

**CONTRACT BETWEEN
THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND
EASTPOINTE**

Contract # 31974

This Contract is hereby entered into by and between the North Carolina Department of Health and Human Services (the "Department"), Division of Medical Assistance ("DMA"), and Eastpointe, (herein referred to as, "Contractor" or "PIHP"), a public Medicaid managed care entity, operating as a Prepaid Inpatient Health Plan pursuant to 42 C.F.R. part 438, with its principal place of business in Beulaville, North Carolina (referred to collectively as the "Parties").

1. **Contract Documents:** This Contract consists of this master document and the following Attachments, all of which are incorporated herein by reference:

- The General Terms and Conditions (Attachment A)
- The Scope of Work (SOW) (Attachment B)
- N.C. DHHS Business Associate Addendum (Attachment C)
- Data Protection (Attachment D)
- Consolidated Federal Certifications and Disclosures (Attachment E)
- Contractor Certifications Required by North Carolina Law (Attachment F)
- Vendor Certification of Compliance with N.C.G.S. § 133-32 and Executive Order 24 (Attachment G)
- Definitions (Attachment H)
- Eligibility Categories (Attachment I)
- Schedule of Benefits (Attachment J)
- Statistical Reporting Measures and Late Submission Sanctions (Attachment K)
- Requirements for Performance Improvement Projects (Attachment L)
- Enrollee Grievance and Appeal Procedures (Attachment M)
- Network Provider Enrollment and Re-Enrollment (Attachment N)
- Credentialing and Re-Credentialing (Attachment O)
- Capitation Rates and Rate Setting Methodology (Attachment P)
- Business Transactions (Attachment Q)
- Clinical Coverage Policies, Bulletins and Manuals (Attachment R)
- Access and Availability Standards (Attachment S)
- Mixed Services Payment Protocol (Attachment T)
- Financial Reporting Requirements (Attachment U)
- Medical Care Decisions and Advance Directives (Attachment V)
- Contract Compliance (Attachment W)
- Program Integrity Activities: Criminal Convictions Disclosures (Attachment X)
- Program Integrity Activities: Audits/Self-Audits/Investigations (Attachment Y)
- Program Integrity Activities: Terminations, Provider Enrollment Denials, or other Actions (Attachment Z)
- Medicaid Payment Amounts (Appendix Y)

These documents constitute the entire agreement between the Parties and supersede all prior oral or written statements or agreements.

2. **Effective Period:** This Contract shall be effective July 1, 2015 and shall terminate on June 30, 2016 with the option to extend for an additional one (1) year period.
3. **Contractor's Duties:** PIHP shall provide the services as described in Attachment B, Scope of Work.
4. **Division's Duties:** DMA shall pay PIHP in the manner and in the amounts specified in Attachment B, Scope of Work, and Attachment P, Capitation Rate-Setting Methodology. The total amount paid by DMA to PIHP under this Contract shall not exceed the capitated amount without a written amendment approved by the Parties. DMA will regularly monitor the cost-effectiveness of the Innovations Waiver program and determine whether the number of slots should be modified. If necessary, DMA will submit a waiver amendment to CMS for approval prior to the addition of any slots. Slot additions are subject to increase in Innovations (c) Waiver funding allocations from the North Carolina General Assembly.

5. **Conflict of Interest Policy:**

Contractor is not a nonprofit entity; therefore, a conflict of interest policy is not required.

6. **Reporting Requirements:**

The Department has determined that this is a contract for purchase of goods and services, and therefore is exempt from the reporting requirements of N.C.G.S. § 143C-6-22 & 23.

7. **Payment Provisions:**

Payment shall be made as described in the Scope of Work, Attachment B and in the Capitation Rate-Setting Methodology, Attachment P. The total not-to-exceed amount of this contract is \$263,182,192.

8. **Contract Administrators:** All notices permitted or required to be given by one Party to the other and all questions about the Contract from one Party to the other must be addressed and delivered to the other Party's Contract Administrator. Notices sent to anyone other than the Contract Administrators listed below, the CEO of Eastpointe, or the Secretary of the Department shall not be effective. The name, post office address, street address, telephone number, and email address of the Parties' respective initial Contract Administrators are set out below. The primary means of communication shall be email. Either Party may change the name, post office address, street address, telephone number, or email address of its Contract Administrator by giving written notice to the other Party within three (3) business days of such change.

DMA's Contract Administrator for Program Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Kathy Nichols Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699	Kathy Nichols Division of Medical Assistance 1985 Umstead Drive, Kirby Building Raleigh, NC 27603 Telephone 919-855-4289 Email katherine.nichols@dhhs.nc.gov

DMA's Contract Administrator for Contract Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Nicole Pluchinsky, Contract Officer Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699	Nicole Pluchinsky, Contract Officer Division of Medical Assistance 1985 Umstead Drive, Kirby Building Raleigh, NC 27603 Telephone 919-855-4141 Email nicole.pluchinsky@dhhs.nc.gov

Contract Administrator for Program Issues for Eastpointe:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Anna North QA Director/Waiver Contract Manager PO Box 369 Beulaville, NC 28518 anorth@eastpointe.net (910) 298-7157	Anna North QA Director/Waiver Contract Manager 514 E. Main Street Beulaville, NC 28518 anorth@eastpointe.net (910) 298-7157

Contract Administrator for Contract Issues for Eastpointe:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Anna North QA Director/Waiver Contract Manager PO Box 369 Beulaville, NC 28518 anorth@eastpointe.net (910) 298-7157	Anna North QA Director/Waiver Contract Manager 514 E. Main Street Beulaville, NC 28518 anorth@eastpointe.net (910) 298-7157

9. Outsourcing:

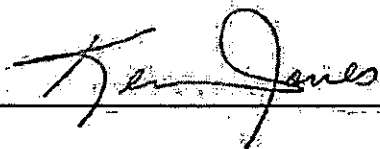
PIHP certifies that it has identified to DMA all jobs related to the Contract that have been outsourced to other countries, if any. Contractor further agrees that it will not outsource any such jobs during the term of this Contract without providing prior written notice to DMA.

10. Signature Warranty:

The undersigned represent and warrant that they are authorized to bind their principals to the terms of this agreement.

In Witness Whereof, PIHP and DMA have executed this Contract in duplicate originals, with one original being retained by PIHP and one being retained by DMA.

For Eastpointe



6/29/2015

Date

ATTEST

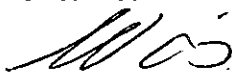


6/29/15

Date

[SEAL]

For North Carolina Department of Health and Human Services
Division of Medical Assistance



6/30/15

Mark Payne, DHHS Chief of Staff

Date

Aldona Wos MD Secretary

ATTACHMENT A
GENERAL TERMS AND CONDITIONS

Relationships of the Parties

Independent Contractor: PIHP is and shall be deemed to be an independent contractor in the performance of this Contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. PIHP represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, DMA.

Assignment: No assignment of PIHP's obligations or right to receive payment hereunder shall be permitted without DMA's consent, which shall not be unreasonably withheld. However, upon written request approved by the issuing purchasing authority, the State may:

- (a) Forward PIHP's payment check(s) directly to any person or entity designated by PIHP, or
- (b) Include any person or entity designated by Contractor as a joint payee on PIHP's payment check(s).

In no event shall such approval and action obligate the State to anyone other than PIHP and PIHP shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract, and all rights of action relating to such enforcement, shall be strictly reserved to DMA and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of DMA and Contractor that any such person or entity, other than DMA or PIHP, receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

Indemnification

PIHP agrees to indemnify and hold harmless DMA, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of PIHP in connection with the performance of this Contract to the extent permitted by law.

Department agrees to indemnify and hold harmless PIHP, and any of its officers, agents and employees, from any claims of third parties arising out of any act or

omission of Department in connection with the performance of this Contract to the extent permitted by law.

Default

Waiver of Default: Waiver by DMA of any default or breach in compliance with the terms of this Contract by PIHP shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this Contract unless stated to be such in writing, signed by an authorized representative of the Department and PIHP and attached to the Contract.

Availability of Funds: The parties to this Contract agree and understand that the payment of the sums specified in this Contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to DMA. The parties further agree and understand that performance by PIHP of the responsibilities specified in this Contract is dependent and contingent upon and subject to the appropriation, allocation, and payment of funds for this purpose to DMA, and subsequent payment to PIHP by DMA in accordance with the terms and conditions of this Contract.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Compliance with Applicable Laws

Compliance with Laws: PIHP shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority. In the provision of services under this Contract, PIHP and its subcontractors shall comply with all applicable Federal and State statutes and regulations, and all amendments thereto, that are in effect when this Contract is signed, or that come into effect during the term of this Contract. This includes, but is not limited to Title XIX of the Social

Security Act and Title 42 of the Code of Federal Regulations.

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by PIHP under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of DMA, except when information, data, instruments, documentation or reports are covered under the North Carolina Public Records Act N.C.G.S. 132. PIHP acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

Oversight

Access to Persons and Records: The State Auditor shall have ready access to persons, property, equipment, and facilities and may examine and copy records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C.G.S. § 147-64.7. Additionally, as the funding authority for this Contract, the Department shall have ready access to persons, property, equipment, and facilities and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: Any records related to the performance of this Contract shall not be destroyed, purged or disposed of except in accordance with APSM 10-6, Local Management Entity Records Retention and Disposition Schedule, and applicable federal regulations governing the retention and disposition of records related to the performance of a PIHP. The Department of Health and Human Services' basic records retention policy requires all records to be retained for a minimum of three years following completion or termination of the contract. If the contract is subject to Federal policy and regulations, record retention will normally be longer than three years since records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this contract has been started before expiration of the three year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three year period described above, whichever is later.

Miscellaneous

Choice of Law and Forum Selection: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are

governed by the laws of North Carolina. The place of this contract and all transactions and agreements relating to it, and their sites and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

Amendment and Modification: This Contract may not be amended or modified orally or by performance. Any amendment or modification must be made in written form and executed by duly authorized representatives of DMA and PIHP. The Purchase and Contract Divisions of the NC Department of Administration and the NC Department of Health and Human Services shall give prior approval to any amendment to a contract awarded through those offices.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this Contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this Contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of this Contract and should not be used to construe the meaning thereof.

Time of the Essence: Time is of the essence in the performance of this Contract.

Key Personnel: PIHP shall notify DMA in writing of any changes in any of the key personnel assigned to the performance of this Contract. The term "key personnel" includes any and all persons identified as such in this Contract and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: PIHP agrees that it shall be responsible for the proper custody and care of any property furnished to it for use in connection with the performance of this contract, if any, and will reimburse DMA for loss of, or damage to, such property. At the termination of this Contract, PIHP shall contact DMA for instructions as to the disposition of such property, if any, and shall comply with these instructions.

Travel Expenses: PIHP shall pay for all travel expenses incurred by PIHP.

Sales/Use Tax Refunds: If eligible, PIHP and all subcontractors shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to N.C.G.S. § 105-164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

ATTACHMENT B
SCOPE OF WORK (SOW)

SECTION 1 - GENERAL PROVISIONS

1.1 Definitions and Construction:

The terms used in this Contract shall have the definitions set forth in Attachment H, except where this Contract expressly provides another definition. References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed to be a part of this Contract.

1.2 Non-Discrimination:

PIHP shall comply with all Federal and State laws which prohibit discrimination on the grounds of race, color, age, creed, sex, religion, national origin, or physical or mental handicap, including Title VI of the Civil Rights Act 42 U.S.C. 2000d and regulations issued pursuant thereto; the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto; Title IX of the Education Amendments of 1972 and regulations issued pursuant thereto; the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et. seq., and regulations issued pursuant thereto; the Rehabilitation Act of 1974, as amended, 29 U.S.C. 794, and regulations issued pursuant thereto; and furthermore shall not use any policy or procedures that discriminate against eligible individuals on the basis of health status or need for health care services.

1.3 Financial Status and Viability:

PIHP's annual financial reports shall be audited in accordance with Generally Accepted Auditing Standards (GAAS) by an independent Certified Public Accountant at PIHP's expense. PIHP shall provide to DMA copies of their most recent annual audit within thirty (30) days of certification to verify PIHP's financial status, solvency and viability. The annual financial audit and cost allocation plans are subject to annual independent verification and audit by DMA staff or a firm of DMA's choosing. The costs for such audits shall be the responsibility of DMA. If determined applicable by DMA, PIHP's annual financial reports may be audited in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A- 87. If determined applicable by DMA, PIHP's cost allocation plan may be audited in accordance with OMB Circular A-122. The DMA Audit Section may also conduct audits of PIHP as determined necessary by DMA. All such audits shall be arranged to occur at dates and times that are mutually agreeable to the Parties, and PIHP shall be provided with reasonable notice of DMA's intent to perform, or cause to be performed, any such audits.

1.4 Departmental Monitoring Team:

DMA will monitor PIHP throughout the term of the Contract. The Department will maintain an Intra-Departmental Monitoring Team (IMT) to provide monitoring and project oversight throughout the course of this Contract. DMA will lead the IMT and have oversight over the Medicaid services covered in this Contract. This IMT shall meet at least four times a year and more often if determined necessary by DMA. The IMT will participate in the External Quality Reviews conducted in accordance with 42 CFR Part 438. Subpart E and ensure the effective operation of PIHP and compliance with State and Federal requirements.

If required by the IMT and requested in writing by the DMA Contract Administrator, PIHP shall develop a Corrective Action Plan to correct deficiencies which are determined by DMA to be severe or recurrent or noted deficiencies that PIHP fails to address in a timely manner. PIHP shall provide the Corrective Action Plan to the DMA Contract Monitor for approval and monitoring until the problem is resolved.

DMA will have the right to impose penalties and sanctions, arrange for Temporary Management, as specified under Section 13, or immediately terminate this Contract under conditions specified in 12.4, independent of the actions of the Intra-Departmental Monitoring Team.

1.5 Scope of Monitoring Activities:

The IMT shall conduct routine and random monitoring to identify problems, deficiencies, and barriers to desired performance, to develop improvement strategies, to determine the need for Corrective Action Plans, and monitor any Corrective Action Plans in place. The Monitoring Review shall include but may not be limited to a review of:

- a. PIHP's compliance with the requirements of this Contract; and
- b. PIHP's compliance with State and Federal laws, statutes, rules and regulations.

The IMT shall also review Performance Indicators, reports and data, and timeliness of submission of reports. Monitoring activities shall be coordinated with Eastpointe to the extent possible.

1.6 Monitoring Process:

The IMT shall use a Continuous Quality Improvement approach to review the performance of PIHP. The IMT shall routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans. The IMT shall monitor improvement strategies and Corrective Action Plans to ensure that identified problems are properly addressed. This process shall document both the challenges and successes of this waiver expansion.

1.7 Conflict of Interest:

As required by 42 C.F.R. § 438.58, no officer, employee or agent of any State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall acquire any personal interest, direct or indirect, in this Contract or in any subcontract entered into by PIHP. No official or employee of PIHP shall acquire any personal interest, direct or indirect, in any Network Provider, which conflict or appear to conflict with the employee's ability to act and make independent decisions in the best interest of PIHP and its responsibilities under 42 CFR Part 438 and other regulations applicable to Medicaid managed care organizations.

PIHP hereby certifies that:

- a. no officer, employee or agent of PIHP;
- b. no subcontractor or supplier of PIHP; and
- c. no member of the PIHP Board of Directors;

is employed by the State of North Carolina, the federal government, or the fiscal intermediary in any position that exercises any authority or control over PIHP, this Contract, or its performance.

Pursuant to CMS State Medicaid Director Letter dated 12/30/97 and Section 1932(d)(3) of the Social Security Act, PIHP shall not contract with the state unless PIHP has safeguards in place that are at least equal to Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

1.8 Restricted Risk Reserve Account:

PIHP shall maintain a restricted risk reserve account with a federally guaranteed financial institution licensed to do business in the state of North Carolina. The following requirements shall apply during the period of this contract:

- a. **Required Minimum Balance:** PIHP shall on a monthly basis deposit into the restricted risk reserve account a minimum amount equal to two (2%) of the capitation payments received from DMA until the amount in the risk reserve account equals fifteen percent (15%) of the total annualized cost of this Contract. Deposits shall be made within 5 business days of receiving the monthly capitation payment.
- b. **Withdrawals or Disbursements:** Withdrawals or disbursements may be made from the restricted risk reserve account in order to fund payments to meet outstanding obligations, such as cost overruns related to program services covered by the Contract, or for any other purpose approved by DMA. For any withdrawals or disbursements that are made, the following requirements apply:
 - 1. **Withdrawal or disbursement notifications:** PIHP must first obtain DMA's prior written approval for any withdrawals or disbursements. DMA will provide a response within 7 calendar days of the request. Expenditures must conform to the requirements for the expenditure of funds under section 1915(b) of the Social Security Act (42 U.S.C. 1396b). The restricted risk reserve shall not be used to pay for items that are not directly related to the provision of services.

2. Replenishing restricted risk reserve account for withdrawals/disbursements: If the risk reserve account drops below the minimum balance required, as a result of withdrawals or disbursements specified in paragraph (1) of this section, PIHP shall deposit on a monthly basis into the restricted risk reserve account an amount not less than 15% of the monthly capitation payments received from DMA until the amount of the withdrawal or disbursement is replenished. PIHP may make contributions to the restricted risk reserve account in excess of the minimum balance required in paragraph (1).
- c. Earnings: All earnings of the restricted risk reserve account shall remain in and become a part of the restricted risk reserve account.
- d. Reporting: PIHP shall report on the status of the restricted risk reserve account monthly as required by Section 9.4 and Attachment U of the Contract.
- e. Failure to Make Required Deposits: If PIHP fails to make deposits to the restricted risk reserve account as provided in items a. and b. of this section, DMA shall send a written notice to PIHP requesting a Corrective Action Plan. PIHP shall submit a written Corrective Action Plan to DMA within 30 working days of the date of the notice. If PIHP fails to submit a Corrective Action Plan that is acceptable to DMA or to implement a Corrective Action Plan that has been approved by DMA, DMA may impose one or more of the sanctions described in Section 12.1 of the Contract.
- f. Termination or Expiration of the Contract: Upon DMA's written satisfaction that PIHP has met all outstanding obligations incurred pursuant to this Contract, the balance of the restricted risk reserve account upon the date of termination or expiration of this Contract shall become the property of PIHP.

1.9 Financial Reporting and Viability Measures:

All funds received by PIHP pursuant to this Contract shall be accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as specified in Section 9.4, Attachment B, and the Financial Reporting Requirements, Attachment U.

DMA shall monitor the Services Expense Ratio and the Administrative Cost Percentage. These expenses shall be analyzed as part of DMA's due diligence in financial statement monitoring and in order to enable DMA to report financial data to CMS.

1.10 Disputes:

Disputes that arise out of this Contract shall be promptly resolved by DMA's Contract Administrators. If either Party identifies a dispute or potential problem with contract compliance, the Contract Administrator shall first obtain all information regarding the issue from the PIHP Contract Administrator and/or relevant Department staff, review all the facts in conjunction with the requirements and terms and conditions of this Contract and confer with Department leadership, if necessary, to determine the appropriate course of action. If the dispute or potential problem is determined to be the fault of the Department or any of its Divisions, agents, employees or subcontractors, the Contract Administrator shall take immediate steps to cure the problem and shall notify PIHP in writing of the timeline for resolution within five (5) business days of such determination. If the dispute or potential problem is alleged to be the fault of PIHP or its agents, employees or subcontractors, the Contract Administrator shall issue a written notice to PIHP advising of the determination and a proposed timeline for resolution or Corrective Action Plan, if necessary. If the dispute is the result of a conflict or lack of clarity within this Contract, the Parties will negotiate an Amendment to resolve the dispute. If the dispute appears to impact more than one PIHP operating under the 1915(b)(c) Waiver, the Contract Administrator shall notify Department leadership, who will develop a plan of action for addressing with multiple PIHPs. The goal of the resolution process is to resolve all problems before they escalate to the next level. The Contract Administrator shall schedule telephone or face to face meetings as necessary in order to achieve resolution without conflict where possible.

If PIHP is not satisfied with the Contract Administrator's decision, PIHP may invoke any legal or administrative remedy available to it under State and Federal law. Pending appeal, PIHP shall proceed diligently with the performance of this Contract, unless PIHP obtains a stay from a court of competent jurisdiction.

1.11 Disclosure of Information on Ownership and Control:

PIHP shall disclose to DMA all information on ownership and control of PIHP prior to the beginning of the Contract term and as set forth in 42 C.F.R. § 455.104 and annually as specified in Financial Reporting Requirements, Attachment U.

1.12 Disclosure of Information on Business Transactions:

In accordance with sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act, contractors that are not Federally qualified HMOs shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act and annually as specified in the Financial Reporting Requirements, Attachment U. Upon request, PIHP and providers must also furnish to DMA and /or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors in accordance with 42 C.F.R. § 455.105(b).

This requirement is detailed further in Attachment Q, Business Transactions.

1.13 Disclosure of Criminal Convictions:

In accordance with 42 C.F.R. § 455.106, PIHP must require all providers to disclose any criminal convictions related to Medicare, Medicaid, or Title XIX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. PIHP shall report such disclosures to DMA within 20 working days from the date PIHP receives such disclosures. Pursuant to 42 C.F.R. § 455.106(b)(1), DMA will report such disclosures to HHS-OIG within 20 working days after notification by PIHP.

Criminal Background Checks of Providers and Persons with Controlling Interest:

In accordance with 42 C.F.R. § 455.434, PIHP must require at enrollment, providers and persons with controlling interest (5% or more) in a provider complete a background check (including fingerprinting) when required to do so under State law or by the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider.

1.14 Excluded Providers:

PIHP shall not employ or contract with Providers excluded from participation in Federal health care programs, including but not limited to exclusion under Section 1128 or Section 1128A of the Social Security Act. DMA shall not reimburse PIHP for any services rendered by Providers excluded as identified above. In addition, PIHP shall not employ or contract with providers excluded from participation in any other North Carolina State health care program, such as Health Choice. DMA will notify PIHP in the event that a provider is excluded from participation in any North Carolina state health care program, including Medicaid and Health Choice, within 20 working days of such exclusion. PIHP shall check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider, including HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM), no less frequently than monthly to ensure that PIHP does not pay federal funds to excluded persons or entities in accordance with 42 C.F.R. § 455.436. PIHP will also develop policies and procedures for appropriate collection and maintenance of disclosure information.

1.15 Prohibited affiliations with Individuals Debarred by Federal Agencies:

Pursuant to 42 C.F.R. § 438.610(a), 42 C.F.R. § 438.610(b) and CMS State Medicaid Director Letter dated 2/28/98, PIHP may not knowingly have a relationship with the following:

- a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a).

The relationship is described as follows:

- a. A director, officer, or partner of PIHP.
- b. A person with beneficial ownership of five percent or more of PIHP's equity.
- c. A person with an employment, consulting or other arrangement with PIHP for the provision of items and services which are significant and material to PIHP's obligations under its contract with the State.

SECTION 2 - CONTRACTOR DESIGNATED AS A SINGLE PREPAID INPATIENT HEALTH PLAN

North Carolina Session Law 2011-264, as amended by Session Law 2012-151, established a public healthcare system capable of managing all public resources available for mental health, intellectual / developmental disabilities and substance use/ abuse (MH/IDD/SA) services through statewide expansion of the 1915(b)/(c) Medicaid waiver, operated since 2005 by Cardinal Innovations Healthcare Solutions, formerly PBH. The goal of expansion of the 1915(b)/(c) waiver is to establish accountability for the development and management of a local system of healthcare that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for persons in need of MH/IDD/SA services; and to use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care for public healthcare beneficiaries in North Carolina through creation of public managed care organizations (MCOs). Given the role of the MCOs to manage all publicly funded MH/IDD/SA services, it is logical and efficient to establish Eastpointe as the single Prepaid Inpatient Health Plan through which all MH/IDD/SA services shall be authorized for Medicaid Enrollees in Eastpointe's catchment area (Nash, Edgecombe, Wilson, Greene, Wayne, Lenoir, Sampson, Duplin, Bladen, Scotland, Robeson, and Columbus Counties).

SECTION 3 - ELIGIBILITY

3.1 Persons Eligible for Enrollment:

To be eligible to enroll in the PIHP established pursuant to this Contract, a person shall be a beneficiary in the North Carolina Medical Assistance (Medicaid) Program in one of the Eligibility Categories listed in Attachment I as determined by the applicable DSS, and with a county of residence for Medicaid eligibility purposes and as set forth in the North Carolina Adult Medicaid Manual of Nash, Edgecombe, Wilson, Greene, Wayne, Lenoir, Sampson, Duplin, Bladen, Scotland, Robeson, or Columbus County.

3.2 Persons Ineligible for Enrollment:

The following categories of people receiving Medicaid are not eligible to enroll in the PIHP operated by Eastpointe:

- a. Medicare Qualified Beneficiaries (MQB);
- b. Non-qualified Aliens or Qualified Aliens during the five year ban;
- c. Medically Needy in deductible status;
- d. Children within the age of 0-36 months, except for Innovations Waiver participants;
- e. Beneficiaries with Presumptive Eligibility; and
- f. Refugee Assistance.

SECTION 4 - ENROLLMENT

4.1 Plan Enrollment:

Individuals receiving Medicaid shall be enrolled in PIHP based on county of residence of Medicaid eligibility. All individuals receiving Medicaid whose county of Medicaid eligibility is either Nash, Edgecombe, Wilson, Greene, Wayne, Lenoir, Sampson, Duplin, Bladen, Scotland, Robeson, or Columbus County shall be subject to enrollment except those persons listed in Section 3.2, above.

4.2 Change of Household Composition:

PIHP shall use best efforts and/or shall require Network Providers to use best efforts, to report to the County DSS any known change in the household composition affecting the Enrollee's eligibility for Medicaid, including changes in family size, marital status or residence, within five working days of such information being reasonably and reliably known to PIHP or its Network Providers.

4.3 Children:

Eligibility for services for children shall begin the first day of the month following the third birthday, except for children participating in the Innovations Waiver. Eligibility for participation in the Innovations Waiver shall begin at birth.

4.4 Effective Date of Enrollment:

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of the Innovations Waiver participants whose enrollment shall be effective on the date of eligibility for participation in the Innovations Waiver.

4.5 Retroactive Disability Determination:

When a retroactive disability determination is made for an Enrollee, the change in payment category shall occur at the time of the change in the Beneficiary's aid program category within DMA's Eligibility Information System (EIS). Changes in beneficiary aid program categories are not generally retroactive for the Blind and Disabled.

4.6 Automatic Disenrollment:

An Enrollee shall be automatically disenrolled from PIHP if the Enrollee:

- a. Changes county of residence for Medicaid eligibility purposes to a county outside the catchment area of Eastpointe;
- b. Is deceased;
- c. Is admitted to a correctional facility for more than thirty days;
- d. No longer qualifies for Medicaid or becomes a beneficiary ineligible for enrollment as defined in Section 3.2; or
- e. Is admitted to a facility that meets the definition of an IMD (Institution for Mental Disease) as set forth in 42 C.F.R. § 435.1010 as determined by DMA and is between the ages of 22 and 64. DMA will notify PIHP in writing of any facility determined to meet IMD criteria.

4.7 Involuntary Disenrollment:

The PIHP is specifically prohibited from engaging in involuntary disenrollment of Medicaid beneficiaries for reasons other than those listed in 4.6 above.

4.8 Disenrollment Date:

When an Enrollee changes county of residence for Medicaid eligibility purposes to a county other than one of the twenty-three PIHP counties, the individual will continue to be enrolled in PIHP until the disenrollment is processed by the Eligibility Information System (EIS). DMA shall continue to pay PIHP a capitated PMPM payment for the Enrollee until disenrollment is effective in the EIS. Disenrollment due to change of residence is always effective at midnight on the last day of the month. PIHP shall be responsible for all medically necessary MH/IDD/SA services to the Enrollee until EIS disenrollment occurs.

SECTION 5 – MARKETING

Because enrollment in PIHP is mandatory, PIHP shall not be required to comply with CMS's marketing regulations.

SECTION 6 - DUTIES AND RESPONSIBILITIES OF PIHP

6.1 Duties of PIHP:

PIHP shall:

- a. Provide all statistical reports identified in Attachment K by the due date listed in Attachment K and at the request of DMA and update those reports as required under this Contract and Attachment K;
- b. Provide timely and accurate clinical reports as delineated in Attachment K and Section 9.5 and at the request of DMA;
- c. Submit Financial Reports as delineated in Attachment U and Section 9.4 in accordance with Generally Accepted Accounting Principles (GAAP) and the most recently monthly report upon request by DMA;
- d. Make available both financial and non-financial data involving Enrollees at the request of DMA;
- e. Provide access to all files, data, and reports to other entities and organizations under contract to DMA for the purpose of conducting audits, studies, data validation and similar activities. Any disputes between other DMA contract entities and PIHP shall be resolved by DMA. If PIHP is not satisfied with DMA's resolution, PIHP may invoke any legal or administrative remedy available to it under State and Federal law;
- f. Employ or contract with professional staff who have all necessary clinical, administrative and financial expertise in managed behavioral health care operations to perform all functions of this Contract;
- g. Have sufficient and documented internal controls and systems in place to account for Contract-related and non-Contract-related revenues and expenses separately, and to prevent and detect fraud or program abuse. Such internal controls and systems shall be documented in the annual PIHP Compliance Plan submitted to DMA in accordance with Section 14.2;
- h. Submit reports as outlined in this Contract and its Attachments as developed and amended by DMA;
- i. Submit ad-hoc reports reasonably requested by DMA at the times mutually agreed upon by DMA and PIHP;
- j. Upon request by DMA, provide clarification on financial reports/accounting issues that arise as a result of analysis by DMA;
- k. Continue to meet the minimum requirements to operate as a defined PIHP; and
- l. Comply with Program Integrity requirements set forth in applicable federal and state law, including but not limited to federal and state reporting requirements.

6.2 Covered Services:

PIHP shall provide, arrange for, or otherwise bear responsibility for the provision of, all Covered Services identified in Attachment J to eligible Enrollees covered under this Contract, through contractual and/or payment arrangements with Network Providers, out-of-network providers, if needed to ensure continuity of and access to care in accordance with 42 CFR § 438.206, and/or providers of Emergency and Post Stabilization care services in accordance with 42 CFR § 438.114. These services shall be provided in the manner set forth in this Contract. The amount, duration, and scope of services must reasonably be expected to achieve the purpose for which the services are furnished. Covered services shall be Medically Necessary and meet EPSDT criteria if applicable for children under 21 years of age, or shall be ordered by the North Carolina Office of Administrative Hearings or a United States District Court, or their respective appellate courts, and shall be provided by a qualified Provider. PIHP shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. PIHP Covered Services are defined in the State Plan, the 1915(b)/(c) Waiver, and the DMA Clinical Coverage Policies, Bulletins and Manuals, which are listed in Attachment R. PIHP shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with requesting Providers when appropriate. PIHP may establish utilization management requirements that are different from State Plan requirements, but are not more restrictive. PIHP may place

appropriate limits on a service on the basis of criteria such as medical necessity and for utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

PIHP and its subcontractors shall have in place and follow written policies and procedures for processing requests for authorizations of services.

Attachment T specifies payment for mixed services; e.g., whether PIHP or the Enrollee's Medical Plan pays for Medicaid covered services.

PIHP shall provide all of the 1915(b)(3) services in the approved waiver when the eligible enrollee meets the requirements and the service limitations are not exceeded, so long as funding for such services is available.

6.3 Emergency Medical Services:

In accordance with Section 1932(b)(2) of the Social Security Act and 42 CFR § 438.114, PIHP shall provide coverage for Emergency Medical Services consistent with the prudent layperson standard, as defined in the Emergency Medical Treatment and Labor Act (EMTALA) of 1986 (Section 1867 of the Social Security Act), as amended by the Balanced Budget Act (BBA) of 1997. Such services shall be provided anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with PIHP.

Pursuant to 42 C.F.R. § 438.114(d):

- a. PIHP shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;
- b. PIHP shall not refuse to cover emergency services based on the emergency room provider or hospital not notifying the enrollee's primary care provider, PIHP, or applicable State entity of the enrollee's screening and treatment within ten calendar days of presentation for emergency services;
- c. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

PIHP shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid Enrollee who is determined to be stable by a medical screening examination, as required by 42 CFR Part 438 and applicable provisions of EMTALA.

As specified in 42 C.F.R. § 438.114(e), post stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 C.F.R. § 422.113(c). PIHP is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by a plan provider or other entity representative. PIHP is financially responsible for post-stabilization care services obtained within or outside PIHP that are not pre-approved by a plan provider or other PIHP representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the entity for pre-approval of further post-stabilization care services. PIHP is financially responsible for post-stabilization care services obtained within or outside the entity that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if—

- a. PIHP does not respond to a request for pre-approval within one hour;
- b. PIHP cannot be contacted; or
- c. PIHP representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, PIHP must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 42 C.F.R. § 422.133(c)(3) is met.

PIHP's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- a. A physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
- b. A physician enrolled with PIHP assumes responsibility for the enrollee's care through transfer;
- c. An PIHP representative and the treating physician reach an agreement concerning the enrollee's care; or
- d. The enrollee is discharged.

PIHP is responsible for educating Enrollees on the availability, location, and appropriate use of Emergency Services and informing Enrollees of their right to use any hospital or other setting for emergency care, as required by 42 C.F.R. § 438.10.

PIHP shall not deny payment for treatment obtained when an Enrollee had an emergency medical condition, as that term is defined in 42 C.F.R. § 438.114(a), even though the absence of immediate medical attention would not, in fact, have led to the outcomes specified in that definition. PIHP shall not deny payment or treatment obtained when a representative of PIHP instructs the Enrollee to seek Emergency Services.

6.4 Accessibility of Services:

In accordance with 42 CFR § 438.206, PIHP shall establish and maintain a Provider Network with a sufficient number, mix, and geographic distribution of Providers to provide adequate access to all services covered under this Contract. PIHP shall ensure, through its written agreements with Network Providers, that medically necessary Covered Services are delivered in a timely and appropriate manner, according to the Access and Availability Standards specified in Attachment S and elsewhere in this Contract.

PIHP shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its Provider Network to meet the needs of all Enrollees, including Enrollees with limited proficiency in English.

PIHP shall conduct analyses of its Provider Network prior to entering into a contract with DMA; at least annually thereafter; and at any time there has been a significant change in PIHP's operations that would affect adequate capacity and services, including changes in services, geographic service areas, payments, or enrollment of a new population in PIHP. In conducting the analyses, PIHP shall consider:

- a. Anticipated membership numbers, characteristics, and needs, including the cultural and language needs of Enrollees;
- b. Anticipated service utilization;
- c. Numbers and types of Providers required to provide the contracted services, including training, experience, and specialization;
- d. The number of Network Providers who are not accepting new referrals; and
- e. The geographic locations of Providers and Enrollees, considering travel distances, travel times, means of transportation, and physical access for Enrollees with disabilities.

PIHP shall submit to DMA a written network development plan, including any reports of findings of the Provider Network analyses. Whenever network gaps are identified, PIHP shall submit to DMA a network development plan within a timeframe specified by DMA, or annually if no time is specified no less than annually.

Provider selection and retention procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment. If Medically Necessary Treatment is required but specialty services are not available in-network, PIHP shall arrange for these services to be provided out-of-network in accordance with 42 CFR § 438.206 and Section 6.5 of this Scope of Work. PIHP shall adequately and timely cover these out-of-network services for as long as PIHP is unable to provide them in-network. PIHP shall ensure that no incentive is given to Providers, monetary or otherwise, for withholding medically necessary services.

PIHP shall:

- a. Establish mechanisms to ensure that Network Providers comply with the timely access requirements specified in Sections 6.5 and 6.6 of this Scope of Work;
- b. Monitor Network Providers regularly to determine compliance; and
- c. Take corrective action if a Network Provider fails to comply. PIHP may, but is not required to, offer plans of correction prior to issuing any sanction or action against a Network Provider.

PIHP shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four hours per day, seven days per week. PIHP shall maintain a record of telephone access-line encounters, including the date of call, type of call, and disposition. PIHP shall educate Enrollees on telephone access and emergency referral procedures.

DMA shall have the right to review periodically the adequacy of PIHP's Provider Network and service accessibility, including but not limited to service locations, the hours of operation, and the availability and appropriateness of telephone response. DMA may require PIHP to take corrective action to improve access. DMA may terminate this Contract if PIHP fails to take corrective action, as specified in Section 12, Default and Termination.

6.5 Customer Services:

PIHP shall provide Customer Services that are responsive to the needs of Enrollees and their families. PIHP's Customer Services shall be monitored in the manner described in SOW Section 7, Quality Assurance and Quality Improvement. Such activities shall include but not be limited to performance improvement projects (SOW Section 7.1); external quality reviews (SOW Section 7.2); and Enrollee grievance and appeals data. In all communications with family members of Enrollees contemplated below, PIHP shall comply with HIPAA and all other applicable confidentiality provisions set forth in state and federal law. PIHP shall:

- a. Respond appropriately to inquiries by Enrollees and their family members (including those with limited English proficiency);
- b. Connect Enrollees, family members, and stakeholders to crisis services when clinically appropriate twenty-four hours per day, seven days per week, 365 days per year;
- c. Provide information to Enrollees and their family members on where and how to access behavioral health services;
- d. Log, acknowledge and attempt to resolve all grievances and provide written notice of the outcome within 90 days of receipt;
- e. Log and acknowledge Enrollee appeals and provide written notice of the outcome as required by 42 C.F.R. § 438.408(e);
- f. Train its staff to recognize third-party insurance issues, Enrollee appeals, and grievances and to route these issues to the appropriate individual or PIHP department;
- g. Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. Eastern Time Monday through Friday, except for designated State or Federal holidays and days that PIHP is closed due to severe inclement weather;
- h. Process referrals twenty-four hours per day, seven days per week, 365 days per year; and
- i. Process Call Center linkage and referral requests for services twenty-four hours per day, seven days per week, 365 days per year.

6.6 Choice of Health Professional:

To the extent reasonably possible, PIHP shall offer freedom of choice to Enrollees in selecting a Provider from within PIHP's qualified Provider Network. PIHP shall ensure a choice of at least two Providers for each service, except specialties specifically identified in Attachment N or otherwise approved as an exception by DMA in writing. Requests for exceptions may be based on such factors as medical necessity and demand. For example, exceptions may be granted if the demand for services, particularly facility based services, specialized services or in rural areas, does not fiscally or operationally support two Providers.

An Enrollee who has received prior authorization from PIHP for referral to a Network Provider or for inpatient care shall be allowed to choose from among all the available Network Providers and hospitals within PIHP, to the extent reasonably possible.

PIHP shall coordinate its services with the services its Enrollees receive from other MCOs, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) in order to avoid unnecessary duplication. In accordance with 42 C.F.R. § 438.208, PIHP shall share with other MCOs, PIHPs and PAHPs serving the Enrollee the results of its identification and assessment of any Enrollee with special health care needs (see

Section 6.13) so that those activities need not be duplicated.

6.7 Facilities and Resources:

PIHP shall provide directly, or indirectly by contract, the following facilities or resources, or staff with the following skill sets or qualifications:

- a. Sufficient numbers of experienced and qualified utilization and care management staff to meet the terms of this Contract. Utilization managers and care managers for individuals with mental health/substance abuse needs **shall be at minimum Master's level Behavioral Health professionals licensed by the State of North Carolina** with a minimum of two years post-Master's experience in a clinical setting with the population served. Nurse Practitioners who are certified as Advanced Practice Psychiatric Nurse Practitioners; Certified Clinical Nurse Specialists who are certified as Advanced Practice Mental Health Clinical Nurse Specialists; Certified Clinical Supervisors; Registered Nurses with two (2) years' experience in mental health or substance abuse treatment are also authorized to review authorization requests for mental health and substance abuse treatment services. Utilization management and care management for developmental disabilities services shall be completed by a 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;
- b. A designated emergency service facility providing care twenty-four hours per day, seven days per week;
- c. Facilities that meet the applicable Federal, State, and local requirements pertaining to health care facilities and laboratories. All clinical laboratory testing sites shall have a CLIA identification number and either a CLIA certificate of compliance, a CLIA certificate of registration, or a CLIA certificate of waiver;
- d. A telecommunications system sufficient to meet the needs of Enrollees twenty-four hours per day, seven days per week. The system shall have an intake line with clinical back-up by a licensed Master's level clinician twenty-four hours per day, seven days per week;
- e. Sufficient support staff;
- f. A physician, **licensed in the State of North Carolina and board certified in psychiatry**, to serve as Medical Director. The Medical Director shall oversee and be responsible for the proper authorization and review of covered services to Enrollees. The Medical Director shall ensure that all staff conducting reviews operate within the scope of their areas of clinical expertise;
- g. A full-time contract manager with at least seven years of management experience, preferably in human services;
- h. A full-time director of management information systems with a minimum of five years' experience in data management and IT project management;
- i. A full-time utilization management director who is a masters-level clinician licensed in North Carolina and has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care;
- j. A full-time clinical director for Innovations (I/DD) services who has a minimum of seven years utilization review, care management, and/or habilitative and case management experience in developmental disabilities care;
- k. A full-time quality management director with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care. The Quality Management Director shall have a Bachelor's Degree in a Human Services Field or a Master's Degree in a human services field;
- l. A full-time finance director with at least seven years' experience managing progressively larger budgets;
- m. A full-time provider network director who is a licensed clinician with at least five years combined clinical, network operations, provider relations and management experience;

- n. A full-time customer services director with at least five years combined customer service, clinical and management experience; and
- o. A designated compliance officer and a compliance committee that are accountable to senior management whose role is to guard against fraud and abuse.

6.8 Information for New Enrollees:

Upon approval of an individual's Medicaid eligibility application, DMA shall send the new Enrollee a written description of the services and benefits provided by PIHP, a written explanation of how to access those services from PIHP, and PIHP contact information.

6.9 Enrollee Written Materials:

Within fourteen days after an Enrollee makes a request for services, PIHP shall provide the new Enrollee with written information on the Medicaid managed care program. PIHP may send information that directs beneficiaries to the PIHP website and instructs beneficiaries to request additional information by mail if they do not have access to the webpage. Written information shall be made available in Spanish and any other non-English languages prevalent in PIHP's service area. Pursuant to 42 C.F.R. § 438.10(c)(1), "prevalent" means a non-English language spoken by a significant number or percentage of potential Enrollees and Enrollees in the State. For purposes of this Contract, a "significant number" is defined as five percent or greater of PIHP's Enrollees. All new Enrollee material shall include at least the following information, as specified in 42 C.F.R. § 438.10(f)(6) and 42 C.F.R. § 438.10(g), which may be included in multiple documents:

- a. A description of the benefits and services provided by PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure that Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan;
- b. A description of all Innovations Waiver services and supports, including a description of Community Guide services and Self-Directed care model(s);
- c. Updates regarding program changes;
- d. A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;
- e. A description of the Enrollee's responsibilities and rights and protections, as set forth in 42 C.F.R. § 438.100;
- f. An explanation of the Enrollee's right to select and change Network Providers;
- g. The restrictions, if any, on the Enrollee's right to select or change Network Providers;
- h. The procedures for selecting and changing Network Providers;
- i. Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided to any Enrollee upon request);
- j. The non-English languages, if any, spoken by each Network Provider;
- k. The extent to which, and how, after-hours and emergency coverage are provided, including:
 - i. What constitutes an Emergency Medical Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR § 438.114 and EMTALA;
 - ii. The process and procedures for obtaining Emergency Services, including the use of 911 telephone services or the equivalent;
 - iii. The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under this Contract;

- iv. That, subject to the provisions of this Contract, the Enrollee has a right to use any hospital or other setting for Emergency Care;
- I. PIHP's policy on referrals for Specialty Care:
 - i. Cost sharing if any; and
 - ii. How to access Medicaid benefits that are not covered under this contract;
- m. Any limitations that may apply to services obtained from Out-of-Network Providers, including disclosure of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of-Network Providers, and the procedures for obtaining authorization for such services;
- n. Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;
- o. Information about medically necessary transportation services provided by the Department of Social Services in each county;
- p. Identification and explanation of state laws and rules governing the treatment of minors;
- q. The Enrollee's right to recommend changes in PIHP's policies and services;
- r. The procedures for recommending changes in PIHP's policies and services;
- s. The Enrollee's right to formulate Advance Directives;
- t. The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;
- u. The accommodations made for non-English speakers, as specified in 42 C.F.R. § 438.10(c)(5);
- v. The availability of oral interpretation service for non-English languages and how to access the service;
- w. The availability of interpretation of written information in prevalent languages and how to access those services;
- x. Information on how to report fraud and abuse; and
- y. Upon an Enrollee's request, PIHP shall provide information on the structure and operation of the company and any physician incentive plans.

The following requirements apply to all printed materials produced for Enrollee use. PIHP shall produce all printed materials in simple, easily understood language and shall produce the materials in more than one format. PIHP shall describe the formats and the means to access them to all Enrollees. PIHP shall produce all printed materials in a manner that accommodates the special needs of those Enrollees with intellectual and/or developmental disabilities, who are visually limited and those Enrollees who have limited reading proficiency. PIHP shall translate all printed materials into the catchment area's prevalent languages. All printed materials intended for Enrollee use will be sent to DMA for approval before the materials are printed for distribution and use.

PIHP shall make oral interpretation of all non-English languages available free of charge to all Enrollees.

PIHP shall give each Enrollee written notice of any "significant change" in the information specified in 42 C.F.R. § 438.10(f)(6) and 42 C.F.R. § 438.10(g) at least 30 days before the intended effective date of the change. A "significant change" is a change that requires modifications to the 1915 b/c Waiver, this Contract or the Medicaid State Plan.

At least once each year, PIHP shall notify all Enrollees of their right to request and obtain the information described above.

6.10 Enrollee Notice of Provider Termination:

When either DMA, PIHP or Provider terminates a Provider Agreement, a Provider Contract, or written agreement with a Network Provider, PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider in the sixty-day period prior to the termination. PIHP shall make good faith efforts to give that notice within 15 calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen calendar days after PIHP terminates the written agreement. PIHP will also electronically copy the DMA Contract Manager, Program Integrity, and Provider enrollment, on all notices of termination of Network Providers.

6.11 Coordination of Care:

For enrollees receiving care coordination, the applicable functions outlined herein shall be performed by licensed or otherwise qualified care coordinators depending upon the population served, including development of an Individual Support Plan or Person-Centered Plan, where applicable. PIHP may provide the following coordination of care functions to Enrollees not receiving care coordination through any mechanism it so chooses.

PIHP shall coordinate Enrollee care by identifying priority populations and performing, at a minimum, the following functions, working within the Four Quadrant Model. PIHP shall have a stated plan for addressing coordination of care needs, including definition of priority populations, levels and types of care coordination tasks, referral pathways to and from medical care managers and other referral sources and resources, and objective outcome measures for care coordination effectiveness (see Attachment K). Coordination of care applies to all Medicaid eligibles for whom PIHP receives a capitation payment, including but not limited to those with dual eligibility (Medicare and Medicaid) and those served under the Innovations Waiver. Additional functions of care coordination for beneficiaries on the Innovations (c) Waiver shall include but are not limited to the following:

1. Assisting the individual with completion of a person-centered toolkit in the completion of the plan;
2. Reviewing the team composition with the individual to make sure that the people the participant would like to have at the meeting are invited;
3. Reviewing with the team all issues that were identified during the assessment processes;
4. Reviewing all information in CCNC Provider Portal and notifying the NCCCN network about the LME-MCO care coordinator and offering the chance to participate in team meetings if the individual agrees;
5. Guiding the development and submission to Utilization Management of the Individual Support Plan (ISP), based on assessed need and living arrangements, at least annually;
6. Explaining the Supports Need Matrix, the service authorization process, and the mechanisms available to the participant to modify their budget;
7. Care Coordinators shall explain how an Enrollee may submit a grievance or an Enrollee's right to a State Fair Hearing, as applicable;
8. Assisting the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP including providing provider listings and arranging provider interviews;
9. Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal;
10. Maintaining close contact with the participant, the legally responsible person or parent or guardian (if applicable), providers, NCCCN care manager (if applicable), and other members of the person centered planning team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner; Answering any questions that the participant/family may have regarding available services;
11. Offering information on individual/family directed supports;
12. Assisting in the appointment of the representative for self-direction, if needed;
13. Assessing the employer of record, managing employer, and representative, if applicable, to determine the areas of support needed to self-direct services;
14. Providing information to waiver participants about their rights, protections and responsibilities, including the right to change providers and the grievance and complaint resolution process;
15. Following up and resolving any issues related to the participant's health, safety or service delivery, bringing any unresolved issues to the attention of the PIHP and provider agency for resolution;
16. Ensuring that services and supports are provided in the most integrated setting;
17. Verifying that participant is satisfied with the services and supports they are receiving;
18. Completing annual re-assessment of level of care;
19. Ensuring that the Freedom of Choice statement is completed;
20. Completing the NC Innovations Risk/ Support Needs Assessment prior to the development of the ISP and updating as significant changes occur with the participant at least annually;

21. Monitoring at least quarterly to ensure any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support plan, as well as the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee;
22. Monitoring services on site to identify potential fraud and abuse and ensure that services are furnished in the best interest of the individual. Monitoring will take place in all service settings and on a schedule outlined in the ISP. Monitoring methods also include contacts (face-to-face and telephone calls) with other members of the ISP team and review of service documentation.
 - a. A standard monitoring checklist shall be used to ensure that the following issues are monitored:
 - i. Verification that services are provided as outlined in the ISP.
 - ii. Participants have access to services and identification of any problems that may arise.
 - iii. The services meet the needs of the participants, that the back-up staffing plans are documented.
 - iv. Issues of health and welfare (rights restrictions, medical care, abuse/neglect/exploitation, behavior support plan) are addressed and that participants are offered a free choice of providers and that non-waiver services needs have been addressed.
 - b. Care coordinator monitoring shall occur monthly to ensure that:
 - i. Participants that are new to the waiver receive face-to-face visits for the first six months and then on a schedule agreed to by the ISP team thereafter, no less than quarterly, to meet their health and safety needs.
 - ii. Participants whose services are provided by guardians and relatives living in the home of the participant receive monthly face-to-face monitoring visits.
 - iii. Participants who live in residential programs receive face-to-face monitoring visits monthly.
 - iv. Participants who choose the individual family directed service option receive face-to-face monitoring visits monthly.
 - v. For months that participants do not receive face-to-face monitoring, the care coordinator has telephone contact to ensure that there are no issues that need to be addressed.
 - vi. At least one service is utilized monthly, per waiver eligibility requirements.
 - vii. That services utilized do not exceed authorization. If there is an emergency, the care coordinator should ensure that enrollee needs are met and ensure that any updates to the LOC and ISP, based upon the changes in needs of the individual, are processed in a timely manner.

If an individual chooses not to participate in the Innovations Waiver and may be eligible for Medicaid or other Medicaid funded services, the care coordinator shall inform the individual of the other services and supports that may be available in lieu of waiver services.

The care coordinator shall assist in coordinating and linking all Medicaid funded services for the individual, as appropriate. The care coordinators may not exercise prior authorization authority over the Individual Support Plan.

a: **Care Coordination Functions**

Care coordination shall involve connecting Enrollees to the appropriate level of care and ensuring they remain connected by identifying and addressing needs and barriers to treatment engagement. Clinical functions of care coordination shall be carried out by licensed care coordination staff for MH/SA care coordination or by Qualified Professionals for care coordination for beneficiaries with Intellectual/Developmental Disabilities. Clinical functions include but are not limited to identification of clinical needs and determination of level of care through case review, enrollee contacts, and arranging for assessments, clinical judgment in communication with providers, and assistance with and oversight of Individual Service Plans and other clinical interventions. Administrative care coordination functions may be carried out by non-licensed staff working in a consultative role with the clinical care coordination staff. Administrative functions may include but are not limited to addressing additional support services and resources, assisting Enrollees with arranging appointments, educating Enrollees about other available supports as recommended by clinical care coordinators, and making phone calls to monitor Enrollee attendance in treatment.

PIHP shall coordinate Enrollee care by performing, at a minimum, the following care coordination/ Care Management functions.

- 1) **Minimums for All Enrollees, Based on Need – All clinical functions must be performed by designated licensed care coordinators for the mental health and substance abuse populations. Some of the following non-clinical functions may be performed by individuals employed by PIHP who are not designated as care coordinators.**
 - a) PIHP shall be available twenty-four hours per day, seven-days per week, to perform telephone assessments and crisis triage for Enrollees receiving care coordination.
 - b) PIHP shall coordinate and monitor behavioral health hospital and institutional admissions and discharges, including discharge planning;
 - c) PIHP shall encourage enrollment in a NCCCN medical home and coordinate care with the NCCCN care manager (if applicable);
 - d) PIHP shall ensure that each Enrollee's privacy is protected in accordance with State and Federal law.
 - e) PIHP shall develop engagement strategies for all Enrollees assigned a care coordinator, including identification of barriers to treatment, treatment needs, and referral needs.
 - f) PIHP shall provide Enrollees with education about all available MH/IDD/SA services and supports, as well as education about all types of Medicaid, state-funded services, and unpaid community supports.
 - g) PIHP shall provide linkage to needed psychological, behavioral, educational, and physical evaluations;
 - h) PIHP shall oversee development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the Enrollee, family, and other all service and support providers;
 - i) PIHP shall monitor the ISP, PCP, and health and safety of the Enrollee;
 - j) PIHP shall coordinate Medicaid eligibility and benefits including NCCCN medical home enrollment;
 - k) PIHP shall offer the same level of care coordination to Medicare/Medicaid dual eligibles for whom the PIHP is paid a capitation payment as is offered to Medicaid-only Enrollees.

2) **Care Coordination for Special Healthcare Needs Population**

PIHP shall identify Enrollees who have the following special healthcare needs.

- a) Individuals with special health care needs are defined as:
 - i) Intellectual and/or Developmental Disabilities:
The following Enrollees are considered a part of the Special Healthcare Needs Population:
 - a. Individuals who are functionally eligible for, but not enrolled in, the Innovations Waiver, who are not living in an ICF-MR facility; or
 - b. Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Division of Juvenile Justice of the Department of Public Safety (DJJ) for whom PIHP has received notification of discharge.
 - ii) Child Mental Health:
The following Enrollees are considered a part of the Special Healthcare Needs Population:
 - a. Children who have a diagnosis within the diagnostic ranges defined below:

293-297.99	298.8-298.9	300-300.99	302-302.6	302.8-302.9	307-
307.99	308.3	309.81	311-312.99	313.81 13.89	995.5-
995.59 V61.21					

AND

Current CALOCUS Level of VI; or

b. Children with an MH or SA diagnosis who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJ or DOC for whom PIHP has received notification of discharge.

iii) Adult Mental Health:

Adults who have a current LOCUS Level of VI and a diagnosis within the diagnostic ranges of:

295-295.99	296-296.99	298.9	309.81
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iv) Substance (non-Opioid) Dependent: Individuals with a substance dependence diagnosis AND Current ASAM PPC Level of III.7 or II.2-D or higher.

v) Opioid Dependent: Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past thirty days.

vi) Co-occurring Diagnoses:

The following Enrollees are considered a part of the Special Healthcare Needs Population:

a. Individuals with both a mental illness diagnosis and a substance abuse diagnosis AND Current LOCUS/CALOCUS of V or higher OR current ASAM PPC Level of III.5 or higher.

b. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis AND current LOCUS/CALOCUS of IV or higher.

c. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis AND current ASAM PPC Level of III.3 or higher.

b) Care Coordination Functions for Special Healthcare Needs population:

PIHP shall prioritize and assign care coordination for Enrollees within the special healthcare needs population and may identify additional priority populations. However, the special healthcare needs population defined here shall receive highest priority for care coordination. Care coordination functions should include the minimums for the general Medicaid population listed above as well as the following as clinically indicated:

i) Pursuant to 42 C.F.R. Part 438.208(c), PIHP shall implement mechanisms to assess each Medicaid Enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring; assessment mechanisms must use appropriate health care professionals, including the Enrollee's primary care physician/NCCCN medical home.

ii) For Enrollees with special health care needs who need a course of treatment or regular care monitoring, PIHP shall be responsible for ensuring that a treatment plan is produced by the treating provider. For Enrollees with recent crisis utilization not engaged in treatment with a behavioral health provider, PIHP shall be responsible for developing a crisis plan and sharing this plan with future providers to be included in the treatment plan. PIHP must ensure that the treatment plan meets the following requirements:

(1) Includes Enrollee participation in the treatment planning process;

(2) Is developed with input from the Enrollee's primary care case manager with Enrollee participation, and in consultation with any specialists' care for the Enrollee. The Enrollee or legally responsible person must sign the treatment plan in order for the service

- authorization request to be processed by Utilization Management. In the event that the Enrollee or legally responsible person does not agree with the treatment plan as developed, they will be given the option of submitting an alternate treatment plan or submitting the treatment plan as developed with a written statement or notation of their disapproval of the treatment plan;
- (3) Allows Enrollees with special health care needs to directly access specialists as appropriate for the Enrollee's condition and identified needs.
 - (4) Complies with Quality Monitoring and the Continuous Quality Improvement Process to ensure that individual treatment plans are developed consistent with 42 C.F.R. § 438.208 and Part 456; and
- iii) Care coordination provided to children in the Special Healthcare needs population should be consistent with the "System of Care" philosophy. Care coordinators must:
- (1) Use a Child and Family Team (CFT) as the mechanism for developing Person Centered Plans (PCP), facilitate the planning process.
 - (2) Build each CFT around the youth and family to meet their unique needs; and include relevant public and private providers including the NCCCN medical home, NCCCN care manager (if applicable), schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the PCP.
 - (3) Ensure completion of a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community and use them to build strategies
 - (4) Included in the PCP which is based on the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT, including sensitivity to racial, ethnic, linguistic and cultural differences of each family.
 - (5) Promote service delivery within the context of families and develop strategies built on social networks and natural or informal supports.
 - (6) Design strategies with consideration given to maximizing the skills and competencies of family members to create greater self-sufficiency for parents and youth
 - (7) Make significant efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs.
 - (8) Ensure regular updates to PCP to take into account changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.
 - (9) Ensure development of proactive and reactive crisis plans in conjunction with the PCP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT is provided a copy of the plan.
 - (10) Ensure that the majority of care coordination be performed in the community at locations and during times that are most convenient for the family and conducive to the active participation of CFT members.

3) Care Coordination for At-Risk-for-Crisis Enrollees

PIHP shall provide follow-up activities for all At-Risk for Crisis Enrollees:

a) At-Risk for Crisis Enrollees include the following:

- i) Enrollees who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or
- ii) Enrollees for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; or
- iii) Enrollees discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis or general hospital unit following admission for a BH or I/DD condition;

b) Follow-up activities shall include the following:

- i) Notify an Enrollee's assigned behavioral health provider of emergency or inpatient utilization if connected to a provider;
 - ii) Consult with any assigned behavioral health provider and NCCCN care manager to address appropriate level of care;
 - iii) Directly identify and address barriers to appropriate treatment for enrollees not yet connected to appropriate treatment providers (e.g., transportation, need for further clinical assessment, identification of available resources, referrals); and
 - iv) Monitor connectedness to treatment until Enrollee is no longer considered At-Risk or is well-connected to treatment.
- c) PIHP shall use best efforts to develop relationships with local emergency departments, hospitals and facilities in order to receive timely notification of Enrollee admissions, discharges and emergency utilization.

b. **Four Quadrant Model for Collaboration with CCNC**

The Four Quadrant Care Management Model determines whether an individual's primary concerns are related to physical health (PH) or behavioral health (BH) and assists in determining whether the Primary Care Case Management (PCCM) network or PIHP takes the lead on high risk/high cost Enrollees. Determination of appropriate Quadrant for a given Enrollee is a clinical judgment that can be reached in consultation with partner agencies (e.g., PCCM) based on the Enrollee's current Medical and MH/IDD/SA condition complexity and risk level. Enrollees may move throughout the Quadrants over time and as conditions change. Whenever an Enrollee is receiving care coordination, PIHP shall determine whether the Enrollee is also being managed by a PCCM care manager and collaborate with that PCCM care manager.

1) Four Quadrants

- a. Quadrant I
 - i. Defined as Enrollees with low MH/IDD/SA and low physical health complexity or risk
 - ii. Enrollees determined to fall into Quadrant I are not likely to need Care Coordination, but are likely best served through AccessLine/STR referral services.
- b. Quadrant II
 - i. Enrollees with high MH/IDD/SA health complexity or risk and low physical health complexity or risk.
 - ii. Enrollees in Quadrant II are the sole responsibility of PIHP and the BH provider to meet MH/IDD/SA needs, as well as to arrange for appropriate referrals for identified physical health needs.
- c. Quadrant III
 - i. Defined as Enrollees with low MH/IDD/SA and high physical health complexity or risk
 - ii. Enrollees determined to fall into Quadrant III are not likely to need intensive Care Coordination, and may be served through AccessLine/STR referral services, depending on level of need and risk for developing significant behavioral health complications.
- d. Quadrant IV
 - i. Enrollees in Quadrant IV have a high level of both MH/IDD/SA and physical health complexity or risk.
 - ii. Enrollees in Quadrant IV are the joint responsibility of PIHP and the BH Provider as well as the PH providers involved in care (including Primary Care Provider and PCCM network if enrolled in PCCM). If an Enrollee is receiving care management through PCCM, PIHP Care Coordination and PCCM Care Managers will jointly determine primary responsibility. If not enrolled in PCCM, PIHP shall involve any applicable healthcare providers in coordination of care.
 - iii. When PIHP is determined to be the lead Care Coordinator, PIHP is responsible for updating the PCCM Care Manager on any medical issues and engaging the Care Manager for

assistance as needed. PCCM Care Managers will retain responsibility for medical aspects of care management in conjunction with PIHP Care Coordinators.

- iv. When PIHP is not determined to be the lead for Care Coordination, PIHP shall collaborate with the primary PCCM Care Manager, offering Care Coordination functions as needed and monitoring the Enrollee's MH/DD/SA engagement. PIHP shall continue to communicate enrollee status to the assigned PCCM Care Manager.

2) Referrals:

- a. Referral pathways shall be developed between PCCM and PIHP.
- b. PIHP shall receive Care Coordination referrals from PCCM Care Managers, determine what level of Care Coordination services are needed, if any, and provide referral status feedback to referring Care Manager;
- c. PIHP shall initiate Care Management and physical health referrals to PCCM as such needs are identified, and receive and document feedback from PCCM regarding the referral status; and
- d. If Care Coordination is not warranted, PIHP shall notify referral source and offer other options for assistance from PIHP in getting the Enrollee connected to treatment.

3) Coordination with PCCM:

- a. PIHP shall ensure the coordination of care with each Enrollee's primary care Provider/PCCM physician /medical home for Enrollees receiving care coordination;
- b. PIHP shall include any assigned PCCM Care Managers in the development of an Enrollee's Individual Service Plans;
- c. PIHP shall involve any assigned PCCM Care Managers in the development and implementation of crisis plans so that both parties may respond appropriately to Enrollee crises; and
- d. PIHP, with the assistance of PCCM, will encourage, support and facilitate communication between Primary Care Providers and BHPs regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons determined to have need.

4) Care Coordination Specific to the Innovations Waiver

When discussing a proposed plan of care with an Innovations Waiver participant, a Care Coordinator shall discuss the duration of the service requested by the participant, and the Care Coordinator shall assure that the proposed plan of care requests authorization for that service at the duration requested by the participant during that plan year.

6.12 Education and Training for Enrollees:

PIHP shall, on an on-going basis, offer education and training about relevant behavioral health topics and issues identified by PIHP, Enrollees, family members, stakeholders and other interested persons. Such education and training shall be available at convenient times, in accessible locations, and at no cost to attendees. Topics may include:

- a. Behavioral Health Referral;
- b. Access to Care;
- c. Appeals and Grievances;
- d. Enrollee/ Member Rights;
- e. Suicide Prevention;
- f. Signs of Mental Illness;
- g. Risks of Substance Abuse;
- h. Substance Abuse Prevention;

- i. Community Guide;
- j. Self-Directed Service Model(s);
- k. Supports Intensity Scale (SIS); and
- l. Resource Allocation.

PIHP shall keep attendance records of all Behavioral Health Education Activities offered by PIHP, and shall make the attendance records available for review by DMA and/or the IMT during on-site reviews.

Education and Training for Innovations Waiver Participants:

PIHP shall develop stakeholder group(s) consisting of Innovations Waiver participants, families, advocates, and providers to provide recommendations regarding implementation of Innovations Waiver services and policy and use of the Supports Intensity Scale (SIS) and Resource Allocation. PIHP shall keep meeting minutes and attendance records of these stakeholder meetings. PIHP shall make these records available for review by DMA and shall report on these efforts at IMT meetings.

6.13 Enrollee Rights:

PIHP must have written policies/procedures regarding the rights of Enrollees in accordance with applicable State and Federal laws, rules and regulations. PIHP must ensure that its staff and Network Providers follow the applicable policies and procedures when furnishing services to Enrollees. Enrollees are free to exercise their rights and the exercise of those rights shall not adversely affect the way that PIHP or its Network Providers treat the Enrollee. Rights include:

- a. The right to be treated with respect and due consideration of dignity and privacy;
- b. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
- c. The right to participate in decisions regarding health care, including the right to refuse treatment;
- d. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
- e. The right to request and receive a copy of his or her medical record, except as set forth in N.C.G.S. 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164.

6.14 Anti-Gag Clause:

PIHP may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient:

- a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- b. For any information the Enrollee needs in order to decide among all relevant treatment options;
- c. For the risks, benefits, and consequences of treatment or non-treatment; and
- d. For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.15 Support Services:

PIHP shall develop strategies for addressing the special needs of the Medicaid population. Strategies should incorporate staff and Network Provider training to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Staff and Network Provider training shall include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

PIHP shall provide the following services as necessary to ensure Enrollee access to and appropriate utilization of Medically Necessary services covered under this Contract:

- a. **Transportation:** PIHP shall provide information about the availability of non-emergency transportation for Enrollees through available public and private services. PIHP shall provide Enrollees with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county.
- b. **Interpreter Services:** Interpreter services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with PIHP and Network Providers. PIHP shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in 42 C.F.R. § 438.10(c)(5).
- c. **Coordination and Referral to Community Resources:** PIHP shall provide referral to available community services, including but not limited to those identified in Attachment J. PIHP shall have staff who are familiar with these resources and shall maintain a written description of appropriate referral procedures.

6.16 Payment to Out-of-Network Providers:

PIHP shall consider each claim for reimbursement for Emergency Services provided to Enrollees by Out-of-Network Providers based upon its own merits and the requirements of this Section, and shall not routinely deny such claims based upon failure to obtain prior authorization.

PIHP shall reimburse Out-of-Network Providers for Covered Services, which may be obtained by Enrollees without prior authorization from PIHP for Emergency Services which could not be provided by a PIHP Network Provider because the time to reach a PIHP Network Provider capable of providing such services would have meant risk of serious damage or injury to the Enrollee's health.

The Enrollee may be required to provide information to PIHP to assist in proper and prompt payment of services. PIHP shall describe in writing the procedures whereby Out-of-Network Providers can appeal claims denied by PIHP.

PIHP shall ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the Network.

6.17 Advance Directives:

PIHP shall maintain written policies and procedures concerning Advance Directives as specified in Article 3, Part 2 of N.C.G.S. Chapter 122C. PIHP shall distribute written information regarding Advance Directive policies to adult Enrollees, including a description of applicable State and Federal laws as outlined in Medicaid Special Bulletin on Advance Directives, May 1999 (See Attachment V) or found at the DMA website at:

<http://www.dhhs.state.nc.us/dma/Forms/advdirective.pdf>.

PIHP's written information regarding Advance Directives shall cover the following topics:

- a. Enrollee rights under State law;
- b. PIHP policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
- c. Information on the Advance Directive policies of PIHP; and
- d. The Enrollee's right to file a grievance with the State Certification and Survey Agency concerning any alleged noncompliance with the advance directive law.

As specified in 42 C.F.R. § 438.6(i), the written information provided by PIHP shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

6.18 Payments from Enrollees:

PIHP shall not require co-payments, deductibles, or other forms of cost sharing from Medicaid Enrollees for Medicaid services covered under this Contract, nor shall PIHP charge Enrollees for missed appointments. Enrollees who obtain services from Out-of-Network Providers without PIHP authorization, except those services

specified in Sections 6.3 and 6.18, shall be responsible for payment of costs associated with such services. As specified in 42 C.F.R. § 438.114(e), PIHP shall limit charges to Enrollees for post-stabilization care services to an amount no greater than what the organization would charge the Enrollee if he or she had obtained the services through PIHP. Enrollees shall not be held liable for payments to Providers in the event that PIHP or its subcontractors become insolvent or DMA does not pay PIHP.

6.19 Inpatient Hospital Services:

DMA will be responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Enrollees who are hospitalized before the effective date of their enrollment in PIHP and shall remain responsible for those costs until such Enrollees are discharged from the hospital.

PIHP shall be responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Enrollees who are hospitalized on or after the effective date of their enrollment in PIHP and shall remain responsible for these costs until such Enrollees are discharged from the hospital, or until the last day of the month in which the beneficiary is enrolled, whichever is earlier.

6.20 Confidentiality:

PIHP shall adopt and implement policies and procedures to ensure that it complies with all applicable State and Federal confidentiality laws, rules, and regulations.

6.21 Indian Health Services:

PIHP shall comply with the protections outlined in section 5006 of the American Reinvestment and Recovery Act regarding the provision of services by Indian health care providers to the extent that services covered by this contract are provided by Indian health care providers.

PIHP shall not charge premiums or cost sharing for services provided to Indian Enrollees by Indian health care providers.

PIHP shall reimburse Indian health care providers other than FQHCs or RHCs, regardless of whether such providers are participating in PIHP provider network, for covered Medicaid managed care services provided to Indian enrollees who are eligible to receive services at a rate equal to the rate negotiated between such entity and the provider involved. If such a rate has not been negotiated, PIHP shall pay the Indian health care provider at a rate that is not less than the amount of payment which PIHP would make for the services if the services were furnished by a provider participating in PIHP network who is not an Indian health care provider.

PIHP shall reimburse Indian health care providers according to the prompt pay requirements in section 1932(f) of the Social Security Act, regardless of whether such providers are participating in PIHP provider network.

If the amount paid by PIHP to a non-FQHC Indian health care provider for services covered under the contract to an Indian Enrollee is less than the Medicaid State plan payment rate, DMA shall provide for payment of the difference between the State plan rate and PIHP rate to the Indian health care provider, regardless of whether the provider is participating in PIHP provider network.

SECTION 7 - QUALITY ASSURANCE and QUALITY IMPROVEMENT

7.1 Internal Quality Assurance/Performance Improvement Program:

PIHP shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 C.F.R. § 438.240 and with the utilization control program required by CMS for DMA's overall Medicaid program as described in 42 CFR 456 and the CMS Quality Framework.

PIHP shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the QA/PI program. This committee shall have regular meetings, shall document attendance by Providers, and shall be accountable to, and report regularly to, the governing board or its designee concerning QA/PI activities. PIHP shall maintain records documenting the committee's findings, recommendations, and actions.

PIHP shall designate a senior executive who shall be responsible for QA/PI program implementation. PIHP's Medical Director shall have substantial involvement in functions that support QA/PI, such as credentialing, utilization review, and the monitoring of PIHP's Network Providers.

PIHP's written QA/PI program shall describe, at a minimum, how PIHP shall:

- a. Meet or exceed CMS, DMA, and PIHP defined minimum performance levels on standardized quality measures annually as described in Attachment K;
- b. Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and Enrollee satisfaction;
- c. Have in effect mechanisms to detect both over and under utilization of services;
- d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with behavioral health care needs;
- e. Include all demographic groups, care settings, and types of services over multiple review periods;
- f. Measure the performance of Network Providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by Providers;
- g. Measure provider performance through medical record audits;
- h. Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of PIHP;
- i. Develop and adopt clinically appropriate practice parameters and protocols/guidelines and provide PIHP's Providers enough information about the protocols/guidelines to enable them to meet the established standards; and
- j. Evaluate access to care for Enrollees according to Sections 6.4, 6.5 and 6.6 of this Contract, and implement a process for ensuring that Network Providers achieve and maintain these standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

By no later than July 31 of each calendar year, PIHP shall submit to DMA a revised and updated QA/PI program and a report on PIHP's progress toward performance improvement goals during the last twelve months.

At no additional cost to DMA, PIHP shall develop and implement the PIHP-specific performance improvement projects described in Contract Attachment L.

At DMA's request, PIHP shall participate in at least one statewide performance improvement project each year at its own expense.

7.2 Annual External Quality Reviews:

Pursuant to 42 C.F.R. §§ 438.310 through 438.370, DMA shall contract with an external quality review organization (EQRO) to conduct an annual independent external quality review (EQR). Three (3) activities are mandatory during these reviews: (1) determining PIHP compliance with federal Medicaid managed care regulations; (2) validation of performance measures produced by the PIHP; and (3) validation of performance improvement projects undertaken by PIHP. CMS-published protocols shall be utilized by the organization conducting the EQR activities. In addition, based on the availability of encounter data, the EQRO shall conduct encounter data validation per the CMS protocols.

7.3 Inspection and Monitoring:

Pursuant to 42 C.F.R. § 438.66, DMA shall monitor PIHP's Enrollee enrollment and disenrollment practices and PIHP's implementation of the grievance and appeal procedures required by federal law.

Pursuant to 42 C.F.R. § 438.6(g), DMA, the United States Department of Health and Human Services, and any other authorized Federal or State personnel or their authorized representatives may inspect and audit any financial records of PIHP or its subcontractors relating to PIHP's capacity to bear the risk of potential financial losses.

Pursuant to 42 C.F.R. § 434.6(a)(5), and as otherwise provided under this Contract, the Department, DMA, and any other authorized Federal or State personnel or their authorized representatives shall evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Contract.

7.4 Utilization Management:

Utilization Management Program: PIHP shall have a Utilization Management Program that is consistent with the requirements of 42 C.F.R. § 456 and 42 C.F.R. § 438, Subpart D. The Utilization Management Program shall include a written Utilization Management Plan which describes the mechanisms used to detect underutilization of services as well as overutilization. The written Utilization Management Plan shall address procedures used by PIHP to review and approve requests for medical services, and shall identify the clinical criteria used by PIHP to evaluate the medical necessity of the service being requested. PIHP shall ensure consistent application of review criteria and shall consult with requesting providers when appropriate. PIHP shall conduct an annual appraisal that assesses PIHP's adherence to the requirements of the Utilization Management Plan and identifies the need for changes in the Utilization Management Plan.

PIHP will use a DMA-standardized Authorization Request Form. PIHP will use LOCUS and CALOCUS scores for medical necessity reviews for mental health services and ASAM for substance abuse services, except for children ages three (3) through six (6). PIHP will use EPSDT criteria when evaluating requests for services for children under 21 years of age.

For children ages three (3) through six (6), PIHP must use one of the following options to determine medical necessity reviews:

- a. The Early Childhood Services Intensity Instrument (ECSII) for Infants, Toddlers and Pre-Schoolers;
- b. The Children and Adolescents Needs and Strengths (CANS); or
- c. Another validated assessment tool for ages 3 to 6, with written approval of the Division of Medical Assistance.

PIHP will maintain separate Utilization Management and Care Coordination business units. This separation will be monitored at all IMT on-site reviews and validated by external monitors (as needed).

PIHP shall have an information technology system that collects, stores, and retrieves the data necessary to perform the required utilization management functions.

Scope of EPSDT Coverage: Section 1905(r)(5) of the Social Security Act sets forth the basic requirements for the EPSDT program. The Act requires that any service that is covered under Section 1905(a) of the Social Security Act which is medically necessary to treat or ameliorate a defect, physical illness, or condition identified through screening must be provided to children under 21 years of age. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration and scope of EPSDT services may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

For conditions identified in EPSDT screenings, PIHP shall ensure that Medically Necessary MH/IDD/SA services meeting EPSDT criteria are furnished to Enrollees under 21 years of age. PIHP shall further ensure that PIHP Network Providers shall coordinate with agencies conducting the screenings.

Practice Guidelines: PIHP shall develop a Clinical Advisory Committee consisting of licensed Network Providers. Practice Guidelines shall be developed in consultation with this committee. Practice guidelines shall be based on valid and reliable clinical evidence (Evidence Based Practice) or a consensus of professionals in the

field. PIHP may also use Clinical Practice Guidelines promulgated by peer-reviewed organizations such as the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. Practice guidelines shall address the needs of Enrollees and shall be reviewed and updated periodically as appropriate and in accordance with changes and developments in clinical research. Practice Guidelines shall be disseminated to Providers and, upon request, to Enrollees. All utilization management decisions, Enrollee education decisions, coverage of services decisions, and all other decisions covered by the Practice Guidelines shall be consistent with the Practice Guidelines.

Requests for authorization to be admitted to, or to remain in, inpatient or intermediate care, shall be reviewed by behavioral health professionals, as defined in 42 C.F.R Part 456. Inpatient and intermediate care in an institution shall be approved by a physician or physician's assistant as required by 42 C.F.R. Part 456.

Requests for authorization to receive, or to continue to receive, outpatient services shall be reviewed by behavioral health professionals, as defined in 42 C.F.R Part 456. A denial of a request for outpatient services shall be made by a licensed clinician whose license is comparable to the license of the Provider requesting the service.

A decision to deny a service or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

PIHP SHALL NOT IMPLEMENT ANY UTILIZATION MANAGEMENT POLICIES OR PROCEDURES THAT PROVIDE INCENTIVES FOR UTILIZATION REVIEWERS TO DENY, LIMIT, OR DISCONTINUE MEDICALLY NECESSARY SERVICES TO ANY ENROLLEE.

Timeframes for Standard Decisions: PIHP shall issue a decision to approve or deny a service within fourteen calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen additional calendar days if:

- a. The Enrollee requests the extension; or
- b. The Provider requests the extension; or
- c. PIHP justifies (to DMA upon request):
 - 1. A need for additional information; and
 - 2. How the extension is in the Enrollee's interest.

Notwithstanding the foregoing deadlines, PIHP shall always issue a decision to approve or deny a service as expeditiously as the Enrollee's health condition requires.

Timeframes for Expedited Decisions: In those cases in which a Licensed Practitioner acting within the scope of his or her practice indicates, or PIHP determines, that adherence to the standard timeframe (pursuant to 42 C.F.R. § 438.210(d)(i) and (ii)) could seriously jeopardize an Enrollee's life or health or ability to attain, maintain, or regain maximum function, PIHP shall issue a decision to approve or deny a service within three calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen additional calendar days if:

- a. The Enrollee requests the extension; or
- b. PIHP justifies (to DMA upon request):
 - 1. A need for additional information; and
 - 2. How the extension is in the Enrollee's interest.

Notice of Termination, Suspension or Reduction of Services: When PIHP decides to terminate, suspend, or reduce a previously authorized Medicaid-covered service (meaning a service for which the authorization has not yet expired), PIHP shall mail notice of the Action at least 10 calendar days before the effective date of the action. PIHP may shorten the period of advance notice to five days if:

- a. PIHP has facts indicating that action should be taken because of probable fraud by the Enrollee; and
- b. The facts have been verified, if possible, through secondary sources.

Notices shall be sent to the Enrollee in accordance with 42 C.F.R. § 438.210(c) and the Grievance and Appeal Procedures outlined in Attachment M.

Service Authorization: PIHP shall define service authorization in a manner that at least includes an Enrollee's request for the provision of a service as required by 42 C.F.R. § 431.201.

7.5 Grievances and Appeals:

PIHP shall maintain Enrollee grievance and appeal procedures that meet the requirements of 42 C.F.R. § 438.228 and 42 C.F.R. 438 Subpart F. The grievance and appeal procedures must:

- a. Provide for prompt resolution of Enrollee grievances and appeals; and
- b. Assure the participation of individuals with the authority to require PIHP to take corrective action when appropriate.
- c. Comply with applicable federal and state laws, rules and regulations and any formal written guidance issued by DMA that complies with same.

PIHP shall use Enrollee grievance and appeal data for QA/PI and shall report Enrollee grievances and appeals to DMA by number, type, and outcome by no later than forty-five calendar days after the end of each quarter of the State fiscal year.

PIHP will attend DMA training on EPSDT and Enrollee due process rights and/or will conduct internal training that meets DMA requirements. Procedures and trainings must be approved by the Department. DMA will monitor attendance at trainings and the implementation of procedures at least annually. PIHP will use DMA pre-approved templates to notify Enrollees of their right to appeal.

PIHP shall implement procedures and trainings to protect Enrollees from discouragement, coercion, or misinformation regarding the type, amount, and duration of services they may request in their plans of care and their right to appeal the denial, reduction, or termination of a service.

PIHP shall utilize a DMA-approved template to notify Innovations Waiver participants of the results of any new SIS evaluation and to inform participants in writing of the opportunity and process for raising concerns regarding SIS evaluations and results, and the opportunity to file a grievance regarding SIS evaluations and results.

PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations Waiver participant and that such desires are reflected in the Innovations Waiver Participant's plan of care, including the desired type, amount, and duration of services.

PIHP shall inform participants that they may make a new request for services at any time by requesting an updated plan of care. If a requested service is authorized for a duration less than the duration requested in the plan of care, unless the service has a maximum benefit duration contained within the Innovations Waiver and the PIHP authorizes the service requested up to that maximum, PIHP shall provide written notice with appeal rights at the time of that limited authorization, which notice shall include the clinical reasons for the decision.

Reporting: PIHP shall submit quarterly reports regarding all Medicaid Enrollee grievances and appeals that identify the following, reported separately: the total number of Enrollees served, total number of grievances categorized by reason, reported separately; the number of grievances referred to second level review or appeal, reported separately; and the number of grievances resolved at each level, total time of resolution and outcome, reported separately. Reports are due to DMA on a quarterly basis, consistent with Reporting Measure reporting schedule (Attachment K).

7.6 Network Provider Qualification:

PIHP shall maintain a Closed Provider Network that provides culturally competent services. In order to achieve cultural competency, PIHP shall encourage providers to participate in the PIHP Cultural Competency Plan, which shall be developed and approved by a Provider Council composed of members of the PIHP Provider Network with representation across all disability groups. Cultural competency shall be achieved within the strictures of state and federal laws, which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, national origin or disability.

The PIHP Closed Provider Network shall be composed of providers that offer quality services, demonstrate competencies in best practices and outcomes for persons served, ensure health and safety for Enrollees, and demonstrate ethical and responsible practices. Through oversight of Network Providers, PIHP shall demonstrate its commitment to the achievement of positive outcomes for Enrollees, Enrollee satisfaction, and accountability for the well-being of Enrollees.

PIHP shall comply with the requirements of 42 C.F.R. § 438.214 regarding the selection and retention of Providers, the credentialing and re-credentialing of Providers, non-discrimination in the selection of Providers, and the prohibition of contracting with excluded providers. PIHP shall not discriminate, solely on the basis of the Provider's license or certification, for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law. PIHP shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. PIHP shall not employ or contract with Providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

PIHP shall consult the United States Department of Health and Human Services, Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), and the System of Award Management (SAM) to ensure that Providers who are excluded from participation in Federal programs are not enrolled in PIHP network. In accordance with 42 C.F.R. § 436, the PIHP will search the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), LEIE and the SAM upon enrollment, reenrollment, credentialing, or recredentialing of Network Providers, and at least monthly thereafter. PIHP may be required to implement other provider screening methods as deemed appropriate by DMA in accordance with 42 C.F.R. § 455.452.

Provider Selection and Retention: PIHP shall have written policies and procedures for the selection and retention of Network Providers. PIHP shall apply these criteria consistently to all Providers.

PIHP shall have the authority to operate a Closed Provider Network and shall not be required to review the qualifications and credentials of Providers that wish to become Network Members if the Network has sufficient numbers of Providers with the same or similar qualifications and credentials to provide adequate access to all services covered under this Contract in accordance with 42 CFR § 438.206. PIHP shall have the sole discretion to determine provider participation in the PIHP Closed Network, including determinations regarding contract renewal and procurement, subject to the requirements of this Contract and applicable federal regulations.

If PIHP is accepting applications for participation in the Network, PIHP shall, at a minimum, consider the following information as part of the qualification and selection process, to the extent available and applicable to each provider type:

- a. Record of the provider's experience and competency. Stability of past operations is important. An assessment of the Provider agency's past record of services, compliance with applicable laws, standards and regulations, the qualifications and competency of its staff, the satisfaction of consumers and family members served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by PIHP prior to enrollment and at regular intervals thereafter.
- b. To the extent that such information is quantifiable, evidence of consumer friendly services and attitudes, including how Enrollees and families are involved in treatment and services. Providers shall have a good system of communication with Enrollees.
- c. Evidence that the provider has the clinical infrastructure, either through their own agency or through collaboration with other providers, to address challenges in meeting specific client needs (such as challenging behaviors or medical problems).
- d. Capacity of the provider to respond to emergencies for assigned Enrollees according to the availability standards for emergent needs as defined in Attachment S of this contract and the service definition requirements for First Responder capacity. Services which must have First Responder capacity are identified in Medicaid Clinical Coverage Policy 8A, "Enhanced Mental Health and Substance Abuse Services," which can be accessed on the DMA website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>. If required, an adequate clinical back up system shall be in place to respond to emergencies after hours and on weekends.

- e. Evidence that the provider has in place accounting systems sufficient to ensure fiscal responsibility and integrity; and
- f. Evidence that agency-based provider staff meet the qualifications to provide behavioral health and developmental disability services, as defined in Medicaid Clinical Coverage Policy, Section 8, and in the Innovations Waiver. The policy and waiver can be accessed at the DMA website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>.

PIHP shall conduct a qualifying review to assess the provider's compliance, competencies and qualifications. A minimum score of 85% must be achieved on PIHP qualification tool for the provider to be enrolled in PIHP Network. If the provider does not achieve a score of 85%, the provider may be offered an opportunity to implement a Plan of Correction to address deficit areas. Failure to complete an appropriate plan of correction will result in a denial to enter the network. Within six months of enrollment, the provider must achieve a score of 100% on PIHP required competencies to remain in the Network.

If PIHP declines to credential, enroll or contract with an applicant for participation in the PIHP Provider Network, it shall give the affected provider written notice of the reasons for its decision but is not required to offer appeal rights.

If PIHP issues a competitive Request for Proposal, PIHP shall develop and utilize a scoring process to assess the provider's competencies specific to the requirements of the Request for Proposal, the service definition, and enrollment requirements as delineated above.

For all initial enrollments, PIHP shall complete an on-site review within 6 months of service initiation.

Retention of agency-based providers depends on the performance of the agency as measured against identified indicators and benchmarks as described above, as well as PIHP's Network Development Plan and needs as identified in the annual assessment described in Section 6.4. As part of the retention process, PIHP may consider any of the following, to the extent available, in addition to other criteria established by the PIHP in accordance with the Network Development Plan (including but not limited to service demand and fiscal sustainability):

- a. Data collected through PIHP's Utilization Management Program;
- b. Data collected through PIHP's Quality Management Program;
- c. Data collected through the Grievance and Appeals process;
- d. Data collected through monitoring, investigation and audit activities;;
- e. Enrollee satisfaction survey results;
- f. The results from other quality improvement activities; and
- g. A review of the Provider's compliance program required by Section 6401 of the Patient Protection and Affordable Care Act and the False Claims Act.

7.7 Credentialing:

Credentialing of Providers shall be conducted in accordance with the procedures delineated in Attachment O. PIHP shall maintain written policies and procedures governing the credentialing and re-credentialing of its Network Providers that comply with applicable federal and state laws, rules and regulations, and PIHP accreditation guidelines. PIHP shall maintain records of its credentialing and re-credentialing activities in order to demonstrate its compliance with these policies and procedures. Upon request, PIHP shall make its records available to DMA for inspection and copying during normal business hours. PIHP's credentialing and re-credentialing criteria shall be consistent with State and Federal laws, rules and regulations governing practitioners who provide the Covered Services. In accordance with 42 C.F.R. § 455.450, PIHP must screen all initial applications including applications for a new practice location and any application received in response to a re-enrollment or revalidating of enrollment request based on a category risk level of limited, moderate, or high in accordance with N.C.G.S. § 108C-3 and 42 C.F.R. § 455.450. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

Hospital Credentialing: In order to decrease the administrative burden on hospitals/ health systems directly enrolled with the NC Medicaid program, PIHP may accept and rely upon DMA's credentialing of hospitals licensed under Chapter 131E of the North Carolina General Statutes, if it so chooses. This may include all facilities and sites affiliated with the hospital/ health system seeking to be credentialed by PIHP to the extent such facilities and

sites are enrolled with DMA and affiliated with the hospital/ health system in the State's MMIS ("NCTracks"). The Department agrees to accept all liability for such credentialing and to indemnify and hold harmless PIHP from and against all claims, damages, losses and expenses, including but not limited to attorney's fees, arising out of or resulting from the credentialing of hospitals performed by DMA or its contractor and relied upon by PIHP in accordance with this Contract. PIHP shall be responsible for credentialing of all practitioners billing through the hospital/ health system, either directly or through a Delegated Credentialing Agreement with the hospital/ health system that meets applicable federal and state laws, rules and regulations and PIHP accreditation standards.

Insurance: PIHP shall require all Network Providers to obtain and continuously maintain the following, if applicable:

- a. General Liability Insurance;
- b. Automobile Liability Insurance;
- c. Worker's Compensation Insurance;
- d. Employer's Liability Insurance; and
- e. Professional Liability Insurance;

in amounts that equal or exceed the limits established by PIHP, which may include exception criteria to ensure adequate access to the services covered under this Contract. Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain Automobile Liability Insurance. PIHP shall review its insurance limits annually and revise them as needed. PIHP shall require all Network Providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the carrier gives 30-days prior written notice to PIHP. PIHP shall require Network Providers to submit certificates of coverage to PIHP. Upon DMA's request, PIHP shall submit copies of these certificates to DMA.

7.8 Written Agreements:

The Provider Network shall be documented by separate written agreements between PIHP and each Provider. PIHP shall utilize a provider agreement based on a template approved by DMA. The provider agreement must comply with this Contract and applicable federal and state laws, rules, and regulations and shall require the Provider:

- a. To participate in PIHP's utilization management, care management, quality management, access, finance, qualification/accreditation and credentialing processes; and
- b. To offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Enrollees;
- c. To comply with all network requirements for reporting, inspections, monitoring, and Enrollee choice requirements;
- d. To participate in the compliance process and the network continuous quality improvement process;
- e. To be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in PIHP's web based billing process.
- f. To have a "no-reject policy" for referrals within the capacity and the parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity; a Provider's competency to meet individual referral needs will be negotiated between PIHP and the Provider.

PIHP shall develop policies and procedures for monitoring Provider compliance with these requirements.

7.9 Site Visits:

In accordance with 42 C.F.R. § 455.432, PIHP must conduct pre-enrollment site visits for any providers designated as moderate or high risk for fraud, waste and abuse. In accordance with 42 C.F.R. § 455.450, PIHP must screen all initial applications including applications for a new practice location and any application received

in response to a re-enrollment or revalidating of enrollment request based on a category risk level of limited, moderate, or high. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

For the first three years of operation in PIHP's counties, PIHP is required to maintain state-established rates for ICF-IIDs.

7.10 Termination of Providers:

In accordance with 42 C.F.R. § 455.416, PIHP shall notify DMA, the State Medicaid agency, if it:

- a. Must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.
- b. Must deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- c. Must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.
- d. Must terminate the provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- e. Must terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- f. Must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

May terminate or deny the provider's enrollment if CMS or the State Medicaid agency—

- a. Determines that the provider has falsified any information provided on the application; or
- b. Cannot verify the identity of any provider applicant.

PIHP shall report any denials it takes on a provider application to join PIHP's network and any termination of a Provider's contract with PIHP to DMA Program Integrity on a monthly basis. Such monthly reports include but may not be limited to the following: denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts, and program integrity reasons which include fraud, waste and abuse. PIHP shall report denials and terminations on Attachment Z (Program Integrity Activities: Terminations, Provider Enrollment Denials, or other Actions). In accordance with 42 C.F.R. § 1002.3(b)(3), PIHP shall notify DMA when it takes action against a Provider for program integrity reasons. DMA will report to HHS-OIG any actions DMA takes to limit a provider's participation in the program

7.11 Provider Manual:

PIHP shall develop, maintain, and distribute a Provider manual that provides information and education to Providers about PIHP. This distribution may occur by making the manual available electronically on its website. DMA shall have the right to review and approve the Provider manual prior to its release. The manual shall be regularly reviewed and updated to reflect changes to applicable federal and state laws, rules, and regulations, Department or PIHP policies, procedures, bulletins, guidelines or manuals, or PIHP business processes as necessary. At a minimum, the Provider manual shall cover the areas listed below.

- a. Purpose and mission;
- b. Clinical Practice Standards;
- c. Provider Responsibilities;
- d. PIHP Closed Network requirements, including: nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
- e. Access standards related to both appointments and wait times;
- f. Authorization, utilization review, and care management requirements;
- g. Care Coordination and discharge planning requirements;
- h. Documentation requirements, as specified in APSM 45-2 or as required by the Physician's Services Manual;
- i. How to access the PIHP dispute resolution process;
- j. Complaint investigation and resolution procedures;
- k. Performance improvement procedures, including at a minimum: Enrollee satisfaction surveys; clinical studies; incident reporting; and outcomes requirements;
- l. Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;
- m. Enrollee rights and responsibilities; and
- n. Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.

PIHP shall provide to Providers any and all training and technical assistance PIHP deems necessary regarding administrative and clinical practices, procedures and requirements, as may be permitted by the PIHP's available resources.

7.12 Provider Reimbursement:

PIHP shall have the authority to establish Provider rates and fee schedule(s) and shall post the Provider Fee Schedule and any changes thereto on the PIHP website. PIHP is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

If applicable, for the first three years of operation in PIHP's counties, PIHP is required to maintain state-established rates for ICF-IIDs.

SECTION 8 – HEALTH INFORMATION AND RECORDS

8.1 Health Information System:

PIHP's information systems needs to perform, at a minimum, the following components in a manner consistent with industry and Center for Medicare and Medicaid Services standards:

- a. A system with real-time access to claims history, member and provider information.
- b. Ability to receive inbound member demographic and eligibility files from the state via an 834.
- c. Maintain member demographic, enrollment and disenrollment information in accordance with the information contained in DMA's Global Eligibility File.
- d. Produce error reports for mismatched eligibility and establish a correction process.
- e. Maintain Provider data including NPI, taxonomy and demographics for billing and rendering/attending providers.
- f. Maintain Provider Fee Schedules with effective and termination dates.
- g. Ability to link provider data to claims and clinical modules in the system.
- h. Ability to receive inbound claims in both paper and electronic HIPAA 837I and 837P formats.
- i. Ability to receive sub-capitated provider encounters in the same format as fee-for-service contracted providers.
- j. Ability to time stamp and track all claims received.
- k. Ability to reject incomplete claims upfront and provide error report to provider.
- l. Ability to adjudicate claims, resulting in payments and denials to providers.

- m. Ability to create system generated remittance advice in HIPAA 835 and paper formats and payments to providers in electronic fund transfer (EFT) and paper checks if necessary.
- n. Maintain edits in claim system to identify non-eligible claims, members or services.
- o. Ability to apply reason codes why a payment is less than the amount billed by the provider.
- p. Ability to apply adjustments to processed claims with adjustment reasons including audit trails of all data activity.
- q. Maintain third party liability information data to ensure coordination of benefits.
- r. Perform coordination of benefits during the claims adjudication process.
- s. Maintain authorization data to match to the claims for adjudication.
- t. Documented software maintenance cycle which describes how changes are implemented into the production environment including version control.
- u. Ability for system backups and retrieval with disaster recovery contingency processes that are established and tested routinely.
- v. Have data repositories used for statistical and financial reporting and the creation of encounter data for submission to DMA in a format pre-approved by DMA and within 10 business days of DMA's request.
- w. On-line reporting capabilities for daily monitoring of clinical and claim operations.
- x. Reporting for claims that have been received but not paid used to monitor claims payment timeliness.
- y. Perform random claims audit for all claims processed.
- z. Processes to perform a capitation payment reconciliation.
- aa. Maintain security standards for data consistent with Federal and State personal health information (PHI) security standards.

PIHP shall maintain a health information system that collects, analyzes, integrates, and reports data for Enrollees with behavioral health, developmental disability, and substance abuse treatment needs. At a minimum, the system shall provide information on utilization management, provider network management, quality management, financial operations, grievances, appeals, and member disenrollment for reasons other than loss of Medicaid eligibility.

PIHP shall be able to transfer data electronically using secure File Transfer Protocols (FTP) and file formats as requested by DMA.

PIHP shall collect data on Enrollee and Provider characteristics as specified by DMA and on services furnished to Enrollees through an encounter claims data system or other methods as required to perform PIHP's obligations hereunder, as required by law or as specified by DMA.

PIHP shall collect service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.

PIHP shall have the ability to send and receive the HIPAA transaction formats to the appropriate Enrollees. Formats that will be used beginning on program inception include the following:

- a. 820 – Premium Payment
- b. 834 – Member Enrollment and Eligibility Maintenance
- c. 835 – Remittance Advice
- d. 837P – Professional claims
- e. 837I – Institutional claims
- f. 270/271 – Eligibility Inquiry and Response
- g. 276/277 – Claim Inquiry and Response
- h. 278- Authorization

PIHP shall have the ability to receive the DMA Global Eligibility File and use this file for mailing Enrollee notices and utilization review decisions.

PIHP must document all Information required to perform its obligations hereunder and obtained through paper, telephone, fax, or electronic methods in one or more electronic databases and enter that data into PIHP's database. All documentation must be available in an electronic format.

PIHP shall ensure that claims and authorization data received from Providers is accurate and complete by:

- a. Verifying the accuracy and timeliness of reported data; and
- b. Screening all data for completeness, logic, and consistency.

PIHP shall make all collected data available to DMA no later than seven calendar days or to CMS within the timeframe specified by CMS. PIHP must provide reports of collected data to DMA as requested herein, in a frequency, form and format necessary to meet operational needs, as described in this Contract.

8.2 Clinical Records:

Network Provider Medical Records: To the extent permitted under State law, the PIHP Provider Manual and written agreements between PIHP and Network Providers shall require Network Providers to maintain clinical records that meet the requirements in the *Records Management and Documentation Manual for Providers* (APSM 45-2) and *Rules for MH/DD/SAS Facilities and Services* (APSM 30-1) and the *Basic Medicaid Billing Guide*, and any other applicable federal and state laws, rules and regulations. Medical Records shall be maintained at the Provider level; therefore Enrollees may have more than one record if they receive services from more than one Provider. PIHP shall monitor Medical Record documentation to ensure that the standards are met. PIHP shall have the right to inspect Provider records without prior notice. PIHP shall also require Providers to submit a plan for maintenance and storage of all records for approval by the PIHP or transfer copies of Medical records of Enrollees served pursuant to this Contract to PIHP in the event that the Provider closes network operations whether the closure is due to retirement, bankruptcy, relocation to another state or any other reason. The PIHP has the sole discretion to approve or disapprove such plan. PIHP shall not be held liable for any Provider records not stored, maintained or transferred pursuant to this provision so long as it has attempted, in good faith, to obtain a written plan for maintenance and storage or a copy of such records from the Provider.

If the Provider's contract is terminated or if the Provider closes network operations (but continues to have operations elsewhere in the State), the Provider may either provide copies of Medical records of Enrollees to PIHP or submit a plan for maintenance and storage of all records for approval by the PIHP. The PIHP has the sole discretion to approve or disapprove such plan.

Abandoned Records: Abandonment of records is a serious HIPAA and contractual violation which can result in sanctions and financial penalties. The following steps are required of any PIHP as soon as the PIHP is made aware of the abandonment of any Medical records of Enrollees served pursuant to this Contract in their catchment area:

- a. The PIHP is to notify DMA Program Integrity about the abandonment: 1-800-662-7030.
- b. The PIHP is to contact the Provider via a registered letter informing them of their report to DMA Program Integrity regarding the abandonment.
- c. The PIHP is to secure the records and complete an inventory log of the records.

PIHP Service Management Records: PIHP shall maintain all Service Management Records in accordance with the terms of this Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. All books and records shall be maintained to the extent and in such detail as shall properly reflect each service provided. PIHP may maintain records in an electronic format. PIHP's Service Management Records shall contain at least the following information:

1. **Documentation for all Enrollees:**
 - a. Demographic information, including:
 - i. Name;
 - ii. Medicaid ID number;
 - iii. Birth date;
 - iv. Sex;
 - v. Address and phone number; and
 - vi. Parent or guardian if under eighteen or adjudicated incompetent;
 - b. Referral or Utilization Management contact information:
 - i. Date of the contact;
 - ii. Service requested; and
 - iii. If the requested service meets medical necessity;
 - c. The amount, duration, and scope of the authorized service; and the basis of, or the information used to make, the medical necessity determination;

- d. If the requested service does not meet medical necessity:
 - i. The rationale for the denial, including the criteria or benefits provision used;
 - ii. The proposed alternative service that does not meet medical necessity for the individual, if any;
 - iii. The notice of adverse action, including the timetable and method for informing the Enrollee and Provider of the denial, reduction, or termination of the authorization for the requested service and the Enrollee Grievance and Appeal rights; and
 - iv. Documentation that the denial of the authorization was made by a physician or practitioner operating within the scope of his/her license;
 - e. The name and credentials of the individual conducting the review;
 - f. The name, signature, and credentials of the individual who made the decision to deny, reduce or terminate authorization for the requested service; and
 - g. A record of the services authorized by PIHP and billed by Network Providers.
2. **Additional Information to be Obtained as Appropriate:**
- a. For 24-hour care:
 - i. Date of the admission;
 - ii. Date of discharge;
 - iii. For inpatient discharges, evidence of an appropriate discharge plan; and
 - iv. For inpatient discharges, follow-up authorization for outpatient care.
 - b. Coordination of care information, which should include:
 - i. Name of primary care/CCNC physician or other key Providers; and
 - ii. Other systems of care involved, such as educational system, Department of Social Services, and Criminal Justice.
 - c. In the presence of clinical risk factors (risk of harm to self or others), evidence of education, outreach and follow up as appropriate for the individual.

8.3 Financial Records:

PIHP and the Network Providers shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract including provision of Covered Services and all relevant information relating to individual Enrollees for the purpose of audit and evaluation by DMA and other Federal or State personnel. Records shall be maintained in compliance with all State and Federal requirements including HIPAA for use in treatment, payment or operations. Records shall be maintained and available for review by authorized Federal and State personnel during the entire term of this Contract and for a period of five years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.

8.4 Access to Records:

All disclosure of records shall be performed in compliance with applicable federal and state confidentiality laws, including but not limited to HIPAA, the HIPAA Privacy Rule codified at 45 CFR Part 160 and Subparts A and E of Part 164, 42 C.F.R. Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), and N.C.G.S. Chapter 122C. Any records requested pursuant to monitoring, audit or inspection as called for in this Contract shall be produced immediately for on-site review or sent to the requesting authority by mail within fourteen days following the request. Written agreements between PIHP and Network Providers shall contain provisions requiring all Network Providers to comply with requests for information and that all requested records shall be provided to PIHP or DMA within fourteen days of the date of the request, at the sole cost and expense of the Network Provider. DMA shall have unlimited rights to use, disclose, and duplicate information and data developed, derived, documented, or furnished by PIHP and in any way relating to this Contract.

PIHP shall cooperate fully with requests for information by any state's Medicaid Fraud Control Unit, including the North Carolina Department of Justice's Medicaid Investigations Division (MID). The MID is a Medicaid fraud

control unit approved by the Secretary of the U. S. Department of Health and Human Services under 42 Code of Federal Regulations § 455.300 (recodified as 42 C.F.R. §§ 1007.1 – 1007.21) and authorized by 42 C.F.R. § 431.107(b) to request that Medicaid providers furnish access to records. The MID is a health oversight agency as defined in the Health Insurance Portability and Accountability Act (HIPAA) in 45 C.F.R. § 164.501 and the Preamble, 65 Fed. Reg. 82462 at 82492. The MCO is required to produce requested information to the MID in its capacity as a health oversight agency. 45 C.F.R. § 164.512(d). Disclosure is permitted under HIPAA pursuant to 45 C.F.R. § 164.512(a). Since this information is requested by a health oversight agency and is required by law, no other requirements need to be met under the applicable federal regulations. 45 C.F.R. § 164.12(d) (1). Upon request by the NC DOJ MID, PIHP shall, in a timely manner, produce all requested documents, data, and information in PIHP's possession, custody, or control. Upon request from MID, the PIHP shall also furnish contact information for relevant employees and make them available for interviews concerning investigations conducted by the MID of providers contracted with PIHP.

Upon request from MID, PIHP shall produce an affidavit certifying that their custodian of records made a thorough and diligent search for the requested documents, data, and information and shall state that the documents, data, and information produced constitute all the documents, data, and information requested to the best of the custodian's knowledge, information, and belief.

In the absence of written patient consent or a court order sufficient to comply with 42 C.F.R. Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), PIHP shall redact all patient-identifying information from records provided directly to the MID involving alcohol or drug abuse programs. The redactions shall be limited to those necessary to prevent the MID from determining the identities of the Enrollees receiving services from alcohol or drug abuse programs. PIHP shall produce the redacted records along with documentation specifying what information has been redacted from those records. PIHP shall not make any other alterations or redactions to the requested documents, data, or information without first obtaining written permission from the MID. Upon receipt of written patient consent or a court order sufficient to comply with 42 C.F.R. Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), PIHP shall produce un-redacted copies of records involving alcohol or drug abuse programs.

SECTION 9 - REPORTS AND DATA

9.1 General

The DMA Contract Administrator shall furnish PIHP with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission. DMA shall furnish such technical assistance in filing reports and data as may be permitted by the DMA's available resources. DMA reserves the right to modify from time to time the form, content, instruction, and timetables for collection and reporting of data pursuant to the terms of this Contract. DMA will involve PIHP in the decision process prior to implementing changes in format, and will ask PIHP to review and comment on format changes. DMA will make every effort to give notice of changes at least 30 days prior to the effective date of any proposed change. The timetable for implementation of new and/or modified reports shall be mutually agreed upon by DMA and PIHP taking into consideration the complexity and availability of the information needed, unless otherwise mandated by law or legislation. DMA will furnish such technical assistance as may be required to implement Contract modifications to reporting requirements. PIHP may request a reasonable extension of time to comply with the new or modified reporting requirements, which shall not be unreasonably refused.

Ad hoc data and reports reasonably requested by DMA shall be submitted by the PIHP to DMA at times mutually agreed upon by DMA and PIHP, unless a timeline is dictated by State or Federal authority.

Timelines: Reports or other data shall be received on or before the scheduled due date. All required reports shall be received by DMA no later than 11:59:59 p.m. Eastern Time on the due date. Requests for extensions shall be submitted to DMA in writing. All reports remain due on the scheduled due date unless DMA approves the extension request in writing. Such approval shall not be unreasonably withheld.

9.2 Enrollment Report and Capitation Payment:

DMA shall provide to PIHP a monthly enrollment report no earlier than the fourth to the last working day before the end of each month and no later than the first day of the ensuing month. The enrollment report shall list all Medicaid beneficiaries who will be enrolled in PIHP during the ensuing month. The list of Medicaid beneficiaries

shall serve as the basis for the ensuing month's capitated payment to the Plan. In the event that the list of Medicaid beneficiaries identified by DMA does not accurately reflect the Medicaid beneficiaries who should be enrolled in PIHP for any given month, the parties will establish a process and procedure for resolving any such discrepancies in a timely fashion, including a process and procedure for ensuring that PIHP receives all capitated payments and any accrued interest due to PIHP pursuant to Section 10 of this Contract.

DMA shall pay PIHP a capitated payment for each Enrollee listed on the report according to the rate methodology listed in Attachment P. All enrollment and disenrollment, with the exception of Innovations Waiver participants, shall be effective on the first day of the calendar month for which the enrollment or disenrollment is listed on the electronic data file. Enrollment for Innovations Waiver participants shall be effective retroactive to the date that all eligibility requirements for participation in Innovations are met.

9.3 Encounter Data:

When the MMIS is revised to accept and process encounter data, PIHP shall submit to DMA an electronic record of every encounter between a Network Provider and an Enrollee within fifteen calendar days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter date. DMA shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. PIHP shall report all encounters that occur up to the date of the termination of this Contract. PIHP is subject to sanctions for late or incomplete submissions in accordance with the terms of SOW Section 13. If the Contract terminates while payments are being withheld by DMA due to inaccurate or late reporting of encounter data, DMA shall continue the withhold until PIHP reports all encounter data according to Contract Attachment U, Financial Reporting Requirements.

Until the MMIS is revised to accept and process encounter data, PIHP shall submit electronic records of encounters to DMA -- or contractors acting on DMA's behalf -- on an as-needed basis for the purposes of rate-setting, quality assurance, waiver amendments, renewals, mandatory external review activities, and other activities deemed necessary by DMA. Encounter data submitted to DMA from PIHP must be signed by PIHP's Chief Financial Officer and must contain a statement certifying the accuracy of the data.

All encounter data submitted by PIHP to DMA, the MMIS or a contractor acting on DMA's behalf shall include the Medicaid provider number of the Network Provider if the Network Provider is enrolled in DMA's fee-for-service Medicaid program. All encounter data submitted by PIHP to DMA, the MMIS or a contractor acting on DMA's behalf shall include the National Provider Identification (NPI) of each PIHP Network Provider.

Encounter data should include, at a minimum:

- a. Member ID
- b. Member Name
- c. Member Date of Birth
- d. Member Gender
- e. Claim/Encounter Number
- f. Rendering Provider Tax ID
- g. Rendering Provider NPI
- h. PIHP ID Number
- i. Claim Type
- j. Billed Amount
- k. Allowed Amount
- l. State Allowed Amount
- m. Paid Amount
- n. Units/Quantity
- o. Form Type
- p. Place of Service
- q. Dates of Service
- r. Procedure Code
- s. Modifier
- t. Diagnosis
- u. Third Party Liability
- v. PIHP Medicaid Provider Number

9.4 Financial Reporting Requirements:

Financial reports shall be submitted in accordance with the reporting requirements delineated in Attachment U. PIHP shall submit financial reports that are timely, accurate, and complete. The submission of late, not fairly presented, or otherwise materially incomplete reports shall constitute a failure to report and PIHP shall be subject to corrective actions or sanctions as specified in SOW Section 13.

As a material condition of this Contract, the PIHP shall submit to DMA, prior to the start of each fiscal year for which this contract is in effect (and 30 days from the date of execution of this contract) a copy of its annual budget, as presented to the Governing Board of the PIHP, in sufficient detail to identify revenues by funding source, including any funding obtained through the use of the Medicaid savings fund balance, to the extent such format complies with applicable provisions of the Local Budget and Government Fiscal Control Act, N.C.G.S. Chapter 159, Article 3. To the extent that any portion of the Medicaid savings fund balance is used specifically for funding of specific projects, the nature and description of such projects shall be provided with the aforementioned copy of the PIHP annual budget.

9.5 Clinical Reporting Requirements:

PIHP shall submit utilization data, report on performance measurements and implement and report on performance improvement projects as described in Attachment K and Attachment L, respectively. Reports shall identify trends and patterns, when appropriate, and describe how the findings are used in PIHP's clinical management and decision making processes. DMA and PIHP may mutually agree on modifications to Attachment K and L, respectively, to include additional quality measures as necessary over the term of this Contract, except when State of Federal authority mandates modification. DMA will provide guidance to PIHP in meeting the clinical reporting requirements of this contract. DMA will work with PIHP vendors to collect and report additional state-wide performance and outcome measures.

PIHP shall submit clinical reports that are timely, accurate, and complete. The submission of late, inaccurate, or otherwise incomplete reports shall constitute a failure to report and PIHP shall be subject to corrective actions or penalties and sanctions as specified in SOW Section 13. The DMA Contract administrator shall furnish PIHP with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission and such technical assistance in filing reports and data as may be permitted by the DMA's available resources. DMA reserves the right to modify from time to time the form, content, instructions, and timetables for collection and reporting of data. DMA agrees to involve PIHP in the decision process prior to implementing changes in format, and shall ask PIHP to review and comment on format changes before they go into effect. The timetable for new reports shall be negotiated by PIHP and DMA, taking into consideration the complexity and availability of the information needed.

9.6 Financial Reports Certification:

All financial reports, information, and data, including but not limited to encounter data, which this Contract requires PIHP to submit to DMA, shall be certified by PIHP as set forth in 42 C.F.R. § 438.606. The certification shall be made by one of the following individuals:

- a. PIHP's Chief Executive Officer;
- b. PIHP's Chief Financial Officer; or
- c. An individual who has been authorized to sign for, and who reports directly to, PIHP's Chief Executive Officer or Chief Financial Officer.

The person signing the certification on PIHP's behalf shall attest that the attached report, information or data is fairly presented, complete and truthful, to that person's best knowledge, information and belief. PIHP shall submit the certification concurrently with the certified data and documents.

SECTION 10 - PAYMENTS TO PIHP

10.1 Monthly Payment:

Capitated payments shall be made on a Per Member Per Month (PMPM), prospective and pre-paid basis at the first check-write of each month. The check-write schedule is provided on the DMA website at:

<http://www.ncdhhs.gov/dma/provider/calendar.htm>.

In full consideration of all services rendered by PIHP under this Contract, DMA shall remit to PIHP the Capitation Rate determined using the methodology in Attachment P by multiplying the number of Medicaid Eligibles in each Rate Cell (whose county of residence for Medicaid purposes is within PIHP's geographic area as determined by the monthly cutoff date in DMA's Medicaid Eligibility data system) by the payment rates for the respective Rate Cells.

The capitation rate is specified in **Appendix Y**.

However, payments shall be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements at 42 C.F.R. § 438.730. Payments made by DMA pursuant to this Contract are conditioned upon the availability to DMA of funds authorized for expenditure in the manner and for the purposes provided herein. DMA shall not be liable for any purchases or subcontracts entered into by PIHP or any subcontracted Provider in anticipation of funding.

In accordance with the rate setting methodology, individuals are considered a year older on the first day of the month following their birthday, regardless of the person's day of birth. For example, a person born August 30, 2002 shall be considered 1 year old on September 1, 2003. As Enrollees transition into different rate bands due to age, the new rate is effective on the first of the month following the month in which the person was born.

The payment is contingent upon satisfactory performance by PIHP of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers. PIHP shall set up the necessary bank accounts and provide written authorization to DMA's Fiscal Agent to generate and process monthly payments through the MMIS.

PIHP shall not use Title XIX funds to pay for:

- a. Services or administrative costs related to non-Title XIX clients; or
- b. Non-Title XIX services rendered to Title XIX clients.

PIHP shall maintain separate accounting for revenue and expenses for the Title XIX program in accordance with CMS requirements as delineated in Section 9.4 and Attachment U.

10.2 Payment in Full:

PIHP shall accept the capitation rate paid each month by DMA for each Medicaid beneficiary listed on the 820 Premium Payment Remittance transaction, including retroactive payments and adjustments as described in SOW Section 10.1, as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. Enrollees shall be entitled to receive all Medically Necessary Covered Services for the entire period for which payment has been made by DMA. Interest generated through investment of funds paid to PIHP pursuant to this Contract shall be the property of PIHP.

10.3 Retroactive Payment Adjustments:

DMA shall make retroactive capitated payments when beneficiaries are determined to be eligible for Medicaid or Innovations Waiver participation retroactively. Payments are made prospectively thereafter.

Payment adjustments may be initiated by DMA when keying errors or system errors affecting correct capitation payments to PIHP occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying information and the payment adjustment amount.

10.4 Calculation of Rates:

PIHP and DMA shall negotiate capitation rates in good faith and PIHP shall have the right to request adjustments to the capitation rates at any time. These rates shall be certified as compliant with the Centers for Medicare and Medicaid Services requirements under 42 C.F.R. § 438.6(c) by actuaries meeting the qualification standards of the American Academy of Actuaries.

The actuary for DMA shall develop capitation rate ranges in accordance with CMS regulations for the populations and services covered under the managed care contract. DMA reserves the right to determine and/or adjust the populations and services covered under this Contract prior to the beginning of each State fiscal year. The State fiscal year (SFY) begins each July 1 and ends on the following June 30.

Reimbursement provided under this Contract is intended for the coverage of medically necessary behavioral health services covered under the North Carolina State Plan, as well as those services identified under section 1915(b)(3) of the CMS approved PIHP waiver and the Innovations Waiver.

Attachment P describes the rate setting methodology for the capitated payments. Using the methodology in Attachment P, the rates shall be recalculated each year. DMA shall notify PIHP at least 30 days prior to the effective date of the new rates. PIHP shall have fourteen business days to review the proposed rates. At the end of the fourteen business day review period, PIHP may choose to accept the new rate, negotiate rate changes, or to terminate the Contract with DMA in accordance with Section 12.

10.5 Rate Adjustments:

Substantive changes in Medicaid services may occur during the Contract year due to Medicaid Program policy changes or mandated legislative changes. If DMA requires PIHP to add or subtract services during any given State fiscal year, DMA and PIHP shall negotiate appropriate adjustments to the capitation rate for the remainder of that State fiscal year.

10.6 Recoupment:

If PIHP:

- a. Erroneously reports (intentionally or unintentionally);
- b. Fraudulently reports; or
- c. Knowingly fails to report;

any information affecting payments to PIHP and DMA consequently overpays PIHP, DMA may either:

- a. request a refund of the overpayment; or
- b. recoup the overpayment by withholding payments due in any one or more subsequent months.

DMA may also recoup erroneous overpayments made to PIHP as a consequence of keying errors or system errors. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Enrollee information and the recoupment amount. DMA shall provide at least ten days' notice to PIHP of the intent to recoup overpayments and shall offer PIHP the opportunity to contest any such alleged overpayments.

10.7 Third Party Resources:

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties for some of the services rendered to Enrollees. PIHP shall make every reasonable effort to determine the liability of third parties, including casualty and other tort liability, to pay for services rendered to Enrollees pursuant to this Contract and to assign Coordination of Benefits responsibility to Network Providers. All funds recovered by PIHP from third party resources shall be treated as income to PIHP.

PIHP shall contractually require its Network Providers to report any third party coverage of its Enrollees to the appropriate county DSS within five days of obtaining the information from a source other than DSS.

If PIHP does not identify and/or begin collection activities against third party resources within twelve months from the date of service PIHP shall relinquish all rights to such resources and DMA may collect and retain any third party recoveries that it should discover.

SECTION 11 - SUBCONTRACTS

11.1 Requirements:

PIHP may enter into subcontracts for the performance of its administrative functions and for the provision of covered services to Enrollees and for the following administrative functions: Information Technology/System; Claims Processing; Customer Service; Provider Enrollment; Credentialing, and Monitoring; Professional Consultation and Peer Review.

All subcontracts and amendments to subcontracts shall be in writing, shall meet the requirements of 42 C.F.R. § 434.6 and 42 C.F.R. § 438.6, and shall:

- a. Clearly identify the functions that are subcontracted;
- b. Identify the Enrollee population covered by the subcontract, if any;
- c. Specify the amount, duration and scope of services to be provided by the subcontractor;
- d. Specify the procedures and criteria for the extension, re-negotiation, and termination of the subcontract;
- e. Fully disclose the method and amount of compensation or other consideration to be received from PIHP;
- f. Provide that PIHP shall monitor the quality of services rendered to Enrollees, if applicable;
- g. Provide that PIHP shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;
- h. Contain a provision that, upon PIHP's identification of deficiencies or areas for improvement in the subcontractor's performance, the subcontractor shall take corrective action;
- i. Contain no provision which provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services from Enrollees;
- j. Prohibit the subcontractor, without PIHP's prior written consent, from assigning the subcontract and subcontracting with lower tier subcontractors;
- k. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including without limitation, the obligation to comply with all applicable Federal and State laws and regulations, all rules, policies and procedures of the Department and DMA, and all standards governing the provision of Covered Services and information to Enrollees; all quality assurance requirements; all record keeping and reporting requirements; the obligation to maintain the confidentiality of information; all rights of DMA and other officials to inspect, monitor and audit operations; the rights of DMA and other State/Federal officials to inspect and audit any financial records; all indemnification and insurance; and
- l. Contain the subcontractor's National Provider Identifier (NPI) if applicable (and the subcontractor's Medicaid provider number, if applicable, until that number is no longer needed for Medicaid reimbursement).

PIHP shall not sign a subcontract with any subcontractor that is excluded from participation in any Federal or State health care program, including but not limited to the NC Medicaid program. No subcontract shall in any way relieve PIHP of any responsibility for the performance of its duties under this Contract. Upon DMA's request, PIHP shall provide DMA with copies of the results of any audits or reviews of the performance of PIHP's subcontractors.

11.2 Timeliness of Provider Payments:

Payments to Providers by PIHP shall be made on a timely basis, consistent with claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act and 42 C.F.R. § 447.45. PIHP shall ensure that ninety percent of all Clean Claims for covered services, for which no further written information or substantiation is required in order to make payment, are paid within thirty days of the date of approval; and that ninety-nine percent of such claims are paid within one hundred eighty days of the date of receipt. PIHP is not responsible for processing or payment of claims that are submitted ninety days after the date of service. Date of receipt is the date PIHP receives the claim, as indicated by electronic data records and the 835 Health Care Claim Payment/Advice Transaction (Electronic Remittance Advice [ERA]) generated for the Provider. The date paid is the date of the check or other form of payment.

PIHP shall follow North Carolina Prompt Pay Requirements as follows: Within eighteen calendar days after PIHP receives an invoice/claim from a Provider, PIHP shall either:

- a. Approve payment of the invoice/claim;
- b. Deny payment of the invoice/claim; or
- c. Determine that additional information is required for making an approval or denial.

If payment is approved, the claim shall be paid within thirty calendar days after it is received. If payment is denied or PIHP determines that additional information is required for making an approval or denial, it is not considered a Clean Claim. The 30 days is inclusive of the first 18 days to determine if a claim can be paid or denied.

If PIHP fails to pay Providers within these parameters, PIHP shall pay to the Providers interest at the annual rate of 8% of the amount owed in excess of the Prompt Pay Requirements, compounded daily.

11.3 DMA's Remedies against Subcontractors:

DMA shall have the right to invoke against PIHP's subcontractors any or all of the remedies available to DMA under this Contract, including the right to inspect records, the right to require the subcontractor to establish a plan of correction, the right to stop payment, to mandate termination of the subcontract, and the right to recoup erroneous payments not already collected by PIHP.

SECTION 12 - DEFAULT AND TERMINATION

12.1 PIHP Breach; Remedies:

If PIHP breaches any material term of this Contract, DMA may issue a written notice of breach to PIHP that describes the material breach and requires PIHP to submit to DMA, within thirty days, a Corrective Action Plan for DMA's approval. If PIHP does not timely cure the breach to DMA's satisfaction, DMA may impose one or more or all of the sanctions listed below:

- a. The suspension, recoupment, or withholding of monthly capitation payments;
- b. The assessment of refundable or non-refundable penalties;
- c. The assessment of monetary damages; and
- d. Termination of this Contract.

Notwithstanding the foregoing, DMA may impose any of these sanctions, or any other available sanctions, against and in accordance with 42 C.F.R. § 438.710, without first giving PIHP an opportunity to cure the deficiency.

12.2 Termination without Cause:

This Contract may be terminated without cause by either party by giving 120 days prior written notice to the other party. The termination shall be effective at 11:59:59 p.m. on the last day of the calendar month in which the ninety day notice period expires. In the event of termination by either party without cause:

- a. DMA and PIHP shall work together to minimize any disruption of services to clients;
- b. PIHP shall perform all of the duties specified in SOW Section 12.5 below;
- c. DMA and PIHP shall resolve any outstanding obligations under this Contract; and

- d. PIHP shall pay DMA in full any refunds or other sums due to DMA under this Contract.

If PIHP exercises its right to terminate this Contract without cause, DMA may require PIHP to pay the non-federal share of reasonable transition costs; i.e., the costs of NC FAST, MMIS, and beneficiaries notifications.

12.3 Termination for Cause:

DMA shall have the right to terminate this Contract immediately for cause -- and provide Medicaid benefits to Enrollees through other options in the State Plan -- if DMA determines that:

- a. PIHP or one of its subcontractors has substantially failed to comply with the material terms of this Contract and PIHP knows or should have known of the noncompliance and fails to take appropriate action immediately to correct the problem;
- b. PIHP or one of its subcontractors has substantially failed to comply with the applicable requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act and PIHP knows or should have known of the noncompliance and fails to take appropriate action immediately to correct the problem;
- c. PIHP has substantially failed to comply with the requirements of any applicable State or Federal law, statute, rule, or regulation and PIHP fails to take appropriate action immediately to correct the problem;
- d. The performance of PIHP or one of its subcontractors threatens to place the health or safety of any Enrollee in jeopardy and PIHP knows or should have known of the issue and fails to take appropriate action immediately to correct the problem;
- e. PIHP becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);
- f. PIHP fraudulently misleads any Enrollee or fraudulently misrepresents the facts or law to any Enrollee and PIHP fails to take appropriate action immediately to correct the problem; and
- g. Gratuities of any kind with the intent to influence are offered or received by a public official, employee or agent of the State by or from Eastpointe, its agents or employees.
- h. Total Expenses: Total expenses (medical and administration), including estimates of Incurred But Not Reported (IBNR) medical expenses and accrued administrative expenses, must not exceed 100% of the total monthly capitation payments IN ANY THREE-CONSECUTIVE MONTH PERIOD.
- i. Current ratio: Current assets divided by current liabilities is less than 1.00 at any point in time.
- j. Defensive interval: Is less not than thirty (30) days. Defensive interval = (Cash + Current investments) / ((Operating expense – Non-cash expense)/Period being measured in days)) at any point in time.
- k. Medical Expense Ratio (MER) – Total service expenses (as reflected on Schedule C – DMA workbook) divided by the total Medicaid revenue, excluding the risk reserve revenue, must not fall below 85% on an year-to-date ("YTD") basis. During the first six (6) months of the term of this Contract, the Parties will monitor the MER but no corrective action will be required if the PIHP's MER falls below 85% on a YTD basis. Following this six-month grace period, if MER falls below 85% in any subsequent quarter, PIHP shall be required to complete and implement a Corrective Action Plan. PIHP shall have three months to implement the Corrective Action Plan and to bring MER above 85%. If, after the three month period of implementation of the Corrective Plan the MER is not above 85%, DMA may, but is not required to, terminate the Contract for cause.

12.4 Automatic Termination:

This Contract shall immediately and automatically terminate without further obligation to the Division of Medical Assistance if:

- a. Either of the two sources of reimbursement for Medical Assistance (appropriations from the North Carolina General Assembly and appropriations from the United States Congress) no longer exists; or
- b. In the event that the sum of all contractual obligations of DMA for Medical Assistance Benefits, exceeds the balance of funds available to DMA for Medical Assistance Benefits for the contract year in which this Contract is effective, then DMA shall have the option to immediately terminate or amend this Contract.

Written certification by the Director of the Division of Medical Assistance that one or the other or both of the conditions described above has been met shall be conclusive and binding upon the parties. The Division of Medical Assistance shall attempt to provide PIHP with ten (10) days' notice of the possible occurrence of events described above.

12.5 PIHP's Obligations upon Contract Expiration or Termination:

Upon the expiration or termination of this Contract, PIHP shall:

- a. Continue to perform all of the duties described in this SOW until 11:59:59 p.m. on the last day of the calendar month for which DMA has paid the monthly capitation rate;
- b. Continue to provide authorization and payment for inpatient psychiatric hospital services and any services directly related to psychiatric inpatient care, to any Enrollees who are hospitalized on the termination date, until each such Enrollee is discharged, or until 11:59:59 p.m. on the last day of the calendar month for which DMA has paid the monthly capitation rate, whichever occurs first;
- c. Provide DMA with a report of all active authorizations and authorization limits, as of the date of termination;
- d. Provide DMA with a list of Enrollees who are hospitalized, and where each Enrollee is hospitalized, if known to PIHP, as of the date of termination;
- e. Provide DMA with a list of Enrollees in psychiatric residential treatment facilities (PRTFs) authorized by PIHP, and where each PRTF Enrollee is hospitalized, as of the date of termination;
- f. Arrange for the transfer of Enrollees to other appropriate Medicaid Providers or managed care entities;
- g. Promptly provide DMA with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;
- h. Take such action as may be necessary, or as DMA may direct, for the protection of property related to this Contract, which is in the possession of PIHP and in which DMA has an interest;
- i. Arrange for the secure maintenance of all PIHP records for audit and inspection by DMA, CMS, and other authorized government officials, in accordance with Section 8 of this Contract;
- j. Provide for the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;
- k. Provide for the preparation and delivery of any reports, forms or other documents to DMA as may be required pursuant to this Contract or any applicable policies and procedures of DMA; and
- l. Notify all Enrollees in writing of the pending expiration or termination of the Contract no less than forty-five (45) days prior to the date of the expiration or termination. If DMA terminates the Contract immediately for cause, pursuant to SOW Section 12.3, PIHP shall provide notice of termination as promptly as possible after PIHP receives the notice of termination from DMA. Similarly, if the Contract is terminated immediately because of a lack of funds, pursuant to SOW Section 12.4, PIHP shall provide notice of termination as promptly as possible after PIHP receives the notice of termination from DMA. In all cases, PIHP's notification letter must be approved by DMA before PIHP mails the notice to Enrollees.

The obligations set forth in this SOW Section 12.5 shall survive the expiration or termination of this Contract and shall remain fully enforceable by DMA against PIHP. In the event that PIHP fails to fulfill each obligation set forth

in this Section, DMA shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of PIHP and PIHP shall refund to DMA all sums expended by DMA, in so doing.

12.6 DMA's Obligations upon Contract Expiration or Termination:

Upon the expiration or termination of this Contract, DMA shall:

- a. Continue to pay the monthly capitation rate through the effective date of expiration or termination;
- b. Continue to provide the monthly list of beneficiaries eligible to be enrolled in the PIHP through the effective date of expiration or termination;
- c. Continue to provide all data required to be shared with PIHP through the effective date of expiration or termination;
- d. Provide assistance to PIHP with respect to the transfer of Enrollees to other appropriate Medicaid providers or managed care entity;
- e. Provide assistance with the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;
- f. Provide assistance with the preparation and delivery of any reports, forms or other documents to PIHP as may be required pursuant to this Contract or state or federal law; and
- g. The obligations set forth in this SOW Section 12.6 shall survive the expiration or termination of this Contract and shall remain fully enforceable by PIHP against DMA. In the event that DMA fails to fulfill each obligation set forth in this Section, PIHP shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of DMA and DMA shall refund to PIHP all sums expended by PIHP, in writing in so doing.

SECTION 13 – PENALTIES, SANCTIONS and TEMPORARY MANAGEMENT:

13.1 DMA may use any one or more of the following options to ensure compliance with the provisions of this SOW:

- a. Corrective Action Plan: To be developed by PIHP at the request of DMA. The Plan must be approved by DMA, in writing and shall be monitored by the Monitoring Team and DMA (SOW Section 1.6: Monitoring Process). DMA is not required to offer a Corrective Action Plan prior to taking any other action against Contractor;
- b. Penalties and Sanctions: (SOW Section 13.2:– Monetary Penalties; SOW 13.3 Sanctions);
- c. Temporary Management: (SOW Section 13.4: Temporary Management); and
- d. Termination: (SOW Section 12: Default and Termination).
- e. Prior to imposing any of the sanctions identified in 42 C.F.R. Part 438, Subpart I and/or Sections 13.2 and 13.3 of this Scope of Work, DMA will provide notice to PIHP in accordance with 42 C.F.R. § 438.710.

13.2 Monetary Penalties:

If PIHP does not adhere to the reporting and data submission requirements and deadlines specified within this Contract, DMA may impose monetary penalties. DMA shall communicate the penalties in writing to PIHP and DMA's fiscal agent.

All financial reports prepared and submitted by PIHP subsequent to the imposition of penalties shall reflect the penalties.

DMA shall have the right to assess monetary penalties pursuant to SOW Section 11.2: Timeliness of Provider Payments and Section 9.4: Reporting Requirements.

13.3 Sanctions:

In addition to the penalties described in Section 13.1, DMA may impose sanctions authorized by 42 C.F.R. § 438.702.

For any of the violations under paragraphs 42 C.F.R. § 438.700(d)(1) and (d)(2), only the sanctions specified in 42 C.F.R. § 438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

Sanctionable actions include but are not limited to failure to provide medically necessary services that the PIHP is required to provide, under law or under contract, imposing premiums on enrollees or charges in excess of the premiums or charges permitted under the Medicaid program, or discrimination among enrollees on the basis of health status or need for health care services.

Intermediate sanctions may include but are not limited to:

Civil monetary penalties as specified in 42 C.F.R. § 438.704, appointment of temporary management for the PIHP, granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll, suspension of new enrollment including default enrollment, and suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the state is satisfied the reason for the sanction no longer exists and is not likely to recur.

13.4 Temporary Management:

DMA shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that PIHP has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act.

In accordance with 42 C.F.R. § 438.706(c), DMA is not required to delay imposition of temporary management in order to provide a Hearing before imposing this sanction. DMA may not terminate temporary management until it determines that PIHP can ensure that the sanctioned behavior shall not recur.

SECTION 14: PROGRAM INTEGRITY

14.1 General:

PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438, 455, and 1000 through 1008, as applicable, including proper payments to providers and methods for detection of fraud and abuse.

PIHP shall have policies and procedures that guide and require the PIHP and the PIHP's officers', employees', agents' and subcontractors' compliance with the requirements of this section.

PIHP shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.

PIHP must investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take the appropriate action.

14.2 Fraud and Abuse:

PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. § 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA PI Unit and Contract Administrator on an annual basis.

PIHP shall designate a Full-Time Compliance Officer and Compliance Committee who meet the requirements of 42 CFR § 438.406 and are responsible for implementing and monitoring the Compliance Plan. The Compliance

Officer shall serve as DMA's contact for Program Integrity issues, and participate in monthly Program Integrity meetings with DMA.

The Compliance Officer must be accountable to senior management

PIHP shall submit monthly compliance committee and special investigations unit meeting minutes to DMA Program Integrity by the fifth of the following month.

PIHP Compliance Officer and Special Investigations unit shall participate in monthly Program Integrity meetings with DMA

PIHP's written Compliance Plan shall, at a minimum, include:

- a. Plan for training and educating the organization's employees, subcontractors, and providers on fraud and abuse.
- b. Plan for communication between the compliance officer and the organization's employees, subcontractors and providers.
- c. Provisions for internal and external monitoring and auditing.
- d. Enforcement of standards through well-publicized disciplinary guidelines.
- e. Provision for prompt response to detected offenses, and for development of corrective action initiatives.
- f. Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act.
- f. Provision for full cooperation with any federal, DMA or Attorney General Medicaid Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for their investigation.

In addition, PIHP shall have written policies and procedures to guard against fraud and abuse. At a minimum, such policies and procedures shall include:

- a. Policies and procedures for detecting and investigating fraud and abuse;
- b. Process for capturing and tracking complaints;
- c. A detailed workflow of the agencies' process for taking a complaint from inception through closure. This process should include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse;
- d. Process for tracking overpayments, collections, and reporting on Attachment Y;
- e. Process for handling self audits and challenge audits;
- f. Process for using data mining to determine leads;
- g. Process for informing employees, subcontractors and providers regarding the False Claims Act;
- h. Verification that services billed by providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements; and
- i. Process for obtaining financial information on potential and current Network Providers enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.

In the event that the Department provides written notice to the PIHP that a provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, the PIHP shall remit any reimbursement amounts due to that provider to the Department on behalf of the provider until the provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied.

PIHP shall identify all overpayments and underpayments to providers and shall offer providers an internal dispute resolution process for program integrity, compliance or monitoring actions taken by PIHP that meets accreditation requirements. PIHP shall not be required to offer providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum unless such opportunity to appeal is required by state or federal law, rule or regulation.

PIHP shall have a special investigation unit responsible for program Integrity activities, including identification, detection, and prevention of fraud, waste, and abuse.

PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of an allegation of fraud. If the PIHP determines that a complaint or allegation rises to potential fraud, the PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.

In each case where PIHP investigates a credible allegation of fraud, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:

- a. Subject (name, Medicaid provider ID, address, provider type).
- b. Source/origin of complaint.
- c. Date reported to PIHP or if developed by the PIHP, the date PIHP initiated the investigation.
- d. Description of suspected intentional misconduct, with specific details including:
 - i. The category of service
 - ii. Factual explanation of the allegation
 - iii. Specific Medicaid statutes, rules, regulations, or policies violated
 - iv. Dates of conduct
- e. Amount paid to the provider for the last three years (amount by year) or during the period of the alleged misconduct, whichever is greater.
- f. All communications between PIHP and the provider concerning the conduct at issue, when available.
- g. Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs.
- h. Sample/exposed dollar amount, when available.

In each case of suspected Enrollee fraud, PIHP shall provide DMA Program Integrity with:

- a. The Enrollee's name, birth date and Medicaid number;
- b. The source of the allegation;
- c. The nature of the allegation, including the timeframe of the allegation in question;
- d. Copies of all communications between the PIHP and the provider concerning the conduct at issue;
- e. Contact information for PIHP staff persons with practical knowledge of the allegation;
- f. Date reported to the State; and
- g. The legal and administrative status of the case.

PIHP shall mutually agree with the Department on program integrity and monitoring forms, tools, and letters that meet the requirements of state and federal law, rules and regulations and are consistent with the forms, tools and letters utilized by other PIHPs.

PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.

PIHPs using FAMS shall work with DMA designated administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. PIHPs using FAMS shall notify the DMA designated administrator within forty-eight (48) hours of FAMS-users changing roles within the organization or termination of employment.

PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format on the fifth day of each month.

14.3 Provider Payment Suspensions:

DMA shall review all allegations of provider fraud received from PIHP and make appropriate referrals to the Medicaid Fraud Control Unit (MFCU) pursuant to 42 C.F.R. § 455.23.

- a. If MFCU indicates that suspension will not impact their investigation, DMA will send a payment suspension notice to the provider and notify PIHP.
- b. If the MFCU indicates that payment suspension will impact the investigation, DMA will temporarily withhold the suspension notice and will notify PIHP.
- c. Suspension of payment actions under this section will be temporary and will not continue if either of the following occur:

- i. The Contractor or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider; or
 - ii. Legal proceedings related to the provider's alleged fraud are completed and the provider is cleared of any wrongdoing.
- d. In the circumstances described in Section 14.3 (c) above, PIHP will be notified and must lift the payment suspension within three business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.

Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.

PIHP shall provide to DMA all information and access to personnel needed to defend at review or reconsideration for any and all investigations and referrals made by the PIHP.

PIHP shall not take administrative action regarding allegations of suspected fraud on any providers referred to DMA Program Integrity due to allegations of suspected fraud. If administrative action is desired, PIHP must consult and obtain approval from DMA Program Integrity.

Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from enforcing its provider contracts separate and apart from any potential fraud identified by DMA Program Integrity, to the extent that such enforcement shall not interfere with the beneficiary's access to care.

14.4 Reporting:

PIHP shall provide a monthly report to DMA Program Integrity of all suspected cases of provider and enrollee fraud and abuse, including but not limited to overpayment and self-audits. The monthly report will be due by the fifth of each month in the format as identified in Attachment Y. DMA Program Integrity shall conduct a preliminary investigation of each allegation of fraud to determine whether there is sufficient evidence to warrant a full investigation.

In addition PIHP must report to DMA Program Integrity all provider terminations, including the reason for the termination and the effective date.

All overpayments collected may be retained by PIHP; however, full financial disclosure to DMA is required and activity will be reflected in the next rate setting. PIHP will copy DMA Program Integrity on all notices of overpayment sent to Network Providers. Recovery Audit Contractors for the Medicaid program may audit providers in the PIHP network and may work collaboratively with PIHP on identification of overpayments.

The Medicaid Investigations Division reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to the MCO.

SECTION 15: U.S. DEPARTMENT OF JUSTICE (DOJ) SETTLEMENT REQUIREMENTS

15.1 Staff:

- a. The PIHP shall have staff to perform "transition planning functions" for the DOJ Special Healthcare Population.
- b. The staff may be Care Coordinators.
- c. The staff shall:
 - i. Except for Certified Peer Support Specialists, meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training;
 - ii. Assure that discharge/transition planning occurs timely effectively for individual described for the DOJ Special Healthcare Population; and
 - iii. Ensure the development of an effective transition plan for the DOJ Special Healthcare Population.
- d. The PIHP must have staff to perform "diversion" and "in-reach" activities for the DOJ Special Healthcare Population. The in-reach staff must be Certified Peer Support Specialists.

15.2 Care Coordination:

- a. The population identified in the DOJ Settlement Agreement is a required "Special Healthcare Population" and Care Coordination shall include clinical functions performed by a licensed Care Coordinator. Administrative functions may be performed by unlicensed staff.
- b. PIHP shall provide "transition planning" for the DOJ Special Healthcare Population.
 - i. Transition planning is the process of developing a person-centered recovery transition plan to assist an individual in transitioning from an Adult Care Home or other congregate community living arrangement to a more integrated community living arrangement. This plan shall be used by the treatment provider to develop the person-centered recovery treatment plan.
 - ii. The transition plan shall follow the guidelines set forth by the Department in support of the DOJ Settlement Agreement.
- c. PIHP shall provide "diversion" and "in-reach activities" for the DOJ Special Healthcare Population. These activities shall follow the guidelines set for by the Department in support of the DOJ Settlement agreement ([click here](#)).
- d. In-reach activities shall be documented using the Department's Transition to Community Living (TCL) Database and include, at a minimum, include the following, as appropriate:
 - i. Full explanations of the benefits and financial aspects of clinically appropriate community-based integrated settings, including supporting housing;
 - ii. Facilitating and accompanying individuals on visits to support housing apartments;
 - iii. Assessing Adult Care Homes residents' interest in supporting housing; and
 - iv. Exploring and addressing the concerns of any Adult Care Home residents who decline the opportunity to move to supportive housing or who are ambivalent about moving to supportive housing despite being qualified for such housing.
- e. PIHP shall maintain up-to-date data on individuals involved in the in-reach or transition process. Complete data shall be entered into the TCL database by the 10th of each month for the previous month. Any documents generated or received by PIHP related to any aspect of the Transition to Community Living Initiative (TCLI) shall be stored and maintained pursuant to the State Record Retention requirements.
- f. PIHP shall deliver ad hoc reports related to Care Coordination to DMA in accordance with Section 9 of this Contract.
- g. PIHP, through the provision of in-reach, transition coordination, and care-coordination services whether provided directly by the PIHP staff or contracted through a provider, is responsible for the oversight of the SA/IH Program funds for each TCLI participant and assuring that eligibility information is provided to the Department of Social Services as required to maintain program eligibility.

15.3 Person-Centered Planning:

- a. A person-centered service plan shall be developed for each individual with an approved housing slot, or receiving ACTT or IPS-SE services, which shall be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the Enrollee in a coordinated manner. Individualized service plans shall include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis. Plans shall be evidence-based, recovery focused, and community based; be flexible and individualized to meet the needs of each individual; help individuals to increase their ability to recognize and deal with situations that may otherwise result in crisis; and increase and strengthen individuals' networks of community and natural supports as well as their use of these supports for crisis prevention and intervention.
- b. PIHP shall provide access to the services and supports that are medically necessary for individuals who are transitioning through TCLI.
- c. PIHP shall engage with Adult Care Home (ACH) providers to provide information on assessment, referrals, and crisis access. The PIHP will also provide equal access to services and supports for individuals who choose to reside in ACH services over transitioning into the community through the TCLI.
- d. PIHP shall develop discharge plans for individuals with Serious Mental Illness (SMI)/ Serious and Persistent Mental Illness (SPMI) residing in ACHs and State hospitals and update them periodically.

15.4 Internal Quality Assurance/Performance Improvement Program:

- a. PIHP shall administer the Quality of Life (QOL) surveys for the DOJ Special Healthcare Population.

- b. QOL surveys shall be administered by the PIHP:
 - i. Prior to the individual transitioning out of the facility;
 - ii. Eleven months after the individual's transition of the facility; and
 - iii. 24 months after the individual's transition out of the facility.
- c. PIHP shall report the survey results to the Department per the US DOJ Settlement Guidelines.

15.5 Clinical Reporting Requirements:

- a. PIHP shall be responsible for reporting on discharge-related measures for the US DOJ Special Healthcare Population, including but not limited to:
 - i. Housing vacancies;
 - ii. Discharge planning and transition processes;
 - iii. Referral processes and subsequent admissions;
 - iv. Time between applications for services to discharge destination;
 - v. Actual date of admission to community-based settings;
 - vi. Information related to both successful and unsuccessful placements; and
 - vii. Problems or barriers to placing or keeping individuals in the most integrated setting.
- b. PIHP shall follow the report schedule and format of the US DOJ Settlement Guidelines.
- c. PIHP shall assure that individuals receiving services from agencies or residing in facilities that are closed get assessed within seven (7) days of notification to PIHP of closure and are linked to services based on medical necessity.

15.6 Assertive Community Treatment (ACT):

- a. PIHP shall contract only with providers who are in fidelity to the Tool for Measurement of ACTT (TMACT) model in accordance with the DOJ Settlement Agreement and current policy.
- b. PIHP shall provide current ACT programs with reasonable training and technical assistance to meet the current service definition requirements.
- c. PIHP shall contract with a sufficient number of providers for ACT services for individuals with SMI/SPMI, including those in the DOJ Special Healthcare Population, in accordance with the DMA Clinical Policy and waiver service description.

15.7 Peer Support Services (PSS):

- a. PIHP shall required to provide evidence-based Peer Support Services (PSS) as a Medicaid 1915 (b)(3) service in accordance with the DMA Clinical Policy and waiver service description.
- b. PIHP shall contract with a sufficient number of providers for PSS services for individuals with SMI/SPMI, including those in the DOJ Special Healthcare Population in accordance with the DMA Clinical Policy and waiver service description.

15.8 Supported Employment (SE):

- a. PIHP shall contract only with providers who are in fidelity to the Individual Placement and Support – Supported Employment (IPS-SE) model in accordance with the DOJ Settlement Agreement and current policy.
- b. PIHP shall provide current IPS-SE programs with reasonable training and technical assistance to meet the current service definition requirements.
- c. PIHP shall contract with a sufficient number of providers for IPS-SE services to individuals with SMI/SPMI, including those in the DOJ Special Healthcare Population, in accordance with DMA Clinical Policy and waiver service descriptions.

15.9 One Time Transitional Supports:

- a. PIHP shall offer 1 (one) time transitional supports as a Medicaid 1915 (b)(3) service for the DOJ Special Healthcare Population.
- b. DHHS will define the use/amount of “1 (one) time transitional supports” based on approved budgets.

15.10 Diversion Process:

- a. PIHP shall assign staff or contract with staff to carry out the requirements of the DOJ Settlement related to diverting individuals from admission to licensed Adult Care Homes.
- b. PIHP shall produce for the Department their criteria and analysis that demonstrates adequate staffing levels.
- c. PIHP shall, directly or through contract, ensure that:
 - i. Community Integration Plans are completed with clear documentation that informed choice drove the individual's decision and the degree to which that decision has been implemented.
 - ii. Medicaid services are offered to individuals whether moving to the community or to an Adult Care Home.
 - iii. Final person-centered recovery plans for individuals transitioning to the community are submitted to DMH/DD/SAS prior to final approval of a requested housing slot. An individual may not move into housing until receipt of the written approval of DMH/DD/SAS.
 - iv. Individuals who choose to be admitted to an ACH are referred for In-Reach, per the in-reach requirements of the DOJ Settlement.
- d. The PIHP shall maintain up-to-date data on individuals in the diversion process. Complete data shall be entered in to the TCL reporting system by the 10th of each month for the previous month's information. Any documents generated or received by the PIHP related to any aspect of TCLI shall be stored pursuant to State Record Retention requirements.
- e. PIHP shall deliver ad hoc reports related to Diversion processes to DMA in accordance with Section 9 of this Contract.

15.11 Communication:

PIHP shall provide publicity, materials and training about the crisis hotline, services, and the availability of information for individuals with limited English proficiency, to all Enrollees in the catchment area consistent with federal requirements at 42 C.F.R. § 438.10 as well as to all behavioral health providers and community stakeholders, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. Peer supports, enhanced ACT, including employment support from employment specialists on ACT teams for individuals with SMI, Transition Year Stability Resources, Limited English Proficiency requirements, crisis hotlines and treatment planning will be implemented in coordination with the current PIHP implementation schedule. PIHP shall comply with federal requirements related to accessibility of services provided under the Medicaid State Plan that they are contractually required to provide.

SECTION 16 - CARE COORDINATION AND DUE PROCESS PRINCIPLES UNDER THE INNOVATIONS WAIVER

16.1 Care Coordination:

- a. When Innovations Waiver Participants are notified of the results of a new Supports Intensity Scale (SIS) evaluation, PIHP must inform the Participant and/or Participant's legally responsible person in writing of the opportunity and process for raising concerns regarding the SIS evaluation. Such processes shall include an opportunity to discuss the results of the SIS evaluation with PIHP and the potential for results to be adjusted if it is determined that particular support needs of the individual were not accurately captured, as well as the opportunity to file a grievance. The failure to request a grievance does not waive the Innovations Waiver Participant's ability to argue that the results of the SIS are incorrect in requesting services, or during reconsideration review or the State fair hearing. PIHP shall ensure that the SIS, or any other similar evaluation, is used only as a tool in guiding the enrollee and Care Coordinator in creating a Participant's plan of care, and the results of the SIS, or any other similar evaluation, do not constitute a binding limit on the services that may be requested by the Participant or approved by the PIHP.
- b. To the extent an employee of PIHP facilitates or assists in making an Innovation Waiver Participant's request for authorization of services, PIHP must ensure that a Participant's request for services is made in a manner consistent with the desires of the enrollee and that those desires are reflected in the Participant's plan of care, including desires for the type, amount, and duration of services. Review of requests for authorization of services shall be made in accordance with 42 CFR § 438.210(d). PIHP must allow Innovations Waiver Participants to make a new request for services at any time by requesting an update or revision to the Participant's plan of care.

- i. PIHP shall discuss the duration of the services expected by the Innovations Waiver Participant and PIHP must ensure that proposed plans of care request authorization for each service at the duration requested by the Participant during the Participant's plan year.
 - ii. PIHP shall assist Innovations Waiver Participants in developing plans of care and explaining options regarding the services available to the Participant.
- c. If PIHP authorizes a requested service for a duration less than the duration requested in the plan of care, PIHP shall provide written notice with appeal rights and clinical reasons for the decision at the time of the limited authorization, unless, for adults enrollees (21 years old and older), PIHP has authorized the services up to the maximum benefit duration for adult Innovations Waiver Participants, as set forth in the waiver.

16.2 Due Process Principles:

- a. If PIHP denies a request for authorization of services by an enrollee, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of service, PIHP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404.
 - i. An appeal filed by an enrollee must not prevent any authorized services from being provided pending the outcome of the appeal. PIHP must not prevent enrollee from making a new request for services during a pending appeal.
 - ii. PIHP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all enrollees from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to appeal the denial, reduction, or termination of a service. PIHP shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file or pursue a grievance or request an appeal.
- b. If PIHP reduces, suspends, or terminates an enrollee's services during an existing authorization period, PIHP shall, upon request of the enrollee, continue the enrollee's benefits as set forth in 42 CFR § 438.420, if all the requirements of 42 CFR § 438.420 are met.
- c. PIHP agrees to attend trainings required by the Department, including but not limited to training on the topics set out in this Contract Amendment and trainings relevant to due process procedures, whether related to the waiver or otherwise. PIHP shall train all relevant staff with the same materials provided by the Department. PIHP shall train new employees within 15 business days of a new employee's start date and shall conduct due process training at least annually for all relevant staff. PIHP further agrees to update any materials publicly posted on PIHP's website that are inconsistent with the terms of this Contract Amendment or inconsistent with any trainings provided by the Department.

ATTACHMENT C

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES BUSINESS ASSOCIATE ADDENDUM

This Agreement is made effective the 1st day of July, 2015, by and between the Division of Medical Assistance ("Covered Entity") and Eastpointe ("Business Associate") (collectively the "Parties").

1. BACKGROUND

- a. Covered Entity and Business Associate are parties to a contract entitled Contract #31975 (the "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 Addendum 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" 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. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
- e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- f. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.
- g. "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.
- h. 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 Protected Health Information 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 electronic protected health information, to prevent use or disclosure of the Protected Health Information 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 Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
- e. 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 protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.

- f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
- h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information 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.
- i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information 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 Protected Health Information 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 Protected Health Information 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; or
 - 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 Protected Health Information 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 may not use or disclose Protected Health Information 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 stated above 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 Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - 2) In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

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.

Ken Jones
PLEASE PRINT NAME

Ken Jones
SIGNATURE

6/30/15
Date

ATTACHMENT D

Data Protection

The requirements of this section apply to all data that the Business Associate may create, receive, maintain, or transmit on DMA's behalf under the terms of this contract. The requirements apply regardless of the Business Associate's status as a HIPAA covered entity.

General Provisions

Business Associate agrees to maintain DMA claims data separately from other data sources in order to ensure data integrity and maintain data security. DMA information is confidential "protected health information" that may be used and disclosed only in accordance with Division of Medical Assistance (DMA), DHHS, State, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended ("HIPAA"), and its implementing regulations, 45 CFR Parts 160, 162, and 164, including the Omnibus Rule. Data should be maintained in keeping with the requirements of the HIPAA and 256-bit encryption must be used for data in transit.

Furthermore, all information listed in N.C.G.S. § 14-113.20(b) as "identifying information" such as social security numbers, employer taxpayer identification numbers, drivers license numbers, and any other numbers or information that can be used to access a person's financial resources, may be used and disclosed only in accordance with the NC Identity Theft Protection Act, N.C.G.S. § 75-60 through 65 and N.C.G.S. § 132-1.10. The Business Associate, its employees, agents, and contractors must protect all such information against theft and misuse at all times: in storage, while in use, and in transit.

The parties agree that for data that is created, received, maintained, or transmitted for the purposes of fulfilling the terms of this contract, DMA has the role of the covered entity under HIPAA and the data owner under NC ID Theft law N.C.G.S. § 75-65(a). The Business Associate does not own the data, but "maintains" or "possesses" the data under the provisions of N.C.G.S. § 75-65(b). The Business Associate shall not take any independent action to notify oversight agencies such as the US Secretary of Health and Human Services or the NC Attorney General's office, or the individuals involved. Any recipient notification or notification of oversight agencies shall be performed directly by DMA or with the approval of DMA. Though the Business Associate may generate a suggested draft, the language of the recipient letter shall be determined and approved by DMA.

Notification of DMA

The Business Associate agrees to notify the DMA when a security or privacy incident takes place. A security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, see 45 CFR 164.304. A privacy incident means an event in which there is *reason to suspect* a breach under HIPAA, that is, the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164 subpart E (Privacy of Individually Identifiable Health Information) which compromises the security or privacy of the protected health information.

The Business Associate shall report to DMA as soon as practical but no later than 24 hours after the discovery of the suspected security incident or privacy incident. The initial report may consist of general information, with more detail to follow as the investigation continues. The requirement to notify DMA is satisfied by notifying the NC DHHS Office of Privacy and Security at: <http://www.ncdhhs.gov/psa/>.

Risk Assessment and Recipient Notification

When a privacy or security incident has occurred, the Business Associate shall:

- notify DMA immediately, but no later than 24 hours;
- provide detailed information, providing complete and accurate answers to questions from DMA within 1 business day unless otherwise agreed upon by both DMA and the Business Associate;
- investigate the incident to determine what, if any, information was disclosed and provide this to DMA within 5 days
- complete a risk assessment within 5 business days of the event and make a preliminary assessment regarding the presence of significant risk of compromise to the data;
- provide a list of all recipients affected within 5 business days of the event;
- update DMA as more information becomes available;
- provide all additional information required by HIPAA (including 45 CFR 164.410) and NC Identity Theft statutes within 5 days of the event;

- perform action to mitigate the compromise of the data and harm to the individuals involved and report this to DMA within 10 days;
- determine the cause of the incident and perform remediation such as training, and policy/process changes to prevent these events in the future and report this to DMA within 10 days;
- pay all costs of notification or provide the notification, at the discretion of the DMA;
- promptly provide any information requested related to privacy/security issues to DMA and remediate problems raised by DMA staff.

Accounting of Disclosures

When it is concluded that the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164 subpart E (Privacy of Individually Identifiable Health Information) which compromises the security or privacy of the protected health information has taken place, the Business Associate shall send Sury Gundarapu the following information via secure email (portal here: <https://web1.zixmail.net/s/login?b=ncdhhs>):

- Date of event
- Names and MIDs of the individuals involved
- Description of information disclosed
- Name, address, and phone number of the individual or entity to whom the data was disclosed

Designated Record Set

The Business Associate shall evaluate their records to identify the records that qualify as a Designated Record Set as defined in 45 CFR 164.501 and required in 45 CFR 164.524 and shall give this information to DMA upon request. The Business Associate shall provide copies of records and allow amendments when required by the HIPAA Privacy Rule (45 CFR 164.526). Copies of records shall be given to DMA within 5-10 business days of the request. There shall be no supplemental charge for these processes.

Policies

The Business Associate shall comply with NC ITS Security standards Chapter 13 (Detecting and Responding to IS Incidents,

[https://www.scio.nc.gov/library/pdf/StatewideInformationSecurityManual/Statewide Information Security Manual April 20 2012.pdf](https://www.scio.nc.gov/library/pdf/StatewideInformationSecurityManual/Statewide%20Information%20Security%20Manual%20April%202012.pdf))

as well as the DHHS Privacy and Security Information Incident Management Policy

Privacy: [http://info.dhhs.state.nc.us/olm/manuals/dhs/pol80/man/Privacy Incident and Complaint.pdf](http://info.dhhs.state.nc.us/olm/manuals/dhs/pol80/man/Privacy%20Incident%20and%20Complaint.pdf)

Security (Chapter 10):

[http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Security Manual.pdf](http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Security%20Manual.pdf)

The Off-Site Storage Security Standard (<https://security.dhhs.state.nc.us/files/Polices-Standards/Off-Site-Storage-Standard.pdf>)

The Business Associate shall comply with all DHHS Privacy and Security Policies

(<http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/>) including the HIPAA Breach Notification for Unsecured PHI policy.

Data Destruction

Section 5c of the attached business associate agreement contains provisions regarding the return or destruction of PHI after the end of this agreement. The Business Associate agrees to notify DMA in writing of the disposition of the data (usually destruction, though other options may be considered as per the BAA) when this project is completed.

ATTACHMENT E

Federal Certifications and Disclosures

The undersigned states that:

- (a) He or she is the duly authorized representative of the Vendor named below;
- (b) He or she is authorized to make, and does hereby make, the following certifications on behalf of the Vendor, as set out herein:
- (a) The Certification Regarding Nondiscrimination;
 - (b) The Certification Regarding Drug-Free Workplace Requirements;
 - (c) The Certification Regarding Environmental Tobacco Smoke;
 - (d) The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - (e) The Certification Regarding Lobbying;
- (c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
- (d) [Check the applicable statement]

- ☐ He or she has completed the attached Disclosure Of Lobbying Activities because the Vendor has made, or has an agreement to make, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

OR

- ☒ He or she has not completed the attached Disclosure Of Lobbying Activities because the Vendor has not made, and has no agreement to make, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action. NOTE: Any lobbyist activities completed by Eastpointe are with local funds.

- (e) The Vendor shall require its subcontractors, if any, to make the same certifications and disclosure.

Eastpointe

Signature of Vendor's Authorized Agent

Date

Printed Name of Vendor's Authorized Agent

Title

Signature of Witness

Title

Printed Name of Witness

Date

This Certification Must Be Signed by the Same Individual Who Signed the Contract

I. Certification Regarding Nondiscrimination

The Vendor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Vendor certifies that it will provide a drug-free workplace by:

- A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Vendor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- B. Establishing a drug-free awareness program to inform employees about:
 - (1) The dangers of drug abuse in the workplace;
 - (2) The Vendor's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
- D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
- E. Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;
- F. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:
 - (1) taking appropriate personnel action against such an employee, up to and including termination; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation

program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional lines if necessary):

Street Address No. 1: Eastpointe Beulaville, 514 E. Main Street, Beulaville, NC 28518

Street Address No. 2: Eastpointe Goldsboro, 100 S James Street, Goldsboro, NC 27530

Street Address No. 3: Eastpointe Rocky Mount, 500 Nash Medical Arts Mall, Rocky Mount, NC 27804

Street Address No. 4: Eastpointe Lumberton, 450 Country Club Road, Lumberton, NC 27360

3. Vendor will inform the Department of any additional sites for performance of work under this agreement.
4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Vendor certifies that it will comply with the requirements of the Act. The Vendor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Vendor]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when

submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. The prospective lower tier participant certifies, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Vendor certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of

Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

- (3) The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all sub recipients shall certify and disclose accordingly.
- (4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

VI. Disclosure of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Sub awards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, Request for Quote number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.
- (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

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Disclosure of Lobbying Activities
(Approved by OMB 0344-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352.

1. Type of Federal Action: ☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	2. Status of Federal Action: ☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	3. Report Type: ☐ a. initial filing ☐ b. material change For Material Change Only: Year _____ Quarter _____ Date Of Last Report: _____
4. Name and Address of Reporting Entity Prime _____ Subawardee _____ Tier (if known) _____ Congressional District (if known) _____		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District (if known) _____
6. Federal Department/Agency: _____		7. Federal Program Name/Description: _____ CFDA Number (if applicable): _____
8. Federal Action Number (if known) _____		9. Award Amount (if known) \$ _____
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI)</i> <i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i>		10.b. Individuals Performing Services (including address if different from No. 10a.) (last name, first name, MI): <i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i>
11. Amount of Payment (check all that apply): Actual \$ _____ ☐ Planned \$ _____		13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other (specify) _____
12. Form of Payment (check all that apply): a. cash b. In-kind: specify nature: _____ specify value: _____		
14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11 (attach Continuation Sheet(s) SF-LLL-A, if necessary): _____		
15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No		
16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.		Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____
Federal Use Only		Authorized for Local Reproduction Standard Form - LLL

ATTACHMENT F
State Certifications
Contractor Certifications Required by North Carolina Law

Instructions

The person who signs this document should read the text of the statutes listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 147-33.95(g): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_147/GS_147-33.95.html

Certifications

- (1) Pursuant to G.S. 143-48.5 and G.S. 147-33.95(g), the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov
- (2) Pursuant to G.S. 143-59.1(b), the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:
 - (a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); and
 - (b) [check one of the following boxes]
 - ☐ Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; or
 - ☐ The Contractor or one of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 but the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.
- (3) Pursuant to G.S. 143-59.2(b), the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.
- (4) The undersigned hereby certifies further that:
 - (f) He or she is a duly authorized representative of the Contractor named below;
 - (g) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
 - (h) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1 and -59.2 shall be guilty of a Class I felony.

Contractor's Name _____

Signature of Contractor's Authorized Agent _____

Date _____

Printed Name of Contractor's Authorized Agent _____

Title _____

Signature of Witness _____

Date _____

Printed Name of Witness _____

Title _____

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.

ATTACHMENT G

Certification of Compliance with N.C. General Statute §133-32 and Executive Order 24

Background

- A. N.C. General Statute §133-32 makes it unlawful for any vendor, contractor, subcontractor, or supplier who: (1) has a contract with a governmental agency; or (2) has performed under such a contract within the past year; or (3) anticipates bidding on such a contract in the future; to make gifts or to give favors to any governmental officer or employee who is charged with the duty of: (1) preparing plans, specifications, or estimates for public contract; or (2) awarding or administering public contracts; or (3) inspecting or supervising construction.
- B. By means of Executive Order 24, signed on October 1, 2009, Governor Perdue expanded the prohibitions in N.C. General Statute §133-32 to ban the giving of gifts and favors to any employee of the Cabinet agencies—the Departments of Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, and Transportation and the Office of the Governor—regardless of the nature of their official duties.
- C. Executive Order 24 can be viewed online at:
<http://www.governor.state.nc.us/News/Items/ExecutiveOrderDetail.aspx?newsItemID=665>
- D. N.C. General Statute §133-32 can be viewed online at:
<http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl>

Certifications

1. I certify that I understand that N.C. General Statute §133-32 prohibits my organization, as an entity seeking a public contract, from giving any gifts or favors to any governmental officer or employee who is charged with the duty of: (1) preparing plans, specifications, or estimates for public contract; or (2) awarding or administering public contracts; or (3) inspecting or supervising construction.
2. I certify that I understand that Executive Order 24 prohibits my organization, as an entity seeking a public contract, from giving any gifts or favors to any employee of Cabinet agencies and the Office of the Governor.
3. I certify, on behalf of my organization and its employees and agents, that I have made reasonable inquiries and have found no evidence that any such prohibited gifts or favors have been offered or promised by any of my organization's employees or agents to any covered State officers or employees.
4. I certify that the language of this certification shall be included in all subcontracts at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all subcontractors shall certify and disclose accordingly.
5. I understand that this certification is a material representation of fact; that the North Carolina Department of Health and Human Services, DMA of Medical Assistance will rely upon this certification if it decides to award a contract to my organization; and that submission of this certification is a prerequisite for State review of the attached proposal.

Eastpointe

<u>K. Jones</u>	<u>6/29/2015</u>
Signature of Vendor's Authorized Agent	Date
<u>Ken Jones</u>	<u>CEO</u>
Printed Name of Vendor's Authorized Agent	Title
<u>Anna Smith</u>	<u>GA Director / UCM</u>
Signature of Witness	Title
<u>Anna Smith</u>	<u>6/29/15</u>
Printed Name of Witness	Date

This Certification Must Be Signed by the Same Individual Who Signed the Contract.

ATTACHMENT H

DEFINITIONS

Action: Pursuant to 42 C.F.R. § 438.400, "action" is defined as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of PIHP to act within the timeframes provided in 42 C.F.R. 438.408(b); and, for a rural area resident with only one MCO, the denial of an Enrollee's request to obtain services outside the network under the following circumstances:

- a. When services from any other provider (in terms of training, experience, and specialization as determined by the PIHP) are not available in the Network
- b. From a provider not part of the PIHP Closed Network who is the main source of a service to the Enrollee—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the Network or does not meet the qualifications, the Enrollee shall be given a choice of participating providers and shall be transitioned to a participating provider within 60 days.
- c. Because the only plan or provider available does not provide the service because of moral or religious objections.
- d. Because the Enrollee's provider determines that the Enrollee needs related services that would subject the Enrollee to unnecessary risk if received separately and not all related services are available within the network.

Appeal: A request for review of an action, as action is defined in this Attachment H and 42 C.F.R. § 438.400.

Beneficiary: An individual who is eligible for the North Carolina Medicaid program and whose eligibility arises from residence in one of the twenty-three counties in PIHP's catchment area.

Best Practices: Recommended practices, including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results.

Capitation Payment: The amount to be advanced monthly to PIHP for each Enrollee covered by PIHP's Benefit Plan based on Eligibility Category and age, regardless of whether the Enrollee receives services during the period covered by the payment.

Care Management: A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.

Catchment Area: Geographic Service Area meaning a defined grouping of counties.

C.F.R.: Code of Federal Regulations

Clean Claim: A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.

CMS: Centers for Medicare and Medicaid Services

Concurrent Review: A review conducted by PIHP during a course of treatment to determine whether services meet Medical Necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

Contract Term: The term of this Contract.

Covered Services: The services identified in Attachment J and included in the capitation paid to PIHP, for which PIHP agrees to provide, arrange for, or otherwise bear responsibility for the provision of, to eligible Enrollees pursuant to the terms of this Contract.

Cultural Competency: The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to systematically translate that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

DHHS: The North Carolina Department of Health and Human Services

Days: Except as otherwise noted, refers to calendar days. "Working day" or "business day" means a day on which DMA and PIHP are officially open to conduct their affairs.

Department: The North Carolina Department of Health and Human Services

Disenrollment: Action taken by DMA to remove an Enrollee's name from the monthly Enrollment following DMA's determination that the Enrollee is no longer eligible for enrollment in PIHP.

DMA: The Division of Medical Assistance

DMH/DD/SAS: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DSS: The County Department of Social Services

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- b. Serious impairment to bodily functions, or
- c. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an emergency service, covered inpatient and outpatient services that:

- a. Are furnished by a provider that is qualified to furnish such services; and
- b. Are needed to evaluate or stabilize an emergency medical condition as defined above.

Emergent Need (Mental Health): 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.

Emergent Need (Substance Abuse): A 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 abuse or dependence.

Encounter Data: A record of a Covered Service rendered by a provider to an Enrollee who is enrolled in PIHP during the date of service. It includes all services for which PIHP incurred any financial responsibility; in addition, it may include claims for reimbursement, which were denied by PIHP.

Enrollment: Action taken by the DMA to add a Medicaid beneficiary's name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area.

Enrollee: A Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by the PIHP or is currently enrolled in PIHP.

Enrollment Period: The time span during which a Medicaid beneficiary is enrolled with a PIHP.

Expanded Services: Services included in Covered Services, which are in addition to the minimum coverage required by DMA and which PIHP agrees to provide throughout the term of this Contract in accordance with the standards and requirements set forth in this Contract.

Facility: Any premises (a) owned, leased, used or operated directly or indirectly by or for PIHP for purposes related to this Contract; or (b) maintained by a sub-contractor to provide services on behalf of PIHP as part of this Contract.

Fee-for-Service: A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.

Fiscal Agent: An agency that processes and audits Medicaid provider claims for payment and performs certain other related functions as an agent of DMA.

Grievance: Pursuant to 42 C.F.R. 438.400, an expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at PIHP level and access to the State Fair Hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights).

Hearing (also referred to as State Fair Hearing): A formal proceeding before an Administrative Law Judge of the North Carolina Office of Administrative Hearings in which parties affected by an action or an intended action of DMA or PIHP shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

Health Plan Employer Data and Information Set (HEDIS): is a set of standardized performance measures designed to reliably compare the performance of managed health care plans.

Individuals with Disabilities Education Act (IDEA): A federal law (PL 99-457) which requires States and public agencies to provide early intervention, special education and related services to children with disabilities from birth to age twenty one (21) years.

Information Systems: The combination of technologies, tools, methods and databases used by the PIHP to support its business operations.

Innovations Waiver: The Section 1915(c) Home and Community Based Services (HCBS) Waiver that operates in the geographic area covered by this Contract. The Innovations Waiver replaced the Community Alternatives Program for Persons with Intellectual/ Developmental Disabilities (CAP-I/DD) in these counties.

Insolvency: The inability of PIHP to pay its obligations when they are due.

Managed Care Entity: means managed care organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plan (PAHPs), Primary Care Case Manager (PCCMs), and Health Insuring Organization (HIOs).

Managed Care Organization: An entity that has, or is seeking to qualify for, a comprehensive risk contract under part, 42 C.F.R. § 438 and that is a Federally qualified HMO that meets the advance directives requirements of subpart I of 42 C.F.R. Part 489; or a public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

- (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
- (ii) Meets the solvency standards of 42 C.F.R. § 438.116.

Medicaid Identification (MID) Card: The Medical Assistance Eligibility Certification card issued monthly by DMA to eligible beneficiaries.

Medicaid for Infants and Children (MIC): A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid for Pregnant Women (MPW): A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

Medical Assistance Program (Medicaid): DMA's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

Medical Record: A single complete record, maintained by the Provider of services, which documents all of the treatment plans developed for, and behavioral health services received by, an Enrollee.

Medically Necessary Treatment: Medically necessary treatment means those procedures, products and services that are provided to Enrollees that are:

- a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition;
- b. Consistent with Medicaid policies and National or evidence based standards, DHHS defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided;
- c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care;
- d. Not provided solely for the convenience of the Enrollee, Enrollee's family, custodian or provider;
- e. Not for experimental, investigational, unproven or solely cosmetic purposes;
- f. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives;
- g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and
- h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment shall be designed to:

- a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team;
- b. Conform with any advanced medical directive the individual has prepared;
- c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- d. Prevent the need for involuntary treatment or institutionalization.

Medicaid Management Information System (MMIS): The mechanized claims processing and information retrieval system used by state Medicaid agencies and required by federal law.

Network Provider: A Provider that meets PIHP's qualification, credentialing, enrollment and/or selection criteria and has entered into a contract for participation in the PIHP Closed Network.

Out-of-Area Services: Covered Services provided to an Enrollee while the Enrollee is outside the catchment area.

Out-of-Plan or non-Covered Services: Health care services, which PIHP is not required to manage or provide under the terms of this Contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

Out-of-Network Provider: Any person or entity providing Covered Services who is not a member of the PIHP Provider Network.

Potential Enrollee: A Medicaid beneficiary who is subject to mandatory enrollment.

Prepaid Inpatient Health Plan: An entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.

Prior Authorization: The act of authorizing specific services before they are rendered.

Provider: Any person or entity providing MH/IDD/SA services.

Provider Network (also referred to as Network, Closed Network and Closed Provider Network): The providers that have been qualified, selected, credentialed and enrolled by PIHP to furnish authorized Covered Services to eligible Enrollees.

Qualified Professional: Any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (N.C.G.S. §122C-3).

Risk Contract: A contract under which PIHP: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because PIHP assumes the risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DMA.

Routine Need (Mental Health): A condition in which the person describes signs and symptoms resulting in impaired behavioral, mental or emotional functioning which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life.

Routine Need (Substance Abuse): A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

Service Management Record: A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers.

State: The State of North Carolina.

State Fair Hearing: A proceeding before an Administrative Law Judge of the North Carolina Office of Administrative Hearings pursuant to N.C.G.S. Chapter 108D in which Enrollees affected by an Action of PIHP shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

State Plan: The North Carolina State Plan for Medical Assistance submitted under Title XIX of the Social Security Act and N.C.G.S. §108A-54 and approved by CMS.

Subcontract: An agreement which is entered into by PIHP in accordance with Section 11.

Subcontractor: Any person or entity which has entered into a subcontract with PIHP.

Third Party Resource: Any resource available to an Enrollee for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans.

Urgent Need (Mental Health): 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 will progress to the need for emergent services and care.

Urgent Need (Substance Abuse): 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 their substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance.

Utilization Management: The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

ATTACHMENT I
ELIGIBILITY CATEGORIES

Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC);
Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF);
Blind and Disabled Children and Related Populations (SSI);
Blind and Disabled Adults and Related Populations (SSI, Medicare);
Aged and Related Populations (SSI, Medicare);
Medicaid for the Aged (MAA);
Medicaid for Pregnant Women (MPW);
Medicaid for Infants and Children (MIC);
Adult Care Home Residents (SAD, SAA);
Foster Care Children;
Participants in Community Alternatives Programs (CAP/DA, INNOVATIONS, CAP/AIDS);
Medicaid recipients living in ICF's-MR; or
Children, beginning the first day of the month following the third birthday (except for INNOVATIONS).

- * **Children under the age of three years are NOT eligible for any services covered under this contract EXCEPT for Innovations Waiver services.**

RATE CELLS FOR CAPITATED PAYMENTS

1. TANF – Adults and children over age 3
2. Foster Children—Over age 3
3. Aged – Ages 65 and above
4. Blind/Disabled – Ages 3-20
5. Blind/Disabled – Ages 21+
6. Innovations Waiver Participants - All Ages

ATTACHMENT J
SCHEDULE OF BENEFITS

PIHP shall ensure the provision of the following mental health, intellectual/ developmental disability and/or substance use/ abuse (MH/IDD/SA) services covered in the State Plan and/or the NC 1915(b)/(c) combined Medicaid waiver to eligible Enrollees, subject to Medical Necessity criteria and Utilization Control mechanisms in accordance with 42 CFR Part 456:

1. All services described in DMA Clinical Coverage Policies 8A through 8P located on the DMA website at <http://www.ncdhhs.gov/dma/mp/index.htm>;
2. All emergency room services, including all professional charges, x ray and lab work that are directly related to evaluation/treatment of a MH/IDD/SA billing diagnosis and fall within the following Diagnostic Range Groups (DRGs): 876, 880-887, 894-897;
3. All 1915(c) Home and Community Based Waiver (HCBS) waiver services as defined in the Innovations waiver;
4. All psychiatric inpatient stays, identified by DRGs 876, 880-887, 894-897;
5. All Section 1915(b)(3) waiver services as defined in the 1915(b) MH/DD/SAS waiver;
6. All Medically Necessary services provided by psychiatrists, licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified clinical nurse specialists, or certified nurse practitioners.

PIHP must follow DMA clinical coverage policies. PIHP cannot be more restrictive than DMA policies or the NC Medicaid State Plan. PIHPs should request approval from DMA for all benefit changes that expand DMA policies. PIHP should produce a benefit plan for approval to DMA each state fiscal year.

ATTACHMENT K

STATISTICAL REPORTING MEASURES AND LATE SUBMISSION SANCTIONS

PIHP shall submit data and measurements to DMA annually for quality of care and service measures and performance improvement projects as defined in Attachment L and as directed by DMA.

PIHP shall complete and submit the quarterly and annual reports listed below to DMA by June 30 of each year, or as designated by DMA. The annual reports submitted shall contain data collected from January 1 through December 31 of the preceding calendar year. Note, however, that PIHP shall submit Grievance and Appeal Reports to DMA on a quarterly basis consistent with Section 7.5. Failure to submit reports on the timeline listed below may result in the imposition of the sanctions outlined below. PIHP shall use the HEDIS Technical Specifications applicable to the subject reporting year. PIHP may seek and receive written approval from DMA for revisions or amendments to the HEDIS specifications, provided it does so before April 1. For all measurements without pertinent HEDIS specifications, PIHP shall use technical specifications provided by DMA. DMA will provide PIHP with the description and data measurement requirements for each measure noted below on or before April 1. Each annual report shall contain an explanation of how the data was calculated. Questions regarding reporting requirements shall be addressed to DMA's Contract Administrator for Program Issues or through quarterly IMT meetings. As used below, "member" includes all of PIHP's Medicaid Enrollees, unless some other meaning is specified.

NOTE: The performance measure indicators for Section 1915(c) waiver Enrollees are reported separately as mandated by the Innovation Waiver requirements.

A. **EFFECTIVENESS OF CARE MEASURES**

1. Readmission Rates for Mental Health
2. Readmission Rates for Substance Abuse
3. Ambulatory Follow-Up within 7 Calendar Days Of Discharge for Substance Abuse facility
4. Ambulatory Follow-Up within 7 Calendar Days Of Discharge for Mental Health

B. **ACCESS/AVAILABILITY**

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
2. Call Answer Timeliness
3. Call Abandonment
4. Gap Analysis/Service Need Assessment
5. Payment Denials
6. Out of Network Services

C. **PATIENT AND PROVIDER SATISFACTION**

1. Grievances/Appeals (*): Report separately all Medicaid Enrollee grievances, and appeals including the total number of Enrollees served, total number of grievances categorized by reason, reported separately; the number of grievances referred to second level review or appeal, reported separately; and the number of grievances resolved at each level, total time of resolution and outcome, reported separately. Reports are due to DMA on a quarterly basis, consistent with PIHP Complaint reporting schedule.

D. **USE OF SERVICES**

1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
2. Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/ Night Care, Ambulatory and Other Support Services
3. Chemical Dependency Utilization Percentage of Members Receiving Inpatient, Day/ Night Care, Ambulatory and Support Services
4. Identification of Alcohol and Other Drug Services (Penetration)
5. Identification of Mental Health Services (Penetration)
6. Integrated Care

E. **HEALTH PLAN STABILITY**

1. Network Capacity

F. **PLAN DESCRIPTIVE INFORMATION:**

1. Unduplicated Count of Medicaid Members
2. Diversity of Medicaid Membership

G. **HEALTH AND SAFETY**

1. Critical Incident Reports

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
Section 9.2	Encounter Data	Monthly	\$100 per calendar day	None
L.A.1	Follow up after hospitalization for mental illness	Annually	\$100 per calendar day	None
L.A.2	Readmission Rates for Mental Health	Annually	\$100 per calendar day	None
L.A.3	Readmission Rates for Substance Abuse	Annually	\$100 per calendar day	None
L.A.4	Ambulatory Follow-up within 7 Calendar Days of Discharge for Substance Abuse Therapy	Annually	\$100 per calendar day	None
L.A.5	Ambulatory Follow-up Within 7 Days of Discharge for Mental Health	Annually	\$100 per calendar day	None
L.B.1	Initiation and Engagement of Alcohol and Other Drug Dependence Programs	Annually	\$100 per calendar day	None
L.B.2	Call Answer Timeliness	Annually	\$100 per calendar day	None
L.B.3	Call Abandonment	Annually	\$100 per calendar day	None
L.B.4	Service Availability/Accessibility	Annually	\$100 per calendar day	None
L.B.5	Payment Denials	Annually	\$100 per calendar day	None
L.B.6	Out of Network Services	Annually	\$100 per calendar day	None
L.C.2	Grievances/Appeals	Quarterly	\$100 per calendar day	None
L.D.1	Inpatient Discharges and Average Length of Stay	Annually	\$100 per calendar day	None
L.D.2	Percentage of Members Receiving Inpatient Day/Night Care, Ambulatory and Other Support Services	Annually	\$100 per calendar day	None

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
L.D.3	Chemical Dependency Utilization Inpatient Discharges and Average Lengths of Stay	Annually	\$100 per Calendar Day	None
L.D.4	Chemical Dependency Utilization Percentage of Members Receiving Inpatient, Day/Night, Ambulatory and Other Support Services	Annually	\$100 per calendar day	None
L.D.5	Identification of Alcohol and Other Drug Services	Annually	\$100 per calendar day	None
L.D.6	Integrated Care	Annually	\$100 per calendar day	None
L.E.1	Integrated Care	Annually	\$100 per calendar day	None
L.F.1	Unduplicated Count of Medicaid Members	Annually	\$100 per calendar day	None
L.F.2	Diversity of Medicaid Membership	Annually	\$100 per calendar day	None
V.A	Balance sheet	Monthly	\$100 per calendar day	None
V.B	Medicaid risk reserve balance	Monthly	\$100 per calendar day	None
V.C	Medicaid income statement	Monthly	\$100 per calendar day	None
V.D	Total profitability	Monthly	\$100 per calendar day	None
V.D1	Medicaid profitability	Monthly	\$100 per calendar day	None
V.D2	Non-Medicaid profitability	Monthly	\$100 per calendar day	None
V.E	Medicaid-only medical services lag	Monthly	\$100 per calendar day	None
V.E1	Medicaid cash summary	Monthly	\$100 per calendar day	None
V.F	Medicaid statistics current year	Monthly	\$100 per calendar day	None
V.F1	Medicaid statistics prior year	Monthly	\$100 per calendar day	None
V.G	Medicaid claim aging	Monthly	\$100 per calendar day	None
V.H	Medicaid claim processing	Monthly	\$100 per calendar day	None
V.I	B3 services current year	Quarterly	\$100 per calendar day	None
V.I1	B3 services prior year	Quarterly	\$100 per calendar day	None

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
V.J	Medicaid third party liability and coordination of benefits	Quarterly	\$100 per calendar day	None
V.K	Medicaid fraud and abuse tracking	Quarterly	\$100 per calendar day	None
V.L	Supplemental working area	As needed	\$100 per calendar day	None
V.AA.	Cost allocation plan	Annually	\$100 per calendar day	None
V.BB	Audited financial statements	Annually	\$100 per calendar day	None
V.CC	OMB circular A-133 audit	Annually	\$100 per calendar day	None
V.DD	Related party transactions and obligations	Annually	\$100 per calendar day	None
V.EE	Physician incentive arrangements	Annually	\$100 per calendar day	None

ATTACHMENT L

REQUIREMENTS FOR PERFORMANCE IMPROVEMENT PROJECTS

PIHP shall develop and implement performance improvement projects as referenced in Attachment B, Section 7.1 of this Contract and in compliance with 42 CFR § 438.240 and the CMS Quality Framework. Project topics will be determined jointly by PIHP and DMA from the list of clinical and non-clinical focus areas listed below. Over the term of the Contract, PIHP shall develop and implement a minimum of three performance improvement projects. During year one of the Contract, PIHP shall develop and implement a minimum of two performance improvement projects. One project shall focus on a clinical area and one shall focus on a non-clinical area. During year two of the Contract, PIHP shall develop and implement at least one additional performance improvement project for a total of three performance improvement projects. Baselines will be established the first year of each project and PIHP shall set benchmarks for each project based on currently accepted standards, past performance data, or available national data. PIHP shall obtain the approval of DMA before terminating any of the required performance improvement projects. Reports on all performance improvement projects shall be submitted to DMA no later than July 31st of each year.

- a. Primary, secondary and/or tertiary prevention of acute mental illness conditions;
 - b. Primary, secondary and/or tertiary prevention of chronic mental illness conditions;
 - c. Care of acute mental illness conditions;
 - d. Recovery/outcome measures;
 - e. Care of chronic mental illness conditions;
 - f. High-volume services;
 - g. High-risk services;
 - h. Continuity and coordination of care;
 - i. Availability, accessibility, and cultural competency of services;
 - j. Quality of provider/patient encounters; or
 - k. Appeals and grievances.
1. Topics shall be identified through continuous data collection and analysis by PIHP of comprehensive aspects of patient care and member services. Topics shall be systematically selected and prioritized to achieve the greatest practical benefit for Enrollees.
 2. The Quality Assurance/Performance Improvement program shall provide opportunities for Enrollees to participate in the selection of project topics and the formulation of project goals.
 3. PIHP's performance improvement for each selected topic is measured using one or more quality indicators. All indicators measure changes in health status, functional status, or satisfaction. Indicators shall be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. PIHP shall select some indicators for which data are available that allow comparison of PIHP's performance to that of similar Medicaid Behavioral Health/ IDD Prepaid Inpatient Health Plans or to local, state, or national benchmarks.
 4. PIHP shall establish a baseline measure of its performance on each selected indicator, shall measure changes in performance, and shall continue measurement for at least one year after the desired level of performance is achieved.
 5. A project demonstrates improvement by achieving a benchmark level of performance defined in advance by CMS or DMA. Benchmarks shall be based on currently accepted standards, past performance data, or available national data.
 6. When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, the sample must be sufficiently large to detect the targeted amount of improvement.
 7. The sample or subset of the study population shall be obtained through random sampling. The samples used for the baselines and repeat measurements of the indicators shall be chosen using the same sampling frame and methodology.
 8. PIHP must be able to demonstrate that any observed improvement is reasonably attributable to interventions undertaken by PIHP (i.e., a project and its results have face validity).

9. PIHP must be able to sustain any observed performance improvements for at least one year after the performance improvement is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed.
10. PIHP is expected to collect and use data from multiple sources, such as medical record reviews, focused care studies, claims and encounter data, HEDIS, grievances, utilization review and member satisfaction surveys. PIHP is expected to use findings from performance improvement projects to analyze:
 - a. the delivery of services;
 - b. quality of care;
 - c. over and under utilization of services;
 - d. disease management strategies; and
 - e. outcomes of care.

ATTACHMENT M

ENROLLEE GRIEVANCE AND APPEAL PROCEDURES

PIHP shall have an internal Enrollee grievance and appeal system with written policies and procedures. The grievance and appeal system shall meet all requirements of 42 CFR Part 438 Subpart F, and shall include a process for filing a grievance, filing an appeal, and accessing the State's Fair Hearing system. PIHP shall conduct its own internal training as approved by DMA. PIHP shall use DMA pre-approved template letters for notifying Enrollees of "actions" as defined at 42 C.F.R. § 438.400 that includes a description of the Enrollee's right to appeal and the process for doing so, and for notifying Enrollees of appeal resolutions as defined at 42 C.F.R. § 438.408. A grievance is an expression of dissatisfaction about matters involving the PIHP or a PIHP Network Provider. Possible subjects for grievances include, but are not limited to, the quality of services provided through PIHP, and aspects of interpersonal relationships such as rudeness of a Network Provider or an employee of PIHP, or failure by PIHP or a Network Provider to respect the rights of an Enrollee.

Pursuant to 42 C.F.R. § 438.400, the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of PIHP to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one MCO, the denial of a Medicaid Enrollee's request to obtain services outside the network:

- a. From any other provider in terms of training, experience, and specialization) not available in the Network.
- b. From a provider not part of the network who is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the Network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
- c. Because the only plan or provider available does not provide the service because of moral or religious objections.
- d. Because the Enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

Enrollees may file a grievance or an appeal with PIHP either orally or in writing. However, an oral appeal must be followed by a written, signed appeal within the appeal timeframe unless expedited resolution, as described in section G below, is requested.

Enrollees must exhaust the internal PIHP appeal process before requesting a State Fair Hearing.

A. General Requirements of Grievance and Appeal System:

1. PIHP must:
 - a. Provide Enrollees any reasonable assistance in completing forms and other procedural steps, including but not limited to, providing interpreter services and toll free numbers with TTY/TDD and interpreter capability;
 - b. Acknowledge receipt of each grievance and appeal;
 - c. Ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making; and
 - d. Ensure that decision makers on grievances regarding clinical matters and appeals are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:

- i. an appeal of a denial based on lack of medical necessity;
- ii. a grievance regarding PIHP's denial of a request for an expedited review of an appeal;
- iii. any grievance or appeal involving clinical issues;
- iv. an appeal of a denial of a service authorization request; or
- v. an appeal of a decision to authorize a service in an amount, duration or scope that is less than requested.

2. Pursuant to 42 C.F.R. § 438.414 and 42 CFR § 438.10(g), PIHP shall provide the following information on grievance, appeal, and State Fair Hearing procedures and timeframes to all Providers and applicable subcontractors at the time they enter into a contract. PIHP shall also provide the following information to all Enrollees:

- a. The Enrollee's right to a State Fair Hearing, how to obtain a State Fair Hearing, and representation rules at a State Fair Hearing;
- b. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
- c. The availability of assistance in filing;
- d. The toll free numbers to file oral grievances and appeals; and
- e. The Enrollee's right to request continuation of benefits in accordance with 42 C.F.R. § 438.420 during an appeal or State Fair Hearing regarding PIHP's decision to reduce, suspend or terminate a previously authorized service (meaning a service for which the authorization has not yet expired), and that if PIHP's action is upheld in a State Fair Hearing, the Enrollee may be liable for the cost of any continued benefits; and
- f. Any appeal rights that the State chooses to make available to providers to challenge the failure of the PIHP to cover a service.

B. Recordkeeping and Reporting: PIHP must maintain records of grievances and appeals as follows:

1. PIHP shall maintain records that include a copy of the original grievance or appeal (if submitted in writing), the response, and the resolution; and
2. PIHP must provide for the retention of the records described above for five (5) years following a final decision or the close of the grievance or appeal. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

C. Timeframe for Resolution of Grievances and Format of Disposition Notice: PIHP shall resolve grievances and provide notice to all affected parties within 90 days of the date PIHP received the grievance. PIHP may extend the timeframe by up to 14 days if:

1. The Enrollee requests the extension; or
2. PIHP demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.

Pursuant to 42 CFR § 438.408(d), the State establishes the method by which PIHP notifies enrollees of the disposition of the grievance. PIHP shall notify enrollees of their findings in writing.

D. Service Authorizations and Notices of Action:

1. Requests for service authorizations must be processed within the following timeframes and requirements: For standard authorization decisions, PIHP must provide notice within fourteen (14) calendar days following receipt of request for the service, with a possible extension of up to fourteen (14) additional calendar days if:
 - i. The Enrollee or provider requests extension; or

- ii. PIHP demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.
 - b. PIHP must make an expedited service authorization decision within three (3) working days after receipt of the request, when following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, with a possible extension of up to fourteen (14) additional calendar days if:
 - i. The Enrollee requests an extension; or
 - ii. PIHP demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.
 - c. If PIHP extends the timeframe, it must give the written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
 - d. Untimely service authorizations constitute a denial and are thus adverse actions. Service authorizations are considered untimely if they are not made within the standard timeframe or expedited timeframe, whichever is applicable.
 - e. PIHP must notify the requesting Provider and Enrollee of any decision to deny a service authorization request, either in whole or part, or to authorize a service in a limited manner, including type, level, amount, duration, or scope, that is less than requested. The notice of adverse action to the Provider need not be in writing; however, the Enrollee notice must be in writing. The notice to Enrollees shall include due process rights in accordance with 42 C.F.R. § 438.400 any time PIHP takes these actions.
2. In accordance with 42 CFR 438.404, the Notice of Action must explain the following:
- 1. The action PIHP has taken or intends to take.
 - 2. The reasons for the action.
 - 3. The enrollee's right to request a reconsideration of the decision by PIHP.
 - 4. The procedures for requesting a reconsideration of the decision by PIHP.
 - 5. The circumstances under which expedited resolution is available and how to request it.
 - 6. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
3. PIHP must make the information and notices described in this Attachment readily available orally and in writing in the recipient's primary language and in each prevalent non-English language in its service area. DMA shall ensure that its templates use easily understood language and format. PIHP shall ensure that written materials provided by DMA pursuant to this Attachment are made available to Enrollees in alternative formats, and are presented in an appropriate manner that takes into consideration those with special needs.
4. All Enrollees and potential Enrollees must be informed that information is available in alternative formats and how to access those formats. PIHP must make these services available free of charge.
5. For all Notices of Action and Notices of Appeal Resolution, the date of mailing shall be the date specified on the Notice. PIHP shall establish and monitor internal mail cut-off times to ensure that all notices are mailed on the date they are dated.
- F. Timeframes for Notice of Action:**
- 1. PIHP shall give written notice to the Enrollee or legally responsible person within the timeframes specified in 42 CFR §§ 438.211, 213 and 214 for standard service authorization decisions that deny or limit services.
 - 2. PIHP shall give written notice to the Enrollee or legally responsible person at least ten (10) days before the date of action when the action is a termination, suspension or reduction of a previously authorized Medicaid covered service (meaning a service for which the authorization has not yet expired), except:

- a. The period of advance notice is shortened to five (5) days if probable recipient fraud has been verified; and
- b. The notice may be given on the date of the action for the following:
 - i. Upon the death of an Enrollee;
 - ii. A signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
 - iii. The Enrollee's admission to an institution where he/she is ineligible for further services;
 - iv. The Enrollee's address is unknown and mail directed to him/her has no forwarding address;
 - v. The Enrollee has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth;
 - vi. The Enrollee's physician prescribes the change in the level of medical care;
 - vii. An adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or,
 - viii. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days (applies only to adverse actions for NF transfers).

3. PIHP may give notice on the date of the action when the action is a denial of payment.

G. Appeal Process

- 1. PIHP must define appeal as the request for review of an "action", as defined by 42 CFR § 438.400. Pursuant to 42 CFR § 438.402(b), the Enrollee, legally responsible person, or a provider or other designated personal representative, acting on behalf of the enrollee and with the enrollee's signed consent, may file a PIHP level appeal.
- 2. The appeal must be filed within thirty (30) days after the date on the notice of action.
- 3. The appeal may be filed either orally or in writing and, unless the Enrollee requested expedited resolution, must follow an oral filing with a written, signed appeal. PIHP shall:
 - a. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Enrollee requests expedited resolution;
 - b. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
 - c. Allow the Enrollee and the Enrollee's representative opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records;
 - d. Consider the Enrollee, the Enrollee's representative, or estate representative of a deceased Enrollee as parties to the appeal.
- 4. PIHP must resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within forty five (45) days from the day PIHP receives the appeal.
- 5. PIHP must provide written notice of disposition. The written resolution notice must include:
 - a. The results and date of the appeal resolution;
 - b. For decisions not wholly in the Enrollee's favor:
 - i. The right to request a State Fair Hearing;
 - ii. How to request a State Fair Hearing;

- iii. The right to continue benefits pursuant to 42 C.F.R. § 438.420 pending a State Fair Hearing, if the appeal concerns the reduction, suspension or termination of currently authorized services.
 - iv. How to request continuation of benefits; and
 - v. If PIHP's action is upheld in a State Fair Hearing, the Enrollee may be liable for the cost of any continued benefits.
- 6. PIHP must continue the Enrollee's benefits pursuant to 42 CFR § 438.420 if all of the following criteria are met:
 - a. The appeal is filed timely, meaning on or before the later of the following:
 - i. Within ten days of PIHP mailing the notice of action; or
 - ii. The intended effective date of PIHP's proposed action; and
 - b. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment; and
 - c. The services were ordered by an authorized provider; and
 - d. The original period covered by the original authorization has not yet expired; and
 - e. The Enrollee requests extension of benefits.
- 7. If PIHP continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - a. The Enrollee withdraws the appeal; or
 - b. The Enrollee does not request a State Fair Hearing within ten (10) days from when PIHP mails an adverse PIHP decision; or
 - c. A State Fair Hearing decision adverse to the Enrollee is made; or
 - d. The authorization that is subject of the appeal expires or authorization service limits are met.
- 8. PIHP may recover the cost of the continuation of benefits furnished to the Enrollee while the appeal was pending if the final resolution of the appeal upholds PIHP's action.
- 9. PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the appeal is pending and the PIHP's decision is reversed on appeal.
- 10. If the PIHP or the State Fair Hearing reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services, in accordance with State policy and regulations.

H. Expedited Appeal Process:

- 1. PIHP must establish and maintain an expedited review process for appeals for situations in which PIHP determines, based on a request from the Enrollee or from a provider on behalf of the Enrollee, that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.
- 2. PIHP is required to follow all standard appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.
- 3. The Enrollee may file an expedited appeal either orally or in writing. No additional Enrollee follow-up is required.
- 4. PIHP must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

5. PIHP must resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed three (3) working days after PIHP receives the appeal.
6. For any extension not requested by the Enrollee, PIHP must give the member written notice of the reason for the delay.
7. In addition to written notice, PIHP must also make reasonable efforts to provide oral notice.
8. PIHP must ensure that punitive action is not taken against a Provider who either requests an expedited resolution or supports an Enrollee's appeal.
9. If PIHP denies a request for expedited resolution of an appeal, it must:
 - a. Transfer the appeal to the standard timeframe of no longer than forty five (45) days from the day PIHP received the appeal,
 - b. Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.
- I. **The State Fair Hearing:**
 1. An Enrollee may request a State Fair Hearing within thirty (30) days from the date PIHP mailed the notice of appeal resolution;
 2. Pursuant to 42 CFR § 408(f), the parties to the State Fair Hearing include PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

ATTACHMENT N

NETWORK PROVIDER ENROLLMENT AND RE-ENROLLMENT

PIHP shall maintain a Provider Network that provides culturally competent services. The Provider Network shall be composed of providers that demonstrate competencies in best practices and consumer outcomes, ensure health and safety for consumers, and demonstrate ethical and responsible practices. PIHP is committed to the achievement of positive outcomes for consumers, as well as consumer satisfaction. PIHP depends on its network of providers to offer quality services and to demonstrate accountability for the well-being of consumers that are served in PIHP system.

PIHP will use provider enrollment and re-enrollment applications approved by DMA.

A. TYPES OF PROVIDERS ENROLLED IN PIHP NETWORK

PIHP shall include the following types of providers in its Provider Network.

1. **Agency-Based Providers:** An agency-based provider is an entity organized as a corporation, limited liability company, partnership or other designation overseen by the NC Secretary of State, either for-profit or not-for-profit, engaged in the provision of Covered Services. Employees of the agency provide the services to the Enrollee, and agency management assures that the employees meet the qualifications to provide services and that all other requirements of the contract between PIHP and the agency-based provider are met. The types of agency-based providers are:
 - a. **Specialty Providers:** Specialty providers are providers that specialize in a specific service (such as vocational or residential) or in serving a specific disability area, or both. Specialty providers are important components of the network because they can focus their efforts on best practice strategies for a specific population. The majority of PIHP providers are specialty providers. These providers offer best practice service options to Enrollees, including enhanced services such as Assertive Community Treatment Team, Multi-systemic Therapy, Mobile Crisis, and Innovations Waiver services.
 - b. **Critical Access Behavioral Health Agency (CABHA):** The CABHA is a type of agency developed to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services. CABHAs are required to provide 24/7 crisis coverage to all individuals served. In accordance with the State Plan, only a certified CABHA can deliver Intensive In-Home, Day Treatment, or Community Support Team services.
 - c. **Residential providers, including ICF-IIDs** licensed in accordance with state law. PIHP shall offer choice of residential providers where available.
2. **Licensed Practitioners and Professional Practice Groups:** Licensed Practitioners in the areas of Psychiatry, Psychology, and Social Work are enrolled in PIHP Provider Network. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy. Practitioners may work for an Agency-based provider (LP) or may directly contract with PIHP (LIP). Enrollees are offered a choice of LIPs or agency-based providers when calling the Access line and requesting evaluation or outpatient treatment services.
3. **Hospitals and Psychiatric Residential Treatment Facilities** licensed in accordance with state law.

B. RE-ENROLLMENT OF PROVIDERS

PIHP shall verify the following information, at minimum, when re-enrolling providers in its Provider Network:

1. Verification of information on the applicant, including;
2. Insurance requirements;
3. Current valid license to practice in each state where the Practitioner will treat Enrollees;
4. Valid DEA certificate; and/or CDS certificate;
5. Board certification if claimed by the applicant;
6. Malpractice claims since the previous credentialing event;

7. Practitioner attestation statement;
8. Query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners (for the specific discipline); and
9. Query for state sanctions and/or license limitations.

ATTACHMENT O

CREDENTIALING AND RE-CREDENTIALING

PIHP shall utilize applications for credentialing and re-credentialing that comply with applicable federal and state laws, rules and regulations, are reasonably consistent with applications used by other PIHPs contracted with DMA, and are designed to gather the information listed below. PIHP shall complete Primary Source Verification (PSV) of the following minimum credentialing requirements, as applicable to the provider type, except that PIHP may rely on the relevant licensure board's PSV of educational status of Licensed Practitioner applicants:

1. Applicants must have a valid North Carolina license issued by the North Carolina Division of Health Service Regulation (if applicable for type of provider) before applying to the network. Licensed Practitioners shall meet state licensure requirements and hold a valid license from the State in which the individual is furnishing services to PIHP Enrollees.
2. Applicants must disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.
3. Applicants must disclose any actions listed in # 2, which are pending.
4. Applicants must furnish PIHP a history of names if the entity has done business under other names or is using a "doing business as" (d/b/a) name.
5. Applicants must identify by name, social security number, date of birth and address all persons with an ownership or control interest of the entity as defined at 42 CFR § 455.101. A list of all owners of more than 5% interest and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company shall be provided.
6. Applicants must furnish PIHP a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR § 455.101, including but not limited to members of the applicant's Board of Directors.
7. Applicants must disclose if it is affiliated by contract or otherwise, with any other provider.
8. Applicants must furnish evidence of all insurance coverage required by Section 7.7 of this Contract.
9. Licensed Practitioner applicants must also provide the following information:
 - i. History of loss of license and/or criminal convictions; actions by licensing board;
 - ii. Names of hospitals at which the practitioner currently has admitting privileges (physicians only);
 - iii. History of loss or limitation of privileges or disciplinary activity (physicians only);
 - iv. Languages spoken proficiently
 - v. Areas of specialized practices; and
 - vi. Identification of an on-call designee, who shall be a member of the PIHP Closed Provider Network or approved by PIHP, and must have the same credentials or higher.

ATTACHMENT P

CAPITATION RATES AND RATE SETTING METHODOLOGY

I. Rate Setting Methodology #1 — Use of Historical Fee-For-Service Data

To develop capitation per member per month (PMPM) rates on an actuarially-sound basis for PIHP using historical FFS data, the following general steps are performed:

1. Summarize the FFS Claims and Eligibility Data,
2. Combine the Multiple Years of FFS Data Together,
3. Project the FFS Base Data Forward,
4. Include the Effect of Program/Policy Changes,
5. Adjust the FFS Data to Reflect Managed Care Principles, and
6. Add an Appropriate Administration Load.

Summarize the FFS Claims and Eligibility Data — FFS claims and eligibility data is summarized for the recipients and services to be covered under PIHP. Normally, three years of FFS data are made available for rate-setting purposes. This data is then adjusted to account for items not included in the initial FFS data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, cost settlements, and other adjustments needed to match the coverage responsibilities of PIHP. The historical data summaries are provided to PIHP in the form of a databook.

Combine the Multiple Years of FFS Data Together — To arrive at a single year of FFS data to serve as the basis for rate setting, the multiple years of FFS data are combined together. Through this process, the older data is projected forward to be comparable to the most recent information. All the data is then blended together to form a single set of base data (with the most recent year of data receiving more weight).

Project the FFS Base Data Forward — The blended base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the FFS program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under PIHP or make changes to the Medicaid fee schedule. These changes are included in the capitation rates by either increasing or decreasing the FFS data by a certain percentage amount.

Adjust the FFS Data to Reflect Managed Care Principles — Since PIHP is a managed care program and not FFS, the projected FFS data needs to be adjusted to reflect the typical changes that occur when changing from an FFS program to a managed care program. This generally involves increasing the cost/use of preventative services, and decreasing hospital and emergency room cost/use.

Add an Appropriate Administration Load - To compensate the prepaid inpatient health plans (PIHPs) for managing and coordinating the care of their Members, a PMPM is included in the rates for administration and treatment planning responsibilities that is designed to cover all of the administrative functions contemplated under this Contract. Consideration for the risk reserve is also made if applicable.

Separate rates are established for State Plan and 1915(b)(3) services based on modeling of 1915(b)(3) services based on expected utilization. This is consistent with requirements in the 1915(b) waiver with CMS.

II. Rate Setting Methodology #2 — Use of Managed Care Data

To develop PMPM capitation rates on an actuarially-sound basis for PIHP using actual managed care data, the following general steps are performed:

1. Summarize, Analyze, and Adjust the Managed Care Data,
2. Project the Managed Care Base Data Forward,
3. Include the Effect of Program/Policy Changes, and
4. Add an Appropriate Administration Load.

Summarize, Analyze, and Adjust the Managed Care Data — DMA will collect encounter or claims data from PIHP. This data is summarized, analyzed, and adjustments (positive and negative) are applied, as needed. These adjustments can account for items such as collection of third-party liability/coordination of benefits (TPL/COB), incurred but unpaid claims, management efficiency, and provider contracting arrangements if applicable. After adjusting PIHP's data, PIHP's claims costs are aggregated together to arrive at a set of base data for each rate cell. The historical data summaries are provided to PIHP in the form of a databook.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under PIHP or make changes to the Medicaid fee schedule. Any new program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by a certain percentage amount.

Add an Appropriate Administration Load — After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration load will be added to the service claim cost component to determine the overall capitation rates applicable to each rate cell. The administration load is applied as a percentage of the total capitation rate (e.g., percent of premium) to generate a PMPM for funding all administrative and treatment planning requirements of this Contract. Consideration for the risk reserve is also made if applicable.

Separate rates are established for State Plan and 1915(b)(3) services based on modeling of 1915(b)(3) services based on expected utilization. This is consistent with requirements in the 1915(b) waiver with CMS.

III. Rate Setting Methodology #3 – Blending of FFS and Managed Care Data

If updated FFS data is unavailable and actual managed care experience first becomes available (year 3 of the program), capitation rates for PIHP may be developed on an actuarially-sound basis using a blending of both data sources using the following two track approach:

1. Project the Prior Year's Rates Forward (Track 1),
2. Include the Effect of New Program/Policy Changes (Track 1),
3. Summarize and Adjust the Managed Care Data (Track 2),
4. Include the Effect of Trend and New Program/Policy Changes (Track 2),
5. Apply Credibility Factors to Each Track and Blend Together, and
6. Add an Appropriate Administration Load. (Track 1 and Track 2)

Project the Prior Year's Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year's capitation rates that were originally developed using historical FFS claims and eligibility data. This service cost component of the prior rates is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new program/policy changes implemented by DMA, that were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by a certain percentage amount.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from PIHP, summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed. These adjustments can account for items such as collection of TPL/COB, incurred but unpaid claims, management efficiency, and provider contracting arrangements if applicable. The historical data summaries are provided to PIHP in the form of a databook.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group, and are used to estimate the future costs of the services that the covered population would generate under managed

care. Any new program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by a certain percentage amount.

Apply Credibility Factors to Each Track and Blend Together — After separately developing the service component of the capitation rates using Track 1 and Track 2, the two sets of rates are combined together. This blending involves applying a credibility weight to each track (e.g., 50/50 split, 60/40 split, etc.) and adding the two components together. The credibility weights may vary between the population groups.

Add an Appropriate Administration Load — After the Track 1 and Track 2 service rates have been blended together, an administration load will be added to the service claim cost component to determine the overall capitation rates applicable to each rate cell. The administration load is applied as a percentage of the total capitation rate (e.g., percent of premium) to generate a PMPM for funding all administrative and treatment planning requirements of this Contract. Consideration for the risk reserve is also made if applicable.

Separate rates are established for State Plan and 1915(b)(3) services based on modeling of 1915(b)(3) services based on expected utilization. This is consistent with requirements in the 1915(b) waiver with CMS.

ATTACHMENT Q

BUSINESS TRANSACTIONS

PIHP shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

- A. Definition of a Party in Interest - As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

(1) Any director, officer, partner or employee responsible for management or administration of PIHP; any person who is directly or indirectly the beneficial owner of more than five (5) % of the equity of PIHP; any person who is the beneficial owner of more than five (5) % of PIHP or, in the case of a PIHP organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation laws;

(2) Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5)% of the equity of PIHP; or has a mortgage, deed of trust, note, or other interest valuing more than five (5) % of the assets of PIHP;

(3) Any person directly or indirectly controlling, controlled by, or under common control with PIHP; or

(4) Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

The provider must disclose to the State Medicaid agency the Name, address, date of birth, and social security number of each person or entity subject to 42 CFR 455.104(b)(1).

- B. Types of Transactions Which Must Be Disclosed - Business transactions which must be disclosed include:

(1) Any sale, exchanges or lease of any property between PIHP and a party interest;

(2) Any lending of money or other extension of credit between PIHP and a party interest; and

(3) Any furnishing for consideration of goods, services (including management services) or facilities between PIHP and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

- C. The information, which must be disclosed in the transactions listed in subsection B between PIHP and a party in interest includes:

- (1) The name of the party in interest for each transaction;
a. A description of each transaction and the quantity or units involved;
b. The accrued dollar value of each transaction during the fiscal year; and
c. Justification of the reasonableness of each transaction.

- D. PIHP must enter into an agreement with each provider under which the provider agrees to furnish to it, Department or to the Secretary of the Department of Health and Human Services on request, information related to business transactions. (42 CFR 455.104(b)(2))

1. A provider must submit, within 35 days of the date on a request by the Department or Secretary of the Department of Health and Human Services, full and complete information about—

a. The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and

b. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

2. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary of U. S. Department of Health and Human Services or the Department.

3. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary of the U.S. Department of Health and Human Services or the Department and ending on the day before the date on which the information was supplied

If this PIHP contract is being renewed or extended, PIHP must disclose information on these business transactions, which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but PIHP has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions, which must be reported, are not limited to transactions related to serving the Medicaid enrollment. All of these PIHP business transactions must be reported.

ATTACHMENT R

CLINICAL COVERAGE POLICIES, BULLETINS and MANUALS

Clinical Coverage Policy #3 – Community Based Services: Private Duty Nursing; CAP/C; CAP/DA; Prior Approval for MPW Recipients; Home Health; Personal Care Services; Personal Care Services-Plus; Hospice; Home Infusion Therapy
(Available on DMA web site at:

<http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>

Clinical Coverage Policy #4 – Medical Equipment: Durable Medical Equipment; Orthotics and Prosthetics
Available on DMA web site at:

<http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>

Clinical Coverage Policy #8 – Behavioral Health: Enhanced Mental Health and Substance Abuse Services; Inpatient Behavioral Health Services; Outpatient Behavioral Health Services; Psychiatric Residential Treatment Facilities; Residential Treatment Services; Intermediate Care Facilities for Individuals with Mental Retardation; Psychological Services in Health Departments and School Based Health Centers; Children's Developmental Service Agencies.
Available on DMA web site at:

<http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>

Basic Medicaid Billing Guide
Available on DMA web site at:

<http://www.dhhs.state.nc.us/dma/medbillcaguide.htm>

Medicaid Bulletins: general and specific
Available on DMA website at:

<http://www.dhhs.state.nc.us/dma/bulletin.htm>

Transportation Policy
Available on DMA web site at:

<http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/>

And:

<http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/>

Administrative Procedures Services Manual 30-1
Administrative Procedures Services Manual 45-2
Administrative Procedures Services Manual 95-1
Available on DMH/DD/SAS web site at:

<http://www.ncdhhs.gov/mhddsas/statpublications/manualsforms/index.htm>

ATTACHMENT S
ACCESS AND AVAILABILITY STANDARDS

ACCESSIBILITY

- A. Geographic Location: Network Providers for all Covered Services must be as geographically accessible to Medicaid Enrollees as to non-Medicaid Enrollees.
- B. Distance/Travel Time: Medicaid Enrollees should have access to Network Providers within thirty (30) miles distance or thirty minutes' drive time, 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility based or specialty Providers.
- C. Facility Accessibility: Contracted Network Provider facilities must be accommodating for persons with physical disabilities. PIHP must require handicapped parking and entrance ramps; wheelchair accommodating door widths; and bathrooms equipped with handicapped railing.
- D. New Enrollee Orientation: Enrollee materials and information shall be sent to each new Enrollee by PIHP within fourteen (14) days of effective date of enrollment.
- E. Enrollee Services: Medicaid Enrollees must have toll-free telephone access to a Customer Services department to provide assistance, information, and education to members.
- F. Support Services:
 - Transportation: Assistance with arrangement for transportation to medically necessary services through public and private means must be made available and communicated to Medicaid Enrollees.
 - Interpreters: Language interpretation services must be made available by telephone and/or in person; enabling Medicaid Enrollees to effectively communicate with PIHP and Providers. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

AVAILABILITY

- A. PIHP shall ensure that Network Providers meet the following Access Standards related to Appointment Availability:
 - 1. Emergency Services – Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by provider staff from the PIHP or directly from an Enrollee; the Provider must provide face-to-face emergency care immediately for life threatening emergencies;
 - 2. Urgent Need Services -- Providers must provide initial face-to-face assessments and/or treatment within forty-eight hours after the date and time a request for urgent care is received by provider staff from the PIHP or directly from an Enrollee;
 - 3. Routine Need Services -- Providers must provide initial face-to-face assessments and/or treatment within 14 calendar days of the date a request for routine care is received by Provider staff from the PIHP or directly from an Enrollee;
- B. PIHP shall ensure that Network Providers meet the following Access Standards related to Office Wait Time:
 - 1. Scheduled Appointments – Sixty minutes after the appointed meeting time;
 - 2. Walk-Ins – within two hours after the Enrollee's arrival. If that is not possible, staff must schedule an appointment for the next available day;
 - 3. Emergencies - PIHP staff must ensure that Enrollees are provided face-to-face emergency care within two hours after the request for care is initiated by PIHP or directly by the Enrollee; life threatening emergencies shall be managed immediately.
- C. After Hours Emergency and Referral

1. PIHP will provide toll-free telephone emergency and referral line twenty four (24) hours per day.
 2. PIHP Return Calls to Enrollees: Telephone inquiries made by Enrollees after hours for access/information must be responded to within one (1) hour of receiving the call.
- D. The Enrollee has a right to a second opinion from a qualified health care professional within or outside the network, at no cost to the Enrollee. Upon request, PIHP shall provide an Enrollee with one second opinion from a qualified health care professional selected by the PIHP, at no cost to the Enrollee. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. PIHP shall not be required to provide an Enrollee with a third or fourth opinion.

ATTACHMENT T

Mixed Services Payment Protocol

Services	Claim Processing And/Or Financial Liability
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	PIHP
Outpatient X-ray and Lab Work	DMA fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: 290-319
Prescribed by a PIHP network provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.	DMA fee-for-service Medicaid fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: 290-319
Prescribed by PIHP network provider on an outpatient basis such as therapeutic drug levels.	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319
Other tests ordered by non- PIHP physician	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319
Drugs	
Outpatient prescription drugs and take home drugs.	DMA fee-for-service Medicaid
Ambulance	
Transport to the hospital when the primary diagnosis is behavioral care	DMA fee-for-service Medicaid
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	DMA fee-for-service Medicaid
Transfers authorized by PIHP from non-network facility to a network facility	PIHP
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	PIHP
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	PIHP
Medical/Surgical on Mental Health/Substance Abuse Unit	DMA fee-for-service Medicaid
Emergency Room Charges – Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	PIHP
Emergency room services where the primary diagnosis on the claim is in the following range: 290-319	PIHP

Services	Claim Processing And/Or Financial Liability
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DMA fee-for-service Medicaid
Emergency Room Facility Charge:	
Emergency room services where the primary diagnosis on the claim is in the following range: 290-319	PIHP
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DMA fee-for-service Medicaid
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning.	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders.	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	PIHP
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or PIHP authorized physician	PIHP
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by Elevated vital signs, agitation, perspiration, Anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by PIHP. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis is in the following range: 290-319.	PIHP
Delirium tremens (DTs), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.	DMA fee-for-service Medicaid except for emergency room visits where the primary diagnosis is in the following range: 290-319

ATTACHMENT U

Financial Reporting Requirements

PIHP shall submit financial data and reports to DMA as listed below. DMA will notify PIHP at least 30 days prior to the effective date of any requested amendment to the financial reports required herein. Financial reporting requirements, instructions, and templates are located in the DMA Financial Reporting Manual for PIHPs.

PIHP shall complete and submit the financial reports to DMA by the due date specified below. Questions regarding reporting requirements may be addressed to the DMA Contract Administrator and/or through IMT meetings.

Schedule	Report name	Frequency	Due date ¹	Format
A	Balance sheet	Monthly	20 days after end of month	Predetermined
B	Medicaid risk reserve balance	Monthly	20 days after end of month	Predetermined
C	Medicaid income statement	Monthly	20 days after end of month	Predetermined
D	Total profitability	Monthly	20 days after end of month	Predetermined
D1	Medicaid profitability	Monthly	20 days after end of month	Predetermined
D2	Non-Medicaid profitability	Monthly	20 days after end of month	Predetermined
E	Medicaid-only medical services lag	Monthly	20 days after end of month	Predetermined
E1	Medicaid cash summary	Monthly	20 days after end of month	Predetermined
F	Medicaid statistics current year	Monthly	20 days after end of month	Predetermined
F1	Medicaid statistics prior year	Monthly	20 days after end of month	Predetermined
G	Medicaid claim aging	Monthly	20 days after end of month	Predetermined
H	Medicaid claim processing	Monthly	20 days after end of month	Predetermined
I	B3 services current year	Quarterly	45 days after quarter end	Predetermined
I1	B3 services prior year	Quarterly	45 days after quarter end	Predetermined
J	Medicaid third party liability and coordination of benefits	Quarterly	60 days after quarter end	Predetermined
K	Medicaid fraud and abuse tracking	Quarterly	60 days after quarter end	Predetermined
L	Supplemental working area	As needed	As needed	Narrative
M	Alternative Payment Arrangements	Monthly	20 days after end of month	Predetermined

Schedule	Report name	Frequency	Due date ¹	Format
AA	Cost allocation plan	Annually	60 days prior to start of fiscal year	Narrative
BB	Audited financial statements	Annually	150 days after year end	Narrative
CC	OMB circular A-133 audit	Annually	120 days after year end	Narrative
DD	Related party transactions and obligations	Annually	60 days after year end	Narrative
EE	Physician incentive arrangements	Annually	60 days after year end	Narrative

¹If a due date falls on a weekend or State recognized holiday, reports will be due the next business day.

ATTACHMENT V

Medical Care Decisions And Advance Directives

WHAT YOU SHOULD KNOW

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.



Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your doctor or other provider that you want to cancel it.

ATTACHMENT W
Contract Compliance

Any instance of contract non-compliance described below except early termination may first result in implementation of a Corrective Action Plan. If a Corrective Action Plan is implemented and does not resolve the problem, the resolutions and actions described below may be initiated by DMA. The Corrective Action Plan must be submitted within 30 days of the date requested by DMA. The Corrective Action Plan must describe the action that will be taken by PIHP to cure the defective performance and to prevent future non-compliance and must include a timetable for the corrective action. DMA will review and either approve or request edits to PIHP's Corrective Action Plan within 10 business days after receipt of the plan from PIHP. DMA will not unreasonably withhold approval, and PIHP shall make all edits reasonably requested by DMA and resubmit the plan by the date specified by DMA in its written rejection notice. Once the plan is approved, PIHP has 60 days to implement the plan. The DMA Director or his designee will determine whether, once implemented, the plan is resolving the problem. Failure to resolve the problem may result in the sanctions below:

Compliance Issue	Resolution/Action
Non-compliance with Federal, and State laws; placing health and safety of recipients in jeopardy and not acting to solve the problem; providing fraudulent information to recipients; offering or providing gratuities to public officials creating a conflict of interest as described in Part II, Section 1.0, Conflict of Interest; State and Federal Medicaid funds no longer available to provide payment.	Immediate termination
Claims are not paid by PIHP to providers in a timely manner as specified in this Contract, Attachment B, Section 11.2. PIHP shall follow North Carolina Prompt Pay Requirements as follows: within eighteen (18) calendar days after PIHP receives an invoice/claim from a provider, PIHP shall either: (a) approve payment of the invoice/claim, (b) deny payment of the invoice/claim, or (c) determine that additional information is required for making an approval or denial. If payment is approved, the claim shall be paid within 30 calendar days after it is approved.	If PIHP fails to pay providers within these parameters, PIHP shall pay to the providers interest in the amount of 8% of the amount owed in excess of the Prompt Pay Requirements.
Early contract termination by PIHP.	PIHP shall provide DMA with a plan to effectively transition Enrollees to Medicaid fee-for-service as specified in Part II 12.4. DMA may require PIHP to pay the non-federal share of transitions (cost of EIS and MMIS and recipient notification)
Failure to submit encounter data, enrollment reconciliation reports or financial reports in accordance with the timelines or requirements specified in this Contract.	Beginning after this Contract has been in effect for 90 calendar days, financial sanctions may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of PIHP's monthly capitation payment due shall be subject to financial sanctions. (Refundable upon receipt).
Failure to authorize Medically Necessary services; inappropriate charges to Enrollees; Physician Incentive Plan non-compliance; falsifying information to Enrollees, DMA or the Department discrimination due to health status/service needs of Enrollees.	Beginning after this Contract has been in effect for 90 calendar days, financial sanctions may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of PIHP's monthly capitation payment due shall be subject to financial sanctions.

APPENDIX Y: MEDICAID PAYMENT AMOUNTS

Below are the Medicaid Capitation Rates for EastPointe for the time period of
July 1, 2015 - June 30, 2016

CAPITATION RATES (State Plan Services)

AFDC	3+	\$37.18
Foster Children	3+	\$583.77
Aged	65+	\$59.42
Blind/Disabled	3-20	\$268.03
Blind/Disabled	21+	\$246.09
CAP-MR	All Ages	\$4,895.55
Total (w/o CAP-MR)	All Ages	\$92.16
Total	All Ages	\$122.91

CAPITATION RATES (1915(b)(3) Services)

AFDC	3+	\$0.31
Foster Children	3+	\$10.60
Aged	65+	\$0.07
Blind/Disabled	3-20	\$15.10
Blind/Disabled	21+	\$4.50
CAP-MR	All Ages	\$0.25
Total (w/o CAP-MR)	All Ages	\$1.76
Total	All Ages	\$1.76

CAPITATION RATES (TOTAL RATE)

AFDC	3+	\$37.47
Foster Children	3+	\$594.37
Aged	65+	\$59.49
Blind/Disabled	3-20	\$301.13
Blind/Disabled	21+	\$250.59
CAP-MR	All Ages	\$4,895.80
Total (w/o CAP-MR)	All Ages	\$93.92
Total	All Ages	\$124.68

Eastpointe Representative

Approved/Accepted

Date 4/29/2015

DHHS Representative

Approved/Accepted

Date 5/11/15

CMS Representative

Approved/Accepted

Date _____