set that may be subject to future withholds

t. ***Section IV. K. Financial Requirements, 2. Medical Loss Ratio*** **is revised to add the following*:***

j. Starting January 1, 2026, the PIHP shall require any risk-bearing Subcontractor, as defined by the Department, to calculate and report the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8(b). The first MLR reporting year for vendors will be January 1, 2026 – June 30, 2026, and aligned with the PIHP rating period thereafter.

i. The PIHP shall require risk-bearing Subcontractors to calculate and report MLR consistent with the Department requirements in 42 C.F.R. § 438.8(d) and 42 C.F.R. § 438.8(k) on an aggregate basis combining experience for Medicaid Expansion Eligible Members and non-Medicaid Expansion populations.

ii. The PIHP's Subcontractor shall apply a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3) using the CMS published credibility factors.

iii. The PIHP's Subcontractor's report shall be submitted to the PIHP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year.

iv. The PIHP may require that all classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity be submitted to the PIHP for review and approval, but only the activities that the PIHP requests to include in the PIHP's MLR calculations must be submitted to the Department.

v. The PIHP shall report the outcome of Subcontractor MLR calculations in the MLR templates and associated instructions to be provided by the Department.

III. Modifications to Section VI. Attachments

Specific Attachments are modified or added as stated herein.

a. ***Third Revised and Restated Attachment A. PIHP Organization Roles and Positions*** **is revised and restated in its entirety as *Fourth Revised and Restated Attachment A. PIHP Organization Roles and Positions* and is attached to this Amendment.**

b. ***Fourth Revised and Restated Attachment D. PIHP Quality Metrics*** **is revised and restated in its entirety as *Fifth Revised and Restated Attachment D. PIHP Quality Metrics* and is attached to this Amendment.**

c. ***Sixth Revised and Restated Attachment I. Reporting Requirements*** **is revised and restated in its entirety as *Seventh Revised and Restated Attachment I. Reporting Requirements* and is attached to this Amendment.**

d. ***Attachment L. Policies, 4. Third Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*** **is revised and restated in its entirety as *Attachment L. Policies, 4. Fourth Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards* and is attached to this Amendment.**

e. ***Attachment L. Policies, Second/Third Revised and Restated Approved <Plan Name> In Lieu of Services*** **is revised and restated in its entirety as *Attachment L. Policies, Third/Fourth Revised and Restated Approved <Plan Name> In Lieu of Services* and is attached to this Amendment.**

f. ***Fifth Revised and Restated Attachment N. Performance Metrics, Service Level Agreements and Liquidated Damages*** **is revised and restated in its entirety as *Sixth Revised and Restated Attachment N. Performance Metrics, Service Level Agreements and Liquidated Damages* and is attached to this Amendment.**

g. ***Attachment R. Business Associate Agreement*** **is revised and restated in its entirety as *First Revised and Restated Attachment R. Business Associate Agreement* and is attached to this Amendment.**

IV. Effective Date

This Amendment is effective January 1, 2026, unless otherwise explicitly stated herein, subject to approval by CMS.

V. Other Requirements

Unless expressly amended herein, all other terms and conditions of the Contract, as previously amended, shall remain in full force and effect.

Execution:

By signing below, the Parties execute this Amendment in their official capacities and agree to the amended terms and conditions outlined herein as of the Effective Date.

Department of Health and Human Services, Division of Health Benefits

_____ Date: _____

Melanie Bush, Deputy Secretary
NC Medicaid

PIHP Plan Name

_____ Date: _____

Plan Authorized Signature

Fourth Revised and Restated Attachment A. PIHP Organization Roles and Positions

Department requires that PIHP staff the following roles. Personnel described in this section, even if the titles are not the same, may perform functions for both the BH/IDD Tailored Plan Contract and the Medicaid Direct Prepaid Inpatient Health Plan Contract. Compliance with similar provisions in the BH I/DD Tailored Plan Contract will be deemed compliance for this Contract.

Section VI. Fourth Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Supervising Care Managers	These individuals are responsible for overseeing assigned care managers delivering Tailored Care Management and care coordination. These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs. These individuals are responsible for ensuring fidelity to the Tailored Care Management model.	• Must meet North Carolina Residency requirements. • If serving Members with BH conditions, must hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD or a TBI must have one (1) of the following minimum qualifications: o A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; OR o A master's degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR o A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI. • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, PIHP and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the enrollee's care manager. • The Department will grant a one-time staff exception ('grandfathering') for specified PIHP staff that: o Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan Contract Award (July 26, 2021). o This exception is based on the staff enrollee possession the required number of years of experience, but not the

Section VI. Fourth Revised and Restated Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		required degree, degree type or licensure type.
2. Care Managers	These individuals shall be responsible for providing: • Integrated whole-person care management under the Tailored Care Management model, including coordinating across BH, I/DD, TBI, LTSS, and Unmet Health-Related Resource Needs; • Care coordination for Members with a behavioral health transitional care need; and • Care coordination for all Members	• Must meet North Carolina Residency requirements. • Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 waiver of experience requirement for Qualified Professionals. • For care managers serving enrollees with LTSS needs: o Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. o This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.
3. Full-time Care Management Housing Specialist(s)	This individual or these individuals act as expert(s) on affordable and supportive housing programs for Members and care managers. This individual or these individuals coordinate with relevant staff at Department or PIHP (e.g., Transition Coordinators and DSOHF staff).	• Must meet North Carolina Residency Requirements
4. Full-Time Transition Supervisor(s)	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	• Must meet North Carolina Residency requirements. • Must meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training.
5. Full-Time Transition Coordinator(s)	This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for: • Individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting.	• Must meet North Carolina Residency requirements. • Transition Coordinators serving individuals with SMI: o Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or o Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. • Transition Coordinators serving individuals with I/DD or TBI: o Must hold a Master's degree in a human services field or licensure as a RN plus one

		(1) year of relevant experience working directly with individuals with I/DD; or o Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. o PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
6. Full-Time Peer Support Specialist(s)	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members with BH diagnoses residing in a state psychiatric hospital or an ACH.	• Must meet North Carolina Residency Requirements. • Must have a North Carolina Certified Peer Support Specialist (NC CPSS) within six (6) months of position state date.
7. Full-Time In-Reach Specialist(s)	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	• Must meet North Carolina Residency requirements. • Must hold a Bachelor's degree in a human services field. • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians. • PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
8. System of Care Family Partner(s)	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold high school diploma or GED. • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid services.
9. System of Care Coordinator(s)	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to PIHP's System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold: o a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or o a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems.
10. DSOHF Admission Through Discharge Manager	These individuals are responsible for: • Coordinating and/or performing transition functions and activities described in Section *IV.G. Care Management* for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. Coordinating and/or performing discharge planning functions for PIHP members who are not receiving transition functions and activities described in Section *IV.G. Care Management* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must meet North Carolina Residency requirements. • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: • Must meet North Carolina Residency requirements. • Must hold:

	Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as PIHP's liaison to ADATCs in the PIHP's region.	○ a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or ○ a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or ○ hold a Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
11. Member Appeal Coordinator	This individual manages and coordinates member appeals in a timely manner.	• Must meet North Carolina Residency requirements.
12. Member Grievance Coordinator	This individual manages and attempts to resolve Member grievances in a timely manner.	• Must meet North Carolina Residency requirements.
13. Full-Time Member Grievance Staff	These individuals work to resolve Member grievances in accordance with state and federal laws and this Contract.	• For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing grievances.
14. Full-Time Peer Review and/or Member Appeals Staff	These individuals work to resolve Member appeals in accordance with state and federal laws and this Contract.	• Peer reviewers must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals.
15. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members	• Must meet North Carolina Residency requirements.
16. Provider Relations and Service Line Staff	These individuals coordinate communications between PIHP and providers.	• Must meet North Carolina Residency requirements.
17. Provider Network Relations Staff	These individuals support the Provider Network Director in network development and management.	• Must meet North Carolina Residency requirements.
18. Provider Grievance Coordinator	This individual manages and resolves provider grievances in a timely manner.	• Must meet North Carolina Residency requirements.
19. Provider Appeal Coordinator	This individual coordinates and manages provider appeals in a timely manner.	• Must meet North Carolina Residency requirements.
20. Full-Time BH/SUD Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing.
21. Full-Time I/DD Utilization Management Staff	These individuals conduct I/DD UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	• Must be a Qualified Intellectual Disability Professional, or Qualified Professional, in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3.

22. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must meet North Carolina Residency requirements.
23. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must meet North Carolina Residency requirements.
24. Special Investigations Unit (SIU) Lead	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, criminal justice, or pre-law, or have at least five (5) years of relevant experience. • Must complete CLEAR training or provide a timeframe as to when it will be complete.
25. Special Investigations Unit (SIU) Staff	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice, or have at least three (3) years of relevant experience.
26. Liaison to the Division of Social Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinated through local DSS offices, and serves as a primary contact to triage and escalate member specific or PIHP questions.	• Must meet North Carolina Residency requirements.
27. Waiver Contract Manager	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1915(i) SPA and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	• Must meet North Carolina Residency requirements. • Minimum of seven (7) years of management experience, preferably in human services
28. Housing Development Coordinator	The Housing Development Coordinator's job responsibilities shall include but not be limited to the following: 1. Map existing permanent supportive housing (PSH), PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process. Utilize the map and other information sources to develop plans to target new stock development or access to untapped existing stock within the PIHP Region. 2. Engage public housing authorities (PHAs), Continuums of Care (COCs), and Balance of State (BoS) with PIHP, NCHFA, grant, and other housing resources to develop housing stock and access throughout the PIHP Region. 3. Develop regional housing databases for the PIHP's Region connecting public stock with private housing options for TCL staff. 4. Utilize public notices of newly initiated housing developments, assertively engage private developers linking them with PIHP, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and	• Must hold a Bachelor's degree with a least two years of experience working with individuals and the housing systems serving people with SMI/SMPI obtaining and maintaining PSH. This position shall apply these skills to the development of permanent supportive housing within the PIHP Region aligned with TCL.

	rehabilitation in exchange for access agreements for individuals with disabilities. 5. Technically assist existing TCL staff and TCL provider engagement with their improved access of computerized housing availability systems, giving priority to, and more effectively offering and getting access for, TCL individuals to Targeted Key Housing. 6. Specify the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams. 7. Ad hoc participation in Local Barriers Committee to address housing barriers and participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations. 8. In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices. 9. In collaboration with DAAS, improve timely communication between DHHS Regional Housing Coordinators, landlords and TCL service providers. 10. Work within the PIHP and with external housing providers to develop Enhanced Bridge Housing, TCL priority to PIHP or Public Housing Authority-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches.	
29. TCL Quality Assurance (QA) Specialist	This position manages TCL Quality Assurance Performance Improvement (QAPI) activities. The TCL Quality Assurance Specialist job responsibilities shall include but not limited to the following: 1. Serve as the organization's TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives. 2. Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of life survey administration, and Root Cause Analyses (RCAs). 3. Develop and implement procedures including member outcomes monitoring to ensure the quality of mental health and employment services and that the frequency and intensity of services are sufficient to help individuals achieve increased independence and community integration, housing stability, and reduced institutional contacts and incidents of harm.	• Must hold a Bachelor's degree with a least two years of experience in QA, preferably in a behavioral or medical managed care environment.

	4. Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits. 5. Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues. 6. Provide support for Local Barriers Committee to identify, aggregate, and report barriers to member community integration and transitions to and maintenance of supportive community housing. 7. Develop and strengthen processes as needed to ensure compliance with and timeliness of required provider reporting, member assessments and surveys, and other data submissions, including incidents of harm reporting via the DHHS IRIS system or its replacement, service outcomes assessments via NC-TOPPS, TCL Quality of Life surveys, and other required data submissions and reporting tools 8. Provide support as needed for TCL team members to develop and implement data collection tools and procedures to ensure all program requirements are met; to support tracking, monitoring, and reporting; and to evaluate and ensure the quality of TCL services and functions	
30. TCL Data Analyst	This position provides data support for TCL Quality Assurance Performance Improvement (QAPI) activities and required reporting and manages and carries out procedures to ensure TCL data accuracy. The TCL Data Analyst's responsibilities shall include but are not limited to the following: 1. Serve as the organization's TCL data quality point of contact for DHHS;. 2. Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVe, internal client data management systems, NCTracks extracts provided by the Department); identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy; 3. Collect and aggregate data for required TCL reporting; 4. Conduct ongoing monitoring to ensure timely Quality of Life survey administration; and 5. Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and	• Must hold a Bachelor's degree with a least two years of experience in data management and analysis, preferably in a behavioral or medical managed care environment.

	evaluation of the effectiveness of QAPI activities and initiatives.	
31. Supported Employment Specialist	This individual's job responsibilities shall include but not be limited to the following: 1. As the PIHP's point of contact, engage in statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE; 2. Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE; 3. Provide direct technical assistance to sustain existing IPS providers by working within the PIHP to implement a stable NC CORE payment model standardized by the Department; 4. Review all provider's current IPS Fidelity Reviews, technically assist with recommended improvements, develop plans of correction for long-standing provider fidelity issues, and when required by reviewers assist during IPS Fidelity Reviews; 5. Facilitate, technically support, record provider feedback, and invite trainers to in-network IPS Collaboratives that include ACT Employment Specialists, and Peer-run Entities involved in IPS support; 6. Ensure and improve providers' NC CORE linkage to Vocational Rehabilitation (VR) offices throughout the PIHP's Region, attend key statewide VR meetings, invite VR offices into IPS collaboratives, and assertively engage VR regional leadership to problem-solve and improve NC CORE service to TCL members; 7. Facilitate the expansion of benefits counseling within network providers, improve VR benefits counseling linkage, and when possible, improve relationships with Social Security Administration offices and IPS providers. Furthermore, serve as the point of contact with the Department for meetings involving the statewide benefits counseling electronic system; 8. Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional PIHP departments; 9. Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve; 10. Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS	• Must hold a Bachelor's degree and have at least two years of experience working with adults with SMI/SPMI. Preference for experience obtaining competitive employment for adults with SMI/SPMI (preferably utilizing Individual Placement and Supports (IPS), Vocational Rehabilitation, or other research-based employment model).

	providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships; and 11. As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models.	
32. Outreach Diversion Specialist	North Carolina Certified Peer Support Specialist with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships. This position applies these skills to Transitions to Community Living for individuals being considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP). The Outreach Diversion Specialist's job responsibilities shall include but not be limited to the following: 1. Educating the member (and their family, as appropriate) on the choice to the remain in the community); 2. Providing referrals and linkages to available individualized community-based supports and services; 3. Developing a Community Integration Plan for those who choose to remain in the community; and 4. Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps taken to address concerns and objections to the admission.	• Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS) within six (6) months of position state date.
33. PIHP Transition Coordinator	This individual shall be solely responsible for performing the following tasks for TCL members, which cannot be delegated to the Tailored Care Manager: (a) Convene a transition team; (b) Schedule and convene transition planning / personal care plan meetings; (c) Facilitate discussion of a crisis plan, disaster plan, and emergency plan; (d) Ensure housing and financial support needs of the TCL member are addressed; (e) Ensure health and safety monitoring needs of the TCL member are addressed; and (f) Plan for and facilitate check-ins between the final transition planning meeting and move-in of the TCL member at the community-based supportive housing.	• Must meet North Carolina Residency requirements. • Transition Coordinators serving individuals with SMI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or ○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. • Transition Coordinators serving individuals with I/DD or TBI: ○ Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD; or ○ Must hold a Bachelor's degree in a human services field or licensure as a RN plus three

		(3) years of relevant experience working directly with individuals with I/DD or TBI. ○ Must meet North Carolina Residency requirements.
34. Olmstead Manager	Provide coordination across PIHP program areas to assist the PIHP in putting in place an array of policies, procedures or practices that support the ADA/Olmstead integration mandate within the PIHP and its provider network.	• Must meet North Carolina Residency requirements. • Must hold: ○ A Bachelor's degree in an area specific to the program from an appropriately accredited institution and three years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience; **or** ○ Master's degree in an area specific to the program from an appropriately accredited institution and two years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience.
35. Housing Supervisor	Role involves but is not limited to the following: • Creating, editing, and implementing existing or new housing policy; • Integrating the housing team into the Plan's TCL efforts and process to develop, fund, and maintain access to supportive housing for TCL members; and • Closely work with the TCL quality assurance staff to provide data reported internally and externally on the Plan's catchment-wide housing strategy, development, access, TCL member tenure, and other housing related issues.	• Five or more years of full time experience working in the field of developing, managing, and/or coordinating access to affordable housing, including without limitation: (1) professional experience in successfully operating a Housing First Model as it applies to people with disabilities transitioning into their chosen community; (2) at least one year as a lead or supervisor of employees in an affordable housing program. • *Any existing staff employed by the PIHP prior to July 1, 2024 in a housing supervisor position shall be grandfathered and shall not be required to meet the qualifications set forth above.
36. TCL Program Manager	Role involves but is not limited to the following: • Facilitate cross-functional teams that create and implement recovery oriented, person-centered care plans; • Create and implement Housing First, Employment First, Integrated Care, Recovery-Oriented Care, and Social Drivers of Health policies and procedures; • Cross-functionally integrate TCL transition efforts across all PIHP departments, and supervise the elevation of transition barriers to the Plan's Local Barriers Committee; and • Closely work with the TCL quality assurance staff to provide TCL data reported internally and externally.	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management • *Any existing staff currently employed by the PIHP prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above
37. Barriers and Training Coordinator	Role involves but is not limited to the following: • Coordinate and help ensure staff completion of all trainings required by the Department pursuant to the Contract for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members; • Develop, coordinate and help ensure staff completion of any additional TCL in-person and	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration.

	virtual trainings which may be required or requested by the Department for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members or the PIHP's TCL efforts; • Coordinate and facilitate BH I/DD Tailored Plan / PIHP's monthly Local Barriers Committee meetings, and track and facilitate any potential barrier issues and questions to be addressed by the BH I/DD Tailored Plan / PIHP and its Local Barriers Committee; • Develop the agenda for Local Barriers Committee meetings, and be responsible for maintaining and forwarding to the Department the minutes of each Local Barriers Committee meeting and the Local Barriers Committee tracker within 14 calendar days after each meeting; • Work collaboratively with Local Barriers Committee members, BH I/DD Tailored Plan / PIHP staff, and network providers to help ensure timely identification and reporting of local barriers; exploration of potential resolutions and mitigation steps for local barriers; and identification of potential barrier patterns, root causes, and any quality improvements needed to mitigate risk and help improve TCL outcomes; • Ensure the Department is notified of any urgent barriers and work collaboratively with the Department to address all unresolved local barriers; • Participate in ad hoc barriers intervention meetings scheduled by the Department; and • Facilitate the identification and tracking of barriers leading to housing separations for TCL members and where applicable, participate in the BH I/TT Tailored Plan / PIHP's root cause analysis process for deaths or level 3 incidents involving TCL members.	• Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management • *Any existing staff currently employed by the PIHP prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above

Fifth Revised and Restated Attachment D. PIHP Quality Metrics

The PIHP will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in North Carolina's Medicaid Quality Measurement Technical Specifications Manual.

Updates to PIHP Quality Metrics

a. The Department will review and update the quality measures annually in January and reflect any updates in North Carolina's Medicaid Quality Measurement Technical Specifications Manual posted on the NC DHHS Quality Management and Improvement website as necessary, to align with the annual January update.
b. The PIHP shall begin to track the updated measures when posted annually in January.
c. The PIHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Fourth Revised and Restated Section VI. Attachment D.* (e.g., for updates to the quality metrics posted in January 2024, the PIHP would report the results in June 2025).

The PIHP will also be required to report the Innovations waiver measures listed, which can be included in reporting for the BH/IDD Tailored Plan. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with PIHPs around these performance measures.

The PIHP will also be required to report the 1915(i) measures listed *in Section VI. Fifth Revised and Restated Attachment D. Table 4: 1915 (i) Performance Measurers*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with the PIHP around these performance measures.

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Section VI. Fifth Revised and Restated Attachment D. Table 1: Survey Measures and General Measures			
Ref #	**CBE #**	**Measure Name**	**Steward**
1.	Reserved		
2.	Reserved		
3.	Reserved		
4.	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA
5	Reserved		
6	Reserved		
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) *	NCQA
8.	Reserved		
9.	2801	Use of Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
10.	Reserved		
11.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
12.	Reserved		
13.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	NCQA
14.	0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
15.	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
16.	N/A	EPSDT Screening Ratio*	NCDHHS
17.	3488	*Follow-Up After Emergency Department Visit for Substance Use (FUA)**	NCQA
18.	0004	*Initiation and Engagement of Substance Use Disorder Treatment (IET)**	NCQA
19.	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN) **	NCDHHS
20.	2801	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA
21.	2940	*Use of Opioids at High Dosage in Persons Without Cancer (OHD) **	PQA
22.	2950	*Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) **	PQA
23.	3400	*Use of Pharmacotherapy for Opioid Use Disorder (OUD) **	CMS

*Department Calculated

Section VI. Fourth Revised and Restated Attachment D. Table 2: Survey Measures and General Measures: Adult			
Ref #	**CBE #**	**Measure Name**	**Steward**
This entire table is reserved.			

Section VI. Fifth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number and percent of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Per Wavier performance measure number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services. Numerator: Number of new C waiver participants who received an initial LOC evaluation.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Number and percent of annual Level of Care evaluations for Innovations Waiver enrollees which were appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
5.	Number and percent of New Level of Care evaluations appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
6.	Reserved.			
7.	Number and percent of Providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Number and percent of new licensed Providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Number and percent of 1915 (c) waiver Providers with a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Number and percent of monitored non-licensed and non-certified Providers, who have been found to be out of compliance and have a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Number and percent of monitored non-licensed, non-certified providers that are compliant with Innovations waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Number and percent of monitored providers agencies wherein all staff completed all mandated training for 1915(c) Waiver.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Number and percent of beneficiaries reporting that their Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Number and percent of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1

Section VI. Fifth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
16.	Number and percent of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
17.	Number and percent of individuals whose annual Individual Support Plan was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
18.	Number and percent of Innovations Waiver beneficiaries for whom an annual Individual Support Plan took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
19.	Number and percent of Innovations waiver participants whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Reserved.			
21.	Number and percent of new 1915(c)-waiver beneficiaries receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Number and percent of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Number and percent of Innovations waiver beneficiaries reporting their Tailored Care Manager helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Number and percent of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percent of deaths where required PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
26	Number and percent of actions taken to protect the beneficiary from additional harm, where indicated as a percent of all actions where protective actions were indicated.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. Fifth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
27.	Number and percent of beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Number and percent of Innovations Waiver beneficiaries not requiring medical treatment or hospitalization due to medication errors.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
29.	Number and percent of incidents that were not critical involving Innovations Waiver enrollees referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Number and percent of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Annually Fiscal Year	November 1
32.	Number and percent of level 2 or 3 incidents where PIHP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Number and percent of level 2 and 3 incidents reported within required state policy timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Reserved.			
35.	Number and percent of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Number and percent of restrictive interventions (both restraint and seclusion) that did not result in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. Fifth Revised and Restated Attachment D. Table 3: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
37.	The number and percent of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver for services rendered.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
38.	Reserved.			
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			
43.	Number and percent of Innovations Waiver enrollees who are receiving services as specified in the Individual Support plan.	NCDHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
44.	Number and percent of Innovations Waiver Members age 21 and older who had a primary care or preventative care visit during the Innovations waiver year.	NCDHHS	Annually Fiscal Year	November 1
45.	Number and Percent of Innovations waiver Members under the age of 21 who had a primary care or preventative care visit during the Innovations Waiver year.	NC DHHS	Annually Fiscal Year	November 1
46.	Reserved.			
47.	Number and percent of capitation payments to the PIHPs that are made in accordance with the CMS approved actuarially sound rate methodology.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
48.	Number and percent of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VI. Fourth Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	Number and percent of new PIHP members who have an independent evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number of PIHP members who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
3.	Number of PIHP members with Serious Mental Illness/Severe Emotional Disturbance who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
4.	Reserved.			

Section VI. Fourth Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
5.	Number of PIHP members with I/DD who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
6.	Number of PIHP members with TBI who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
7.	Number of PIHP members on the Innovations waitlist who received an independent evaluation during the fiscal year.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of independent re-evaluations completed at least annually for PIHP members using 1915(i) services.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 1
9.	Proportion of new independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
18.	Reserved.			
19.	Percentage of beneficiaries reporting that their Care Plan/Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
20.	Reserved.			
21.	Proportion of Care Plans/Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
22.	Reserved.			
23.	Reserved.			
24.	Reserved.			
25.	Reserved.			
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/Individual Support Plan within 45 days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
27.	Reserved.			
28.	Proportion of PIHP members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available.	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of PIHP members using 1915(i) services reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Reserved.			
32.	Reserved.			
33.	Reserved.			

Section VI. Fourth Revised and Restated Attachment D. Table 4: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Frequency**	**Submission**
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly July 1 –September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	Percentage of PIHP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death.	NC DHHS	Annually July 1 – June 30	November 1
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November
37.	Reserved.			
38.	Reserved.			
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident“ and "what can be done to prevent future occurrences" fields.	NC DHHS	Annually Fiscal Year	November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled PIHP members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled PIHP members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled PIHP members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
46.	The percentage of continuously enrolled PIHP members using 1915(i) services who are age twenty (20) or older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Seventh Revised and Restated Attachment I. Reporting Requirements

The following tables detail the reports PIHP must submit to Department.

PIHP shall submit select reports, as identified in *Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements* and *Sixth Revised and Restated Attachment I. Table 2: PIHP Data Extracts*.

1. Although the Department has indicated the reports that are required, PIHP may suggest additional reports.
2. As part of Readiness Review, PIHP shall submit to Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. PIHP shall submit complete and accurate data required by Department for tracking information on Members obtaining Medicaid in Medicaid Direct PIHP and with providers contracted to provide those services.
    a. This information shall include information on Member eligibility for services, Member demographics, adverse events and service outcomes for Members served by PIHP; and in-reach visits, diversion activities, transition planning and leasing and service information for individuals transitioning out of State hospitals and transitioning out of or diverted from adult care homes.
4. PIHP shall submit all data on a schedule provided by Department and shall participate in data quality improvement initiatives specified by Department.
5. PIHP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to Department.
6. PIHP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to Department.

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Administration and Management		
1. PIHP Operating Report	Annual report of each entity identified under the PIHP Operating Report, providing evidence of PIHP oversight activities and entity performance (i.e., metrics, CAPs, sanctions).	Annually
B. Members		
1. Member Services Quality Assurance Report	Quarterly report of survey results which measures Member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PIHP including the total number of appeal and grievance requests filed with the PIHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly
3. PIHP Enrollment Summary Report	Monthly summary report highlighting key member enrollment activities, consistent with 42 C.F.R. § 438.–6(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid eligibility category, number of Member welcome packets sent, and time to distribute Member welcome packets.	Monthly
4. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
5. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
6. CIE Data Collection Tool	Report generated by completion of the CIE Data Collection Tool provided by the Department, regarding individuals receiving Adult	Quarterly

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	Developmental Vocational Program (ADVP) services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment. This report includes without limitation and as applicable the following information regarding the individuals: involvement in post-secondary education, employment assessments, career planning, Supported Employment, Informed Choice Decision Making, engagement in CIE, and the Member's hire date. For members engaged in CIE, the following data is also included: wages earned, and average hours worked per week.	
C. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-Weekly summary of Members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-Weekly
2. EPSDT Reports	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.	Quarterly
3. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver reserved capacity, and list of Members on the Registry of Unmet Needs (waiting list). Report can be included with TP Innovations Waiver Slot and Waiting List Report.	Monthly
4. Reserved.		
5. Monthly CWCN	Monthly report containing the names and member Medicaid ID numbers, and all data fields as outlined in the approved DHHS CWCN data template of members identified as CWCN per the PIHP Plan's Region.	Monthly
6. Ongoing Transitions of Care Status Reports	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the PIHP on an ongoing basis.	Monthly
7. Innovations Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
8. TBI Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
9. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(i) state plan performance measures.	Quarterly
10. Emergency Department (ED) and DSS Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department, DSS Officer, hotel or similar temporary setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the ED over thirty (30) consecutive hours or within one (1) Business Day of notification of DSS boarding, document escalation to appropriate parties including but not limited to the PIHP Clinical Director or designee.	Weekly
11. Daily Reporting on Community Integration Services and Supports	Daily report of information on community integration services (e.g., housing, in-reach and transition, diversion, Assertive Community Treatment (ACT), CST, supported employment, and	Daily

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	other services) for members SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Transition to Community Living Database (TCLD), or other systems determined by the State.	
12. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Daily reporting of rental subsidy and leasing information and updates for individuals including , but not limited to, Members with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) platform or other systems determined by the State.	Daily
13. 1915 Service Authorization Report	Authorized and billed 1915(i), 1915(c), 1915(b)(3) services for community living supports, community networking, supported employment, and supported living.	Quarterly
14. Service Associated Request Report	PIHPs decision regarding the service requested on the Request to Move: Provider Form.	Monthly
15. Brain Injury Screening Report	Quarterly report of Members screened by the PIHPs for brain injury including call date, completion of status screening, age of injury, cause of injury, county, insurance coverage, self-identification status, co-occurring diagnoses, and referrals initiated. The screening data is utilized to analyze the number of Members living with brain injuries, identify prevalence rates, locate geographic concentrations, and aid in developing targeted service delivery strategies. The screening data is used to inform on the number of individuals living with brain injury, prevalence and any geographic concentrations, as well as support the development of targeted service delivery needs and future implementation of the TBI waiver as directed in S.L. 2023-134, Section 9e.16(d).	Quarterly
16. 1915(i) Transition Report	This report tracks the status of individuals transitioning to 1915(i) including assessment completion, assessment submission, and transition to 1915(i) services.	Monthly
D. Care Management and Care Coordination		
1. Care Needs Screening Report	Quarterly report of Member screening results, including Healthy Opportunity & Care Needs Screening of Members who have opted out of TCM or ineligible TCM due to receipt of a duplicative service.	Quarterly
2. Reserved.		
3. TCM Provider Status Change Report	Monthly reporting on tracking TCM provider status changes and the associated decision reasoning.	Monthly
4. TCM Provider Contracting and Integration Report	Monthly TCM Provider contracting and integration status report.	Monthly
5. Data Elements for Enhanced Validation (DEEV) Report	Monthly report. PIHPs will leverage the template to support post-production monitoring for Tailored Care Management (TCM).	Monthly
E. In-Reach and Transitions		
1. IDD In Reach, Diversion, Transition Activity Report	This report is for IDD members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by	Quarterly

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
2. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
3. TBI In Reach, Diversion, Transition Activity Report	This report is for TBI members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by	Quarterly

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
	the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH)	
F. Providers		
1. Reserved.		
2. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
3. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
5. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and corresponding statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
6. Reserved.		
7. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
8. Capitation Reconciliation Report	Monthly report to inform the State of any capitation-related payment discrepancies observed. PIHPs will include records of members where no payment was received from the State or payment received differed from the amount expected. PIHPs will only include member records with discrepancies on this report to the State. The PIHP Capitation Reconciliation Report will be submitted on a monthly cadence. PIHPs will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
9. Reserved		

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
10. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Quarterly
11. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
12. Reserved.		
G. Quality and Value		
1. Reserved.		
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
3. Quality Measures Report	Annual PIHP performance on quality measures.	Annually
4. Reserved.		
5. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
6. Reserved.		
H. Stakeholder Engagement		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PIHP to collaborate with county organizations to address issues by county/Region.	Monthly
2. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
3. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.	Quarterly
I. Program Administration		
1. Reserved		
2. Reserved		
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
J. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the PIHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential fraud, and actual waste and abuse by Participating Providers, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential fraud, and actual waste and abuse by Members, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems pursuant to *Section IV. C. Compliance, 5.* The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The communication includes the Provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.	Quarterly
K. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. 438.3(m).	Monthly
2. PIHP Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the PIHP template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually

Section VI. Seventh Revised and Restated Attachment I. Table 1: PIHP Reporting Requirements (Effective May 1, 2026)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
3. Claims Monitoring Report	This report provides a summary of the claims that have been received and processed by the Health Plan during the reporting period based on the Statuses and Claim Types defined within the report template.	Monthly
4. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to PIHP claim adjustment processing. The PIHP must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc
5. TPL Recovery Match Report	Report detailing those claims upon which the PIHP has been unable to effectuate Third Party Liability (TPL) recovery within one (1) year of the date of service.	Monthly

Section VI. Sixth Revised and Restated Attachment I. Table 2: PIHP Data Extracts (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
A. Members		
1. PIHP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets.	Weekly
2. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of Adverse Benefit Determination issued by the PIHP to a Member and each grievance received by PIHP from Members.	Daily
3. Monthly Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	Monthly
B. Benefits and Care Management		
1. Medical Prior Authorization Extract*	Weekly extract providing information on behavioral health prior approval requests by individual Member, service type, determination date, and approval status. *For BH prior authorization requests only	Weekly
2. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
C. Providers		
1. Reserved.		

Section VI. Sixth Revised and Restated Attachment I. Table 3: PIHP Reporting Requirements for Healthy Opportunities Pilot (Required Only for PIHPs Participating in the Pilot) (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. Healthy Opportunities Pilot Key Metrics Report	Report of Healthy Opportunities Pilot key metrics, including at a minimum: Members served, services used, total service delivery costs, and Member cost and utilization metrics related to the Healthy Opportunities Pilot.	Quarterly
2. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PIHP may submit if the Department notifies the PIHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PIHP's anticipated spending through the remainder of the Pilot service delivery year.	Optional, or at the discretion of the PIHP
3. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of PIHP Pilot service delivery spending.	Monthly
4. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PIHP Pilot administrative fund spending.	Quarterly
5. Reserved.		

Section VI. Sixth Revised and Restated Attachment I. Table 4: TCL Reporting Requirements (Effective July 1, 2025)		
PIHP Report Name	**PIHP Report Description**	**Frequency**
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due last day of the month for the prior month, or the first Business Day following the last day of the month if the last day falls on a weekend or holiday.
2. TCL Annual Service Capacity Report	Capacity analysis for ACT, CST, TMS, Crisis Services and IPS. Includes identification of barriers and projects/steps implemented to remove barriers	Annually Fiscal Year 2025
3. TCL Housing Performance Plan Measures Reporting Template	Report tracking TCL Housing Performance Plan Measures. This report indicates measures for each PHIP per quarter based on their reported Tier 1, Tier 2 Expectations, results provided by the PIHP and the Department's verified results.	Quarterly
4. TCL IPS Population and Utilization Report	Report on IPS TCL population and utilization of the service, includes updates on IPS cohorts (as part of ACT and standalone IPS)	Quarterly
5. TCL IPS Strategic Plan Progress Report	Report on TCL Strategic Plan progress, includes data required as part of the Department approved IPS Strategic Plan (as part of ACT and standalone IPS)	Quarterly

6. TCL ACT and IPS Report	Monthly report to monitor the total number of individuals receiving ACT, In-reach, and transition supports; the number of individuals receiving IPS services, including those served by fidelity teams, and the total that are in the priority population; information on the individuals receiving fidelity IPS services, including In/At-Risk checklist and identification of new IPS or ACT teams	Monthly

Attachment L. Policies, Fourth Revised and Restated Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards

A. Background

The BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards provides the PIHPs with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

B. Behavioral Health Services

i. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.

ii. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.

iii. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.

iv. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.

v. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.

vi. Clinically Managed Low-Intensity Residential Treatment Services: a Medicaid crisis service for the purpose of network adequacy standards.

vii. Clinically Managed Population Specific High-Intensity Residential Program: a Medicaid crisis service for the purpose of network adequacy standards.

viii. Clinically Managed Residential Services: a Medicaid service for the purpose of network adequacy standards.

ix. Clinically managed residential withdrawal management services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.

x. Medically Monitored Inpatient Withdrawal Management Services (Non-Hospital Medical Detoxification): a Medicaid crisis service for the purpose of network adequacy standards.

xi. Reserved.

xii. Reserved.

xiii. Reserved.

xiv. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xv. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvi. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds (ASAM Level 4): inpatient BH services for the purpose of network adequacy standards.

xvii. Medically managed intensive inpatient withdrawal management services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standard.

xviii. Hospitals with Adult Inpatient Substance Use Beds (ASAM Level 4 and ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standards.

xix. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xx. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xxi. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xxii. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xxiii. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xxiv. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xxv. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.

xxvi. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxvii. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxviii. Urgent Care for Mental Health:

1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxv. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards

xxvi. Emergency Services for SUDs: Services to treat life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxvii. Urgent for SUD.

1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxviii. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxix. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

Attachment L. Policies, 7. Third/Fourth Revised and Restated Approved <PIHP NAME> In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid State Plans or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.
The PIHP may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows.

1. The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to the Department by the PIHP demonstrating such cost effectiveness and clinical effectiveness;
2. The PIHP shall ensure that Members are provided the rights outlined in *Section V.F.1.g. In Lieu of Services* for all approved In Lieu of Services;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the PIHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise.

In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process. In accordance with *Section IV.F. Benefits*, the following In Lieu of Services have been approved by the Department:

ILOS that have received conditional approval from the Department are effective through December 31, 2023. If the PIHP wishes to continue offering the conditionally approved ILOS beyond December 31, 2023, the PIHP shall resubmit the Department's standardized ILOS Service Request Form at least ninety (90) Calendar Days prior to December 31, 2023.

Attachment L. 7. Third Revised and Restated Approved Alliance Health In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data**	**Effective Date**
Child Assertive Community Treatment	Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.	Psychiatric Residential Treatment Facility (PRTF) Level III Group Home	Eligible population includes youth with a primary mental health diagnosis. High risk for out-of-home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment. Symptoms at a severity level where PRTF or other intensive residential treatment. The duration of service is up to 28 weeks maximum and provided per week.	H0040 U5 HA	04/01/2023
In Home Therapy Services:	Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or multisystem involvement.	Intensive In-Home Services (IIHS)	Eligible population is for children and adolescents ages 3-20 years of age in need of individual and family therapy services, parenting, and coping skills practice in their environment, as well as some coordination of care due to complex psychosocial situations and/or multisystem involvement. The duration of service is 1 unit per week, with length of service (180 days)	H2022 HE U5 H2022 TS U5	04/01/2023
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions.	Residential Level II Family Type (TFC) Psychiatric Residential Treatment Facility (PRTF)	Eligible population involves a step down from a higher level of care, DSS involvement in the last year, Juvenile Justice involvement in the last 6 months, behavioral health Emergency Room visit and/or hospitalization in the last 6 months, multiple school suspensions within the past year, and crisis intervention in the last 6 months. FCT treats the youth and his/her family through individualized therapeutic interventions. Decrease in crisis episodes and inpatient stays. FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	04/01/2023

			length of stay and reduce the risk of readmission. The duration of service is 6-months		
Transitional Youth Services (TYS)	The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently. The interventions focus on rehabilitating member strengths and skills as well as linking the member to available resources to assist him/her in relearning a sense of accountability for his/her own behavior.	Residential Level II Family Type (TFC) Level III Residential Facility Services	Eligible population is Members who are leaving the foster care or juvenile justice systems, or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. The duration of service is one unit for 9-12 months length of service.	H2022 U5	04/01/2023
Behavioral Health Crisis Assessment and Intervention (BHCAI)	BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting. Members experiencing a behavioral health crisis meeting Emergent or Urgent Triage Standards. BHCAI-Per Event-Per Diem (2-23 hours). Rapid Response-Per Diem (14 days or less).	Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)	Eligible population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	T2016 U5 or T2016 U6	04/01/2023
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders.	Emergency Depts Inpatient Psychiatric Hospitalization	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	04/01/2023

High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW. The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.	Residential Level II Family Type (TFC) Residential Treatment Services Level II Group Home	Eligible population Children, youth, and young adults with Serious Emotional Disturbance (SED) that have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and substance use problems, Involved in (or history of) multiple child-serving systems (e.g., child welfare, juvenile justice). The duration of service is 9-12 months	H0032 - U5	04/01/2023
Short Term Residential Stabilization	Residential Supports provides individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the person's life skills, provide the supervision	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Facility Based Crisis	Eligible population includes individuals in need of and receiving comprehensive and intensive habilitative supports– aggressive, consistent implementation of a program of specialized and generic habilitative training. Medicaid eligible Age 21 or older Meet ICF-IID eligibility criteria and/or the definition of developmental disability. The duration of service is 30 days for initial authorization and for	T2016 TF U5	04/01/2023

	needed, maximize their self-sufficiency, increase self- determination and ensure the person's opportunity to have full membership in his/her community. Residential Supports includes learning new skills, practice and/or improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source. Residential Supports are provided to individuals who live in a community residential setting that meets the home and community-based characteristics. Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be		concurrent is every 30 days. Services maximum is 180 days.		

	billed on the same day as Residential Supports.				
Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)	Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Psychiatric Residential Treatment Facility (PRTF)	Eligible population includes Individuals with Complex Needs are the ages of 5 and under 21, with a developmental and/or intellectual disability and a mental health disorder diagnosis who are Medicaid eligible and at risk of not being able to return to or maintain placement in a community with I/DD diagnosis and meet the ICF/IDD level of care consistent with the Innovations Wavier. The individual also has co-occurring MH diagnosis or significant behavioral challenges for which services and supports require significant experience and expertise in dual diagnosis. Initial authorization is for 120 days and concurrent every 30 days.	H0018 HA	04/01/2023
Long Term Community Supports (LTCS)	Long Term Community Supports (LTCS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community.	Individuals with Intellectual Disabilities (ICF)	Eligible population includes individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. Medicaid eligible: Age 22 or older and meet ICF-IID eligibility criteria	T2016 U5 U1- Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5	04/01/2023-12/31/2024

Attachment L. 7. Third Revised and Restated Approved Partners Health Management In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data**	**Effective Date**
Long Term Community Supports (LTCS)	Long Term Community Supports (LTCS) consist of a broad range of residential and day services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community. LTCS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD). ICF-IID is an all-inclusive service that includes residential and also supports the members' meaningful day activities. Our LTCS service is broken down into 5 levels which delineate the services provided at each level. Each level of our LTCS service supports staffing to create a person-centered meaningful day for the member.	Individuals Community and Residential (ICF-IDD)	Eligible population includes Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; age 22 and over. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services.	T2016 U5 U1 –Level 1 T2016 U5 U2 –Level 2 T2016 U5 U3 –Level 3 T2016 U5 U4 –Level 4 T2016 U5 U6 –Level 5	04/01/2023-12/31/2024
Rapid Response	Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency or licensed alternative family living (AFL) homes that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This	Emergency Department-Family Based Crisis (ED/FBC) Psychiatric Residential Treatment Facility (PRTF)	Target population includes members aged 5-20 with Child MH/SU, including individuals with MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their condition and presenting symptoms. Youth are presenting in crisis, however, do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed.	S9484 U5 (low) S9484 HK U5 (high)	04/01/2023

	emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment, and prevent or minimize the need for out-of-home placements.		Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and reevaluation/assessment and further development of the crisis plan as needed.		
In Home Therapy Services	In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents.	Intensive In-Home (IIHS)	Target population includes children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. Duration of Service is 1 unit a week, 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5	04/01/2023
Assertive Community Treatment Step Down (ACT-SD)	ACT Step-Down (ACT-SD) is the next lower level of care under ACT Team and supports individuals who no longer need the full array of ACT Team services but are not yet prepared to move to office-based care. ACT-SD provides longer-term clinical, and recovery supports of moderate intensity.	Assertive Community Treatment (ACT)	An ACT-SD unit is an event. An event is a 15-minute face-to-face contact defined as lasting at least eight minutes. Only two units may be billed per month, although individuals are expected to be seen by the ACT-SD Team face-to face at least three times per month. 24 units per year- ACT-SD is a longer-term service. Prior Authorization for ACT-SD is required. Initial authorization for services may not exceed six months. Re-Authorization must be conducted every six months. There are no specific limitations on length of stay.	H0040 U5	04/01/2023-05/31/2024
Behavioral Health Urgent Care (BHUC)	Behavioral Health Urgent Care (BHUC) A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital	Emergency Department Visit Inpatient Psychiatric Hospital Admission	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent	T2016 U5	04/01/2023

	Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referrals.		triage standards. The duration of service is per 1 unit per event (2 hours per episode)		
Child Focused Assertive Community Treatment (Child ACT)	Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their community-based home setting. This includes homes, kinship placements, Department of Social Services (DSS) foster homes, or may begin during transition from a Therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED).	PRTF Level III Group Home	Child ACT meets the needs of youth who are at high risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment and Have a history of multiple psychiatric hospitalizations or History of one or more long term (greater than 30 calendar days) psychiatric hospitalization(s) at a state facility or Have a history of multiple episodes of Residential Treatment Services and/or Psychiatric Residential Treatment Facility (PRTF) services. The duration of service is 24 units or 6 months	H0040 U5 HA	04/01/2023
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders	Inpatient Psychiatric Hospitalization	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	04/01/2023
Rapid Care Services Children and Adults with Mental Illness and/or Substance use disorders	Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period to determine if symptoms increase or decrease; response to any administered medication; or	Emergency Department Visit Inpatient Psychiatric Hospitalization	Target population includes members ages 3 and older and provides an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses. Rapid Care Services may be provided to members in crisis who need short-term intensive evaluation, which can include	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High	04/01/2023

	other treatment interventions to determine the ongoing treatment needs of the member.		a multi-disciplinary team of individuals such as clinicians, psychiatrists, nurses, and peer support specialists. The member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation AND the individual's medical needs are stable and appropriate for this level of care. Duration of Service 1 unit per day-Maximus length of service is 23 hours.		
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.	Intensive In-Home Residential Treatment Level III	Target population includes members ages 3-20 with mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is monthly maximum of 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	04/01/2023
Residential Services-Complex Need	Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Inpatient Psychiatric Hospitalization	Target population includes children and adults, ages 5 through 21 with either: Primary mental health (MH) diagnosis and I/DD diagnosis or borderline intellectual functioning with traits that inhibit optimal functioning OR Primary I/DD diagnosis with co-occurring MH diagnosis.	H0018 HA	04/01/2023

Individual Rehabilitation, Coordination, & Support Services	The purpose of this service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the individual's living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, person-centered, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the individual's Person-Centered Plan. This service was developed in response to COVID-19 state of emergency and intended to be used only during a state of emergency, natural disaster, or situation where member is unable to attend PSR on site due to personal extenuating circumstances.	Psychosocial Rehabilitation	Target population includes ages 18 and older for individual has receiving a comprehensive clinical assessment and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or Substance use disorder (SUD). Duration of service is 1-unit per week, 52 weeks.	H2017 U5	04/01/2023
High Fidelity Wraparound (HFW)	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, physical health, child welfare, juvenile/criminal justice, and education), experience serious emotional or behavioral difficulties, have dual	Psychiatric Residential Treatment Facility (PRTF) Residential Level III Placement	Target population includes Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability AND Based on the current comprehensive clinical assessment including the use of the CALOCUS or CANS, functional impairment is demonstrated to indicate this level of service.	H0032 U5	04/01/2023

	diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in PRTFs or other institutional settings, and/or are aging out of Department of Social Services (DSS) care.		Duration of Service is 12-18 months		
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-up to age 21with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently. Transitional Youth Services staff assist and support the member in identifying goals and addressing barriers to independence. This process considers all systems affecting the member, including family, school/work, peers, individual needs, and the community. All services are delivered in the member's natural environment to increase the likelihood of sustaining the progress made during the intervention. The aim of the program is to give members the skills and resources to resolve and prevent future problems in areas like housing, employment, parenting, or involvement with the court or social services. The interventions focus on member strengths and skills, as well as linking the member to available resources. Transitional Youth Services' staff work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning the life skills needed to support themselves, and working or	Residential Level II Family Type (TFC) and Rapid Response Intensive In-Home Services (IIHS)	Target population includes members ages 16-21 are eligible for this service when there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference manual), must demonstrate a deficit in at least one independent living skill or essential life component. Duration of service is 1-unit= 1 month or according to the Benefit Plan. 9 months-12 months	H2022 U5	04/01/2023

	pursuing education. The assigned Transitional Youth Services Staff will work closely with the probation officer, courts, family, and any other involved formal and informal resources to ensure collaboration around the goals of services, interventions being provided, and discharge recommendations.				

Attachment L. 7. Fourth Revised and Restated Approved Trillium Health Resources In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data**	**Effective Date**
Child First	Child First is an innovative, home-based, early childhood intervention, embedded in a system of care that works to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among the most vulnerable young children and families.	Intensive In-Home Therapeutic Foster Care	Target Population includes DSM 5 (or the most current DSM) diagnosis assessed or v-code identified based on developmental delays or behavioral concern identified by a medical professional, therapist, or caregiver. The Family Resource Partner should have a minimum of 1. Families are served for an average of 9 months. Services may continue beyond 12 months with pre-approval from Trillium Health Resources (Trillium) services and the Child First Regional Clinical	H2022 TJ	04/01/2023-06/01/2024
Behavioral Health Crisis Assessment and Intervention (BH-CAI)	A designated service that is designed to provide triage, crisis risk assessment, evaluation, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital Emergency Department.	Emergency Departments	Target population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. (Per Event) 1-Per Person/This service is designed to be completed during regular and extended business hours of Tier III settings up of at least 12 hours; and up to 23 hours, 59 minutes in Tier IV settings.	T2016 U5 or T2016 U6	04/01/2023
Family Centered Treatment (FCT)	Family Centered Treatment is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice. Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is intended to promote permanency goals.	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)	Target Population include ages 03-21 with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	04/01/2023

	FCT treats the youth and his/her family through individualized therapeutic interventions.				
Community Living Facilities and Support (CLFS)	Community Living Facilities and Supports (CLFS) consist of a broad range of services for adults with developmental disabilities who, through the Person Center Plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community. CLFS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities. CLFS for individuals with Intellectual disability is an alternative definition in lieu of ICF-IID under the Medicaid 1915 b benefit. This service enables Trillium to provide comprehensive and individualized active treatment services to adults to maintain and promote their functional status and independence. This is also an alternative to home and community-based services waivers for individuals that potentially meet the ICF/ID level of care.	Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)-Community & Institutional	Target Population includes for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. •Medicaid eligible •Meet NC GS 122c definition for Developmental Disability	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5	04/01/2023-12/31/2024
High Fidelity Wrap-around (HFW)	High Fidelity Wraparound (HFW) is an intensive, team based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual	Level II Group Setting & Program Level II Family Setting & Program	Target Population includes ages 3-20 children, youth, and young adults with Serious Emotional Disturbance (SED) and have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and/or substance use problems. Duration of service is 12 months:	H0032 - U5	04/01/2023

	diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. Typically, this would be for youth with primary mental health diagnosis with co-occurring substance use disorder or an individual with co-occurring intellectual or developmental disabilities in the mild-moderate range. High Fidelity Wraparound is also utilized in a pro-active manner to serve those high-risk youth that are involved with multiple agencies.				
Family Navigator	Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience IDD or TBI. Family Navigator is a way of working with children, adolescents and/or adults with an IDD or TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. home, hospitals, jail, shelters, streets, etc.) using a variety of methods. It is designed as a short-term	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Targeted Population includes ages 3-64 for members diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems. Service is designed to meet the needs of the member. Maximum per month is 40 units (15 minutes) per month	T2041 U5	04/01/2023

	outreach and engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.				
Acute and Subacute Services Provided in an Institute for Mental Disease	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD. Providers must follow the requirements for inpatient level of care outlined in the Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.	Emergency Department Inpatient Stay	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	01/05/2024

Attachment L. 7. Third Revised and Restated Approved Vaya Health In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data**	**Effective Date**
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD.	Inpatient hospitalization Facility Based Crisis	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	04/01/2023
Outpatient Plus	Outpatient Plus ("OPT Plus") is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals of any age with complex clinical needs that basic outpatient therapy cannot adequately address.	Intensive In-Home Community Support Team	Target Population includes members age 4 and older with a mental health or SUD diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material); AND Member does not have service restrictions due to their NC Medicaid program eligibility category that would make them ineligible for this service. Duration of service is one unit equals one hour of service- 412 units with length of service 180 days.	H2021 U5	04/01/2023
Critical Time Intervention Termination effective date: 03/31/2025	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition, CTI defines a	Community Support Assertive Community Treatment Team Emergency Department visits Inpatient Psychiatric Admission	Target Population includes individuals discharge from psychiatric inpatient settings, release from correctional settings, transition out of foster care settings into adult services, transition from homelessness in housing.	H0032 U5 HK	04/01/2023-03/31/2025

	critical transition as occurring within no more than 45 days from the start of service.				
Case Support	Case support activities are performed by an individual employed by a provider agency. The activities are for members who do not have other services in place that provide this type of clinical support and need help coordinating social determinants of health or healthcare services.	Day Treatment Peer Support	There is a DSM-5 (or subsequent editions) diagnosis present, or the person has a developmental disability as defined at N.C.G.S. 122C-3 (12a). Level of Care Criteria, LOCUS/CALOCUS, ASAM, or SNAP/SIS deemed eligible for services based on a documented developmental delay or disability. Has unmet, identified needs from multiple agencies inclusive of, but not limited to, Social Services, Division of Juvenile Justice, school system, health care system. 1-Unit=15 mins (36 to 240 units per person – this is a broad estimate as it is currently unknown as to the length of time members will not have access to the typical service array due to the pandemic)	T1016 U5	04/01/2023-11/30/2023
Behavioral Health Crisis Risk Assessment and Intervention (BHCAI)	A designated service that is designed to provide triage, crisis risk assessment, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital emergency department (ED). Individuals receiving this service have primary behavioral health needs and an urgency determination of urgent or emergent. Individuals receiving this service will be evaluated, stabilized, and/or referred to the most appropriate level of care.	Emergency Department Inpatient Hospital	Targeted Population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. Members experiencing a behavioral health crisis meeting emergent or urgent triage standards. One unit per event-4-6 hours. One per crisis episode. If two visits occur within 30-90 days, the LME/MCO must be notified of the rapid recidivism.	T2016 U5 or T2016 U6	04/01/2023
Family Centered Treatment	Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the	Residential Level II Program Type Residential Level III (1-4 beds)	Target Population includes Children and adolescents (ages 3-21) who have an MH/SUD diagnosis (some with co-occurring IDD) and are at risk of out of home placement or have previously been unsuccessful in residential treatment, or currently in residential treatment where discharge has been delayed due to identified need for family systems treatment.	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	04/01/2023

	child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services. FCT is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.		Duration of service is 6-months:		
Residential Services – Complex Needs	This short-term residential treatment service focuses on members with primary diagnoses of intellectual/developmental disabilities (I/DD) with co-occurring mental health (MH) diagnoses or significant behavioral challenges. The members being served would benefit most from a multi-disciplinary approach with staff that are trained to treat I/DD, MH, and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Target Population includes children and adults with dual diagnoses (I/DD and MH) who have high-level behavioral needs, have experienced multiple placements, and have difficulty functioning in community settings. This service is provided in a small group home or alternative family living setting with very structured supports. Families are actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential treatment settings, such as the member's own home or family home. Duration of service is billed one per day/180 units with length of service 6-months.	H0018 HA	04/01/2023-11/30/2025
Rapid Care Services	Rapid Care Services allow time for extended assessment, which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if symptoms increase or decrease; response to any administered medication;	Emergency Department Inpatient Hospital	Targeted Population includes mental health and/or substance use disorder(s), the member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation. Duration of service is billed as one unit = one event per day and will utilize a two-tiered billing system based on the amount of time spent at the site as outlined below. If a member receives less than 1.5 hours of intervention, the applicable outpatient, psychiatric, or	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High	04/01/2023

	or other treatment interventions to determine the ongoing treatment needs of the member. This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).		other CPT codes would be utilized. This level of care is generally used for a duration of 23 hours or less, with optimal utilization between four to six hours per event. Rapid Care Services may be provided up to 23 hours per episode and will be performed in a facility that operates 24/7/365 days a year under psychiatric supervision. This facility must be able to accept individuals who are currently under involuntary petition for first evaluations.		
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in a Psychiatric Residential Treatment Facility (PRTF) or other institutional settings, or are aging out of Department of Social Services (DSS) care.	Residential Level II	Target Population includes youth with a mental health or substance use disorder diagnosis, youth requires coordination between two or more service agencies, including medical or non-medical providers; and youth has current or past history within the last six months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior Duration of service is 36-48 units per member/12 months; maximum of 18 months.	H0032U5	04/01/2023
In-Home Therapy Services	In-Home Therapy Services (IHTS) consist of evidence-based therapy services and coordination of care interventions provided in the home for individuals with complex clinical needs that outpatient therapy alone cannot adequately address in a time-limited fashion.	Intensive In-Home	Target Population includes a mental health (MH) and/or substance use (SU) diagnosis, symptoms and behaviors at home, school, or in other community settings, due to the member's MH and/or SU disorder, are moderate to severe in nature and require intensive, coordinated clinical interventions; evidence of problems in at least two major life domains that are significantly affecting the member's behavioral health needs. Duration of service is one unit per week with a minimum of two hours combined therapy and coordination of care- 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5	04/01/2023

Enhanced Crisis Response (ECR)	Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible but no longer than two hours from receipt of the referral. For other referrals, response will be on the same day or by the end of the following day.	Emergency Department Inpatient Hospitalization	Target Population includes members ages 3-21 with mental health (MH) diagnoses, co-occurring MH and intellectual/ developmental disability (I/DD) diagnoses, and/or co-occurring MH and substance use disorder (SUD) diagnoses, OR potential diagnoses of the above based on current symptoms/behavioral health needs. This service targets youth abandoned in the ED who are also at risk of intervention from DSS. The expected outcome is that the ECR provider quickly engages the guardian(s), creates a crisis plan, and links the member to services to support the guardian's ability to allow the youth to return home. The service also includes youth in DSS custody (in a DSS foster home or DSS shelter) who are at risk of presenting to the ED as a measure to assist with maintaining the youth in the community. Additionally, the intent of this service is to work with youth who remain inpatient due to difficulty with discharge planning. Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery.	H2011 U5 U1 weekly unit	04/01/2023
Long-Term Community Supports (LTCS)	Long-Term Community Supports (LTCS) is a community-based comprehensive service for adults (age 22 and older) with intellectual/ developmental disabilities (I/DD) that provides individualized services and supports to a person who would otherwise be institutionalized in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Target Population includes members 22 of age or older, meet ICF/IID level of care and/or the definition of developmental disability specified in NCGS § 122C-3(12a). Reside in an ICF/IID (when used for transition from an ICF/IID into a home or community-based setting) or is at risk of being placed in an ICF/IID, and be able to maintain health, safety, and well-being in the community with LTCS and other services and supports delivered in the home or community.	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3	04/01/2023-12/31/2024

Child- Focused Assertive Community Treatment	Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multidisciplinary approach to serve children in their residential setting. This includes homes, kinship placements, and Department of Social Services (DSS) foster homes, or the service may begin during transition from a therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). The team members providing the direct interventions to the child and family may vary based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within one to two hours.	Psychiatric Residential Treatment Facility (PRTF)	Target Population includes at risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment. Duration of service is 1-Unit per week-24 Units-6 months.	H0040 U5 HA	04/01/2023
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses in reestablishing the knowledge and skills necessary to live independently.	Level II Family Type, Therapeutic Foster Care Residential Level II Program Type Residential Level III	Target Population includes members who are leaving the foster care or juvenile justice systems or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. Duration of service is billed one unit per month/The service is expected to achieve outcomes within six to 12 months (six-12 units of service). Additional units may be authorized in exceptional cases as medical necessity dictates. Transitional Youth Services Specialists work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning the life skills needed to support themselves, and working or pursuing education.	H2022 U5	04/01/2023

Assertive Community Treatment Step Down (ACT SD)	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT SD is a community based, person-centered and recovery focused service designed to assist the beneficiary in maintaining stable functioning and wellness while providing support for continued recovery.	Assertive Community Treatment (ACT)	Target Population includes beneficiaries with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six months	H0040 U5	04/01/2023-12/31/2025
Family Navigator	Family Navigators can assist members and families to navigate challenging times and understand the changes in systems through lived experience. NC already offers this for adults who experience mental health and substance use disorders using a peer support model.	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Targeted Population includes Member diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems. Duration of service is 12 months Up to 40 units per month (480 units)	T2041 U5	04/01/2023-11/30/2023
First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) *New ILOS*	First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member's or beneficiary's first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration. First-Episode Psychosis –	Assertive Community Treatment (ACT) Assertive Community Treatment (ACT) Program.	Target Population includes members must have NC Medicaid or NC Health Choice based on residence in a county located within Vaya's region and be enrolled in Vaya's Behavioral Health and I/DD Tailored Plan or NC Medicaid Direct PIHP; The member must between the ages 15-30 years old, currently experiencing first-episode/onset of psychosis. Duration of Service is one event (or per diem) defined as a 15-minute, face-to-face contact, lasting a minimum of eight minutes. Target Population includes members ages 15-30 years old, currently experiencing first-episode/onset of psychosis and has significant functional impairment with performing the range of routine tasks required for age-appropriate functioning in the community.	H0040 HK U5	07/01/2025

	Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member's or beneficiary's first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration.				
Dual Diagnosis Capable (DDC) ACT *New ILOS*	Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD services with MH services. It helps people address both disorders at the same time—through the same	SAIOP Facility-Based Crisis	Target Population include ages 18 and older with a primary SUD diagnosis and a co-occurring MH diagnosis. A member who is appropriate for this service needs assertive engagement to develop treatment motivation. The member does not benefit from receiving services across multiple, disconnected providers, and may be at greater risk of hospitalization, relapse, and/or incarceration.	H0040 HH U5	07/01/2025

	service organization by the same team of treatment providers. Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD services with MH services. It helps people address both disorders at the same time—through the same service organization by the same team of treatment providers.				

Sixth Revised and Restated Attachment N. Performance Metrics, Services Level Agreements and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VI. Sixth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective May 1, 2026)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$1,250 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section III.B.15. Disclosure of Conflicts of Interests* and *Section IV.A.6. Staffing and Facilities.*	$2,500 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.B.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.*	$250 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.B.17. Disclosure of Ownership Interest*.	$625 per contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in *Section III.B.46 Subcontractors.*	Up to $12,500 per occurrence
6.	Failure to open a Medicaid help center case or to confirm or request that DSS open a Rapid Response Team case as described in *Sections IV.O.1.a.* or *IV.O.2.a.* of the Contract within one (1) Business Day of the PIHP receiving a notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract.	$250 per Member per Calendar Day
7.	Failure to develop a *Rapid Response Plan* and attach the Rapid Response Plan to the Member's Medicaid help center or Rapid Response Team case within three (3) Business Days of the PIHP receiving notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract.	$250 per Member per Calendar Day
8.	Failure to update a Member's *Rapid Response Plan* and attach the updated *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last Rapid Response Plan update on a Member for whom the PIHP received notification described in *Sections IV.O.1.* or *IV.O.2.* of the Contract and who is staying in the Emergency Department, DSS Office, hotel, or similar placement while awaiting placement in a clinically appropriate setting for medically necessary behavioral health, I/DD, and/or TBI services.	$250 per Member per Calendar Day
B. Members		
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section IV.E.4. Marketing.*	$1,250 per occurrence
2.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section IV.E.1 Eligibility and Enrollment for PIHP.s*	$125 per occurrence per Member
3.	Reserved.	[redacted]

Section VI. Sixth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective May 1, 2026)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section IV.E.3 Member Engagement.*	Up to $12,500 per occurrence
5.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section IV.E.6. Member Grievances and Appeals.*	$125 per occurrence
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$1,250 per occurrence
7.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section IV.E.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by Department for the timeframe specified by Department. AND $125 per Calendar Day for each day PIHP fails to provide continuation or restoration as required by Department.
8.	Failure to attend mediations and hearings as scheduled as specified in *Section IV.E.6. Member Grievances and Appeals.*	$250 for each mediation or hearing that PIHP fails to attend as required
9.	Failure to comply with Transition of Care requirements as specified *Section IV.G.3. Care Coordination and Care Transitions for all Members.*	$25 per Calendar Day, per Member AND The value of the services PIHP failed to cover during the applicable transition of care period, as determined by Department.
10.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the PIHP in connection with the internal plan appeal within the requirements in *Section III.D. 37 Response to State Inquiries and Request for Information*.	$125 per occurrence.
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	$1,250 per occurrence per Member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section IV.F.1. Behavioral Health and I/DD Benefits Package.*	$1,250 per standard authorization request $1,875 per expedited authorization request
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section IV.H.1. Provider Network.*	$250 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section IV.F.1. Third Revised and Restated Table 6: Required Clinical Coverage Policies.*	$625 per occurrence

Section VI. Sixth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective May 1, 2026)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by *Section IV.G.2. Tailored Care Management.*	$62.50 per Calendar Day
2.	Reserved.	[redacted]
3.	Reserved.	
4.	Reserved.	
5.	Failure to comply with minimum care coordination requirements for members with a BH transitional care need as described in *Section IV.G. Care Management and Care Coordination.*	$62.50 per occurrence per Member
6.	Failure to comply with federal conflict-free case management requirements for Members enrolled in the Innovations Waiver.	$125 per occurrence per Member
7.	Reserved.	[redacted]
8.	Failure to schedule and attend meetings with County Child Welfare Workers for Members involved in the child welfare system, as described in *Section IV.G Care Management and Care Coordination.*	$500 per occurrence
9.	Reserved.	[redacted]
10.	Failure to timely document and honor a Member's request to opt out or opt back in to Tailored Care Management where the Member has submitted a Tailored Care Management Opt-out Form to the PIHP as described in *Section IV.G.2.d.ii.* of the Contract.	$250 per occurrence per Member
11.	Failure to ensure that the Member's choice of Tailored Care Management is processed as described in *Section IV.G.2.f.* of the Contract.	$250 per member per occurrence per member
12.	Failure to comply with minimum Transitional Care Management requirements for Members engaged in Tailored Care Management as described in *Section IV.G.2. Tailored Care Management* of the Contract.	$65 per occurrence per Member
13.	Failure to comply with minimum care coordination requirements for Members with a Behavioral Health transitional care need as described in *Section IV.G.2. Care Management* of the Contract.	$65 per occurrence per Member
E. Providers		
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section IV.H.2. Provider Network Management.*	$250 per confirmed incident
2.	Failure to report notice of provider termination from participation in the PIHP's provider network (includes terminations initiated by the provider or by the PIHP) to the Department or to the affected Members within the timeframes required by *Section IV.H.2. Provider Network Management.*	$25 per Calendar Day per Member for failure to timely notify the affected member or Department
3.	Reserved.	[redacted]
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section IV.H.1. Provider Network.*	$1,250 per Calendar Day
5.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section IV.H.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$625 per month for failure to meet any of the listed standards, either individually or in combination

Section VI. Sixth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective May 1, 2026)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
6.	Failure to timely submit a PIHP Network Data File that meets the Department's specifications.	$62.50 per Calendar Day
7.	Reserved.	[redacted]
8.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section IV.L. Technical Specifications*.	$250 per occurrence
9.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PIHP Network File within one (1) Business Day as specified in *Section IV.H.2. Provider Network Management*.	$25 per provider per Business Day
F. Quality and Value		
1.	Failure to submit all required quality measures including audited HEDIS results within the timeframes specified in *Section IV.I.1. Quality Management and Quality Improvement.*	$1,250 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section IV.I.1. Quality Management and Quality Improvement.*	$250 per Calendar Day
G. Claims and Encounter Management		
1.	Failure to timely submit monthly encounter data set certification.	$250 per Calendar Day
H. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$250 per calendar day
3.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section IV.K.2. Medical Loss Ratio* and *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per Calendar Day
I. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section IV.C. Compliance.*	$1,250 per Calendar Day that Department determines PIHP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section IV.C. Compliance and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$250 per Calendar Day
3.	*Failure to timely submit the Recoveries from Third Party Resources Report described in Section IV.C.4. Third Party Liability (TPL) and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$62.50 per Calendar Day

Section VI. Sixth Revised and Restated Attachment N: Table 1: Liquidated Damages (Effective May 1, 2026)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$625 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to PIHP's own conduct, a provider, or a member.	$62.50 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section IV.C. Compliance and Section VI. Fourth Revised and Restated Attachment I. Reporting Requirements.*	$500 per Calendar Day
7.	Failure by the PIHP, as determined by the Department, to ensure the privacy, security, and confidentiality of any data and/or electronic or hardcopy documents that contain Member Protected Health Information (PHI), in accordance with the standards of the DHHS privacy and security policies, state regulations, and/or federal regulations including: the Privacy Rule at 45 C.F.R. Parts 160 and 164, the Security Rule at 45 C.F.R. Parts 160, 162 and 164, and the applicable provisions of HIPAA and HITECH that results in a breach of a member PHI.	$125 per Member per occurrence AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PIHP's failure to comply with the terms of this Contract, the PIHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
J. Technical Specifications		
1.	Reserved.	[redacted]
2.	Failure by the PIHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per occurrence
3.	Failure by the PIHP to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	$125 per Member per occurrence, not to exceed $2,500,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per Calendar Day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above.	$ 5,000 per occurrence per plan or program
5.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	$125 per Calendar Day for each day the CAP is late, or for each day PIHP fails to comply with an approved CAP
6.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$125 per occurrence.

Table 2: Metrics, SLAs and Liquidated Damages

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PIHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PIHP to its system to trigger enrollment and disenrollment processes.	Daily	$250 per twenty-four (24) hour period Note: Effective one (1) month prior to Medicaid Direct PIHP launch.
2.	Member Welcome Packet Timeliness –Single Mailing of Entire Welcome Packet *Applies if the PIHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	The PIHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during the measurement period.	Monthly	98.99% - 95%:$1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month
3.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PIHP utilizes separate mailings to send components of the Welcome Packet*	The PIHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section IV.E.3. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the PIHP within the required timeframe divided by the total number of new Members enrolled in the PIHP during the measurement period.	Monthly	98.99% - 95%: $1,250 per month 94.99% - 80%: $1,875 per month 79.99% or less: $2,500 per month
4.	Provider Welcome Packet Timeliness	The PIHP shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in *Section IV.H.3.b.iv Provider Relations and Engagement.*	The number of Provider Welcome Packet sent by the PIHP within the required timeframe divided by the total number of new providers who have executed a contract with the PIHP during the measurement period.	Quarterly	97.99% - 95%: $1,250 per quarter 94.99% - 80%: $1,875 per quarter 79.99% or less: $2,500 per quarter

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
B. Member Grievances and Appeals					
1.	Member Appeals Resolution -Standard	The PIHP shall resolve at least ninety-eight percent (98%) of PIHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	96.00%-97.99%= $1,250 per month 95.99% or less= $2,500 per month
2.	Member Appeals Resolution -Expedited	The PIHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	99.01% - 99.49% = $1,875 per month 99.00% or less = $2,500 per month
3.	Member Grievance Resolution	The PIHP shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PIHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	96.00% - 97.99% = $875 per month 95.99% or less = $1,250 per month
C. Care Management					
1.	Contracting with AMH+ and CMAs	The PIHP shall contract with one hundred percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in *Section IV.G.2 Tailored Care Management.*	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the PIHP divided by the total number of certified and willing AMH+ practices and CMAs.	Monthly	$12,500 per month

Section VI. Fifth Revised and Restated Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
D. Encounters					
1.	Encounter Data Timeliness	The PIHP shall submit ninety-eight percent (98%) of encounters within thirty (30) Calendar Days after payment whether paid or denied. *For purposes of this standard, medical encounters include value-based payments to Providers as specified in the Encounter Data Submission Guide.*	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$12.50 per encounter per Calendar Day
2.	Encounter Data Accuracy	The PIHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate. *For purposes of this standard, medical encounters include value-based payments to Providers as specified in the Encounter Data Submission Guide.*	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$6,250 per month
3.	Encounter Data Reconciliation-	The encounters submitted by the PIHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PIHP.	Monthly	$2,500 per month

Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot)

Section VI. Fifth Revised and Restated Attachment N. Table 3: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot) (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
1	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.	$125 per Calendar Day that the Department determines the PIHP is not in compliance
2	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes.	$125 per Calendar Day
3	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes.	$125 per Calendar Day per HSO
4	Failure to comply with the following provisions enumerated in *Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* of to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs:	$125 per occurrence

	• Ensure that PIHP workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data; • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials; and • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment.	

First Revised and Restated Attachment R. Business Associate Agreement

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made between North Carolina Department of Health and Human Services, Division of Health Benefits ("DHB" and "Covered Entity") and PIHP NAME ("Business Associate") (collectively the "Parties").

1. **BACKGROUND**
   a. Covered Entity and Business Associate are Parties to an agreement entitled Contract #30-2022-007-DHB-# Medicaid Direct Prepaid Inpatient Health Plan ("Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
   b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
   c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.
   d. The Parties enter into this Business Associate Agreement as an attachment to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose Protected Health Information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. **DEFINITIONS**

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:
   a. "Electronic protected health information" or "ePHI" shall have the same meaning as the term "Electronic protected health information" in 45 C.F.R. § 160.103.
   b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
   c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a Person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
   d. "Person" shall have the same meaning as the term "person" in 45 C.F.R. § 160.103 and shall include a human being that is born alive, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.
   e. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
   f. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information compiled, created, or received by Business Associate from or on behalf of Covered Entity.

g. “Required By Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
h. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or the Person to whom the authority involved has been delegated.
i. “Security Rule” shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subpart C.
j. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. **OBLIGATIONS OF BUSINESS ASSOCIATE**
   a. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.
   b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the ePHI other than as provided for by this Agreement.
   c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
   d. Business Associate agrees to comply with all applicable requirements of the Security Rule (45 C.F.R. Part 164, Subparts A and C) with respect to electronic protected health information.
   e. Business Associate shall implement physical, administrative and technical safeguards that reasonably protect the confidentiality, integrity and availability of any ePHI that it creates, receives, maintains or transmits on behalf of the NC DHHS.
   f. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410.
   g. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
   h. Business Associate agrees to make available PHI as necessary to satisfy Covered Entity’s obligations in accordance with 45 C.F.R. § 164.524.
   i. Business Associate agrees to make available PHI for amendment and incorporate any amendment(s) to PHI in accordance with 45 C.F.R. § 164.526.
   j. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
   k. Business Associate agrees to make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

4. **PERMITTED USES AND DISCLOSURES**
   a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:

1) Would not violate the Privacy Rule if done by Covered Entity; or
2) Would not violate the minimum necessary policies and procedures of the Covered Entity.

b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
   1) The disclosures are Required By Law; and
   2) Business Associate obtains reasonable assurances from the Person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the Person, and the Person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate shall not use or disclose PHI if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. **Term**. This Agreement shall be effective as of the effective date of the Contract and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
   1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
   2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
   3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.
   1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
   2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. **GENERAL TERMS AND CONDITIONS**
   a. This Agreement amends and is part of the Contract.
   b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
   c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.
   d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

IN WITNESS WHEREOF, Business Associate agrees to and executes this Agreement as of the Effective Date of the Contract.

PIHP NAME

_____ _____

PIHP POC Date
POC Title

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

_____ _____

Melanie Bush Date
Deputy Secretary, NC Medicaid