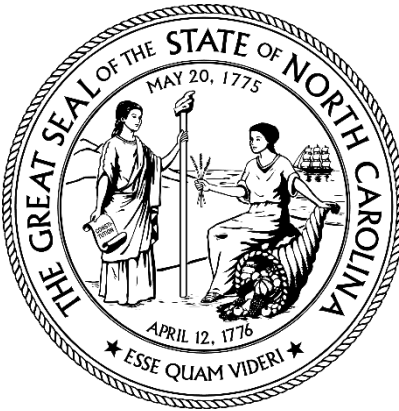


# STATE OF NORTH CAROLINA

Department of Health and Human Services

Contract #30-2022-007-DHB-X

Medicaid Direct Prepaid Inpatient Health Plan Contract



## STATE OF NORTH CAROLINA

**Contract #30-2022-007-DHB-X**

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For internal State agency processing, please provide your company's Federal Employer Identification Number or alternate identification number (e.g., Social Security Number). Pursuant to North Carolina General Statute 132-1.10(b) this identification number shall not be released to the public. **This page will be redacted**, before the contract is made available for public inspection.

**ID Number:**

**XXXXXXXXXX**

Federal ID Number or Social Security Number

**XXXXXXXXXXXXXXXXXX**

Health Plan Name

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## I. Parties to the Contract

This Contract #30-2022-007-DHB-X for Prepaid Inpatient Health Plan services (“Contract”) is entered between the North Carolina Department of Health and Human Services (“Department”), Division of Health Benefits (“DHB”) and XXX (“Contractor” or “PIHP”). Department and Contractor may be individually referred to as “Party” and collectively as the “Parties.

Each Party is executing this Agreement at this time under the expressed commitment by each other to negotiate in good faith a formal amendment for execution prior to the Effective Date. The Parties envision that Amendment will align and perform a “true-up” of the requirements of this Medicaid Direct PIHP contract with the requirements of the pending or any other Tailored Plan Amendment. The Parties each further agree to negotiate in good faith to eliminate inconsistencies in, to minimize duplicative efforts and obligations between, and to reconcile these related contracts. Until execution of this proposed amendment, the Department agrees it will not hold PIHPs responsible for any readiness or other perceived issues that relate to such inconsistencies and needed amendment.

## II. Definitions and Abbreviations

### A. Definitions

Unless otherwise specified herein, the following definitions apply to this Contract

1. **Advance Directive:** Has the same meaning as Advance Directive as defined in 42 C.F.R. § 489.100 and includes advance instructions for mental health treatment as defined in Part 2 of Article 3 of Chapter 122C of the General Statutes.
2. **Advanced Medical Home (AMH):** State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.
3. **Advanced Medical Home Plus (AMH+):** Primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population and have been certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch) as such.
4. **Adverse Benefit Determination:** Has the same meaning as Adverse Benefit Determination as defined in 42 C.F.R. § 438.400.
5. **Alcohol and Drug Abuse Treatment Center (ADATC):** State-operated treatment center that provides inpatient treatment, psychiatric stabilization, and medical detoxification for adults with substance use and other co-occurring mental health diagnoses to prepare for ongoing community-based treatment and recovery.
6. **Allocation Letter:** Letter by which the Department disburses specific state or federal funds to the PIHP and specifies the binding terms and conditions for using those funds.
7. **American Society of Addiction Medicine (ASAM) criteria:** Evidence-based guidelines for placement, continued stay, and transfer/discharge for the treatment of adolescents and adults with addiction and co-occurring conditions.
8. **Appeal:** Has the same meaning as Appeal as defined in 42 CFR § 438.400(b).
9. **Authorized Representative:** An individual, Provider or organization designated by a Member, or authorized by law or court order, to act on their behalf in assisting with the individual's participation

in the Medicaid Managed Care program. With written consent of the Member, or as otherwise legally authorized, an authorized representative may, for example, request an Appeal, file a Grievance, or request a State Fair Hearing on behalf of the Member with the exception that a Provider cannot request continuation of PIHP benefits. Authorized Representative may be used interchangeably with member wherever a member has a right under this Contract for purposes of exercising a right on behalf of that member. Sometimes referred to as Legally Responsible Person (LRP).

10. **Automated Call Distribution System (ACD):** An automated call center system that disperses incoming calls of all Members and potential Members to appropriate service line staff.
11. **Automated Voice Response System (AVRS):** An automated system that allows members to perform self-service activities and resolve simple inquiries without the need to interact with an agent. The AVRS interacts with the Member through voice prompts and recognition or numeric prompts.
12. **Behavioral Health (BH):** Mental health and substance use disorder.
13. **Behavioral Health Crisis Line:** A confidential, toll-free service line available twenty-four (24) hours a day, seven (7) days a week, every day of the year to Members which provides emergency referral with immediate access to trained, skilled, licensed BH professionals who provide assistance for any type of BH issue the Member may be experiencing and offers assistance in linking Members to supportive available community resources.
14. **Behavioral Health Crisis Referral System (BHCRS):** A secure web-based application that connects a statewide network of facilities that make referrals (Referring Facilities) with facilities that offer inpatient or facility-based treatment (Receiving Facilities) to assist facilities in timely and appropriate placement of individuals experiencing a BH crisis.
15. **Behavioral Health and Intellectual/Developmental Disability Tailored Plan (BH I/DD Tailored Plan):** Has the same meaning as BH I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4).
16. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid or NC Health Choice programs but who may or may not be enrolled in the Medicaid Managed Care program.
17. **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals with: HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving Innovations or TBI waiver services.
18. **Business Associate Agreement (BAA):** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the written agreement between a HIPAA-covered entity and HIPAA Business Associate, as defined in 45 C.F.R. 160.103.
19. **Business Day:** Business days are defined as traditional State workdays, Monday – Friday and includes traditional work hours 8:00 AM – 5:00 PM EST. North Carolina State holidays are excluded. A list of North Carolina State Holidays is located at the following link, accurate as of the date of execution of this Contract: <https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays>.
20. **Calendar Day:** Includes the time from midnight to midnight each day, and all days in a month, including weekends and holidays. Unless otherwise specified within the Contract, days are tracked as Calendar Days.
21. **Care Coordination:** The act of organizing Member care activities and sharing information among all the participants involved with a Member’s care to achieve safer and more effective care. Through

organized care coordination, Members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care addressing the member's clinical needs and unmet health related resource needs.

22. **Care Management:** Team-based, person-centered approach to effectively managing patients' medical, social, and behavioral conditions. Care Management shall include, at a minimum, the following:
- a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
  - b. Care Needs Screening;
  - c. Identification of members in need of care management;
  - d. Development of Care Plans (across priority populations);
  - e. Development of comprehensive assessments (across priority populations);
  - f. Transitional Care Management: Management of member needs during transitions of care and care transitions (e.g., from hospital to home);
  - g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
  - h. Chronic care management (e.g., management of multiple chronic conditions);
  - i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
  - j. Management of unmet health-related resource needs and high-risk social environments;
  - k. Management of high-cost procedures (e.g., transplant, specialty drugs);
  - l. Management of rare diseases (e.g., transplant, specialty drugs);
  - m. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
  - n. Development and deployment of population health programs.
23. **Care Management Agency (CMA):** Provider organization with experience delivering BH, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management to BH I/DD Tailored Plan members assigned to it, under the Tailored Care Management model as certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch).
24. **Care Management Comprehensive Assessment:** A person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform the Member's ongoing Care Plan and treatment.
25. **Care Management for At-Risk Children:** Care management services provided to a subset of the Medicaid population ages 0-5 identified as being "high-risk."
26. **Care Management for High-Risk Pregnant Women:** Care management services provided to a subset of the Medicaid population who is pregnant and identified as "high-risk" by Providers, local health departments (LHDs), social service agencies, Standard Plans, and/or BH I/DD Tailored Plans, and/or PIHP.
27. **Care Plan:** A written individualized person-centered plan of care for Members with BH needs, that is developed using a collaborative approach led by the Member or their guardian when appropriate, incorporates the results of the Care Management Comprehensive Assessment, and identifies the Member's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the member to achieve those outcomes.

28. **Care Transitions:** The process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g., school-related transitions).
29. **Caregivers:** Family members, friends or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.
30. **Carved Out Services:** Services provided by Children's Developmental Services Agency and Local Education Agencies
31. **Child and Adolescent Level of Care Utilization System (CALOCUS):** A level of care assessment tool that measures a child or adolescent's current clinical needs to determine the intensity of mental health and SUD services required. The Department has authorized the use of the CALOCUS for mental health services only.
32. **Child and Adolescent Needs and Strengths (CANS):** A multi-purpose tool developed for children and adolescent BH and developmental services to support decision making, including level of care and service planning; facilitate quality improvement initiatives; and allow for the monitoring of outcomes of services.
33. **Child/Adolescent Psychiatrist:** A physician who has completed an ACGME-accredited child/adolescent psychiatry fellowship and/or is board certified or has board-diplomate status as a child/adolescent psychiatrist.
34. **Children with Complex Needs:** Medicaid eligible children ages five (5) through twenty (20) with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting. The term "at risk" is defined for this purpose as acts or behaviors that present a substantial risk of harm to the child or to others.
35. **Child and Family Team:** Group consisting of a child/youth receiving services, parent/caregiver/guardian, and other community supports as determined by the child/youth and/or their parent/caregiver/guardian. The Child and Family Team is responsible for creating, implementing, and updating an individualized child and family plan on the child/youth's needs. Child and Family team may include extended family members, community members, and individuals involved in the child/youth's education, care, and support.
36. **Children with Medical Complexity (CMC):** Also known as "complex chronic" or "medically complex," children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations, high health care need or utilization, and often the need for or use of medical technology.
37. **Choice Counseling:** Has the same meaning as Choice Counseling as defined in 42 C.F.R. § 438.2.
38. **Civil Monetary Penalty:** Financial penalties authorized or required to be imposed by States under federal requirements for certain conduct as set forth in 42 C.F.R. § 438.700.
39. **Claim:** A request for payment by a healthcare Provider to an insurer, including a PIHP, for rendered services. Also refers to (1) a bill for services, (2) a line item of service, or (3) all services for one beneficiary within a bill, as referenced at 42 CFR §447.45(b). Claims may be filed for professional, institutional, or other appropriate transactions in conformance with existing laws (e.g., HIPAA) and using relevant industry standards (e.g., ASC X12N, NCPDP) and typically include information on the patient, Provider, diagnoses, procedures performed, or services rendered, and related charges.



40. **Claim Adjudication:** The process of paying Claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.
41. **Claim Adjudication Date:** The date the PIHP or its Subcontractor processed a Claim for determination of payment, acceptance, denial, or rejection.
42. **Clean Claim:** A Claim submitted to a PIHP by a Participating Provider which can be processed without obtaining additional information from the Participating Provider or their authorized representative in order to adjudicate the Claim. Pursuant to 42 CFR § 447.45(b), Clean Claim does not include a claim from a service provider who is under investigation for fraud or abuse or a claim under review for medical necessity.
43. **Clinically Integrated Network (CIN) or Other Partner:** Entities with which Provider practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or CMA.
44. **Closed Loop Referral:** The capacity to know whether a Member accessed the social services to which they were referred.
45. **Closed Network:** Has the same meaning as Closed Network defined in N.C. Gen. Stat. § 108D-1(6).
46. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs (4141.R06.00; the approved waiver document is available at the following link, accurate as of the date of execution of this Contract: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8233> ).
47. **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement; the approved waiver document is available at the following link, accurate as of the date of execution of this Contract: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8232>.
48. **Community Collaboratives:** Local and regional convenings of county agencies, community-based organizations, non-profits, Members, relatives/ natural supports, health care Providers, and peers that meet regularly to identify and address community needs through coordinated efforts and system planning.
49. **Community Integration Plan (CIP):** A planning document completed as part of the diversion process that documents that community integration planning occurred and indicates which residential option and other services were chosen by the Member and/or their relatives or guardian.
50. **Compatible Medicaid NCCI Methodologies:** The six (6) NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology

with medically unlikely edits for durable medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.

51. **Conflict of Interest:** Impermissible actual situations or circumstances through which the PIHP, or entities or individuals closely affiliated with the PIHP, will derive, or reasonably may be perceived as deriving, direct financial or other pecuniary benefit from its performance of this Contract other than through the compensation received according to the Contract for performance of the Contract, or that might impair, or reasonably be perceived as impairing, the PIHP's ability to perform this Contract in the best interests of the State.
52. **Contractor:** The entity contracted to perform the services and requirements defined under this Contract. The Contractor is a PIHP.
53. **Contract Year:** As specified in Section III.A., the period beginning with when the PIHP begins providing services under this Contract until the next June 30<sup>th</sup> and each subsequent twelve-month period thereafter.
54. **Credentialing:** The approach to collecting and verifying Provider qualifications (e.g., the Provider's training and education, licensure, liability record); and determining, for Medicaid Managed Care and State-funded Services, whether to allow the Provider to be included in a PIHP's Closed Network, subject to certain Department requirements.
55. **Cross Area Service Program (CASP):** DMH/DD/SAS designated specialty service program that is funded by the DMH/DD/SAS through federal and/or State funds to provide targeted services to an identified population segment (e.g., pregnant women, families, etc.). A CASP is designated by the Division of MHDDSAS as a result of a critical federal grant initiative or a priority state service initiative
56. **Cross-over Population:** Refers to North Carolina Medicaid and NC Health Choice beneficiaries that are enrolled in the NC Medicaid Direct program and will transition to Medicaid Managed Care at a specific date determined by the Department.
57. **Cultural and Linguistic Competency (or Culturally and Linguistically Competent):** The ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of individuals are met. The ability to interact effectively with people of different cultures helps to ensure that the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural and Linguistic Competency means to be respectful, responsive, and sensitive to the health beliefs, practices, cultural and linguistic needs of diverse populations and groups.
58. **Culturally and Linguistically Appropriate Services (CLAS):** Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.
59. **Date of Payment:** The point in time following the Claim Adjudication Date when reimbursement is generated for services, either initiated by date of Electronic Funds Transfer (EFT) or processes to generate a paper check.
60. **Denied Claim:** When a PIHP or its Subcontractor refuses to reimburse a Participating Provider for all, or a portion of the services submitted on the Claim.
61. **Diversion:** The process of identifying individuals living in the community who are at risk of requiring care in an institutional setting or an adult care home, and providing additional, more intensive

supports and services to prevent further deterioration of their condition that could result in placement in an institutional setting or an adult care home.

62. **Dually-Eligible for Medicare and Medicaid:** Describes beneficiaries eligible for both Medicare and Medicaid.
63. **Duplicate Claim:** Any claim submitted by a Participating Provider for the same service provided to an individual on a specified date of service that was included in a previously submitted Claim.
64. **Durable Medical Equipment (DME):** Has the same meaning as Durable Medical Equipment as defined in 42 C.F.R. § 414.202.
65. **Eastern Band of Cherokee Indians (EBCI):** A federally recognized Indian Tribe located in southwestern North Carolina whose members are exempt from Medicaid managed care.
66. **Eastern Band of Cherokee Indians (EBCI) Tribal Option.** The tribal-designed and operated managed care primary care case management entity option developed collaboratively by the Department and the EBCI. This includes the following counties: Cherokee, Graham, Haywood, Jackson, and Swain Counties. Eligible Members in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania.
67. **Emergency Closure:** A closure of licensed residential care facilities that occurs without the facility providing the required 30-day notice to residents and the state (or sixty (60) Calendar Days' notice as required for I/DD facilities pursuant to N.C.G.S. § 122C-63(b)) as described in posted lawful guidance.
68. **Emergency Medical Condition:** Has the same meaning as Emergency Medical Condition as defined in 42 C.F.R. § 438.114(a).
69. **Emergency Services:** Has the same meaning as Emergency Services as defined in 42 C.F.R. § 438.114(a).
70. **Encounter:** A record of a rendered service provided by a Provider irrespective of whether payment is required. Encounter data typically includes information otherwise present on a Claim.
71. **Enrollment:** The process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, BH I/DD Tailored Plan, Medicaid Direct PIHP, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program.
72. **Enrollment Broker (EB):** Has the same meaning as Enrollment Broker as defined in 42 C.F.R. § 438.810(a).
73. **Essential Providers:** Federally qualified health centers, rural health centers, free clinics, local health departments, State Veteran's Homes, and any other Providers as designated by the Department in accordance with N.C. Gen. Stat. § 108D-22(b).
74. **Excluded Person:** A person or corporate entity who appears on one or more of the Exclusion Lists.
75. **Exclusion List:** Lists the PIHP must check to determine the exclusion status of all providers and ensure that the PIHP does not pay federal funds to excluded persons or entities, including:
  - a. State Excluded Providers List;
  - b. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
  - c. The System of Award Management (SAM);
  - d. The Social Security Administration Death Master File (SSADMF);

- e. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
  - f. Office of Foreign Assets Control (OFAC).
76. **Exempt Population:** Beneficiaries in Exempt Populations may voluntarily enroll in Medicaid Managed Care on an opt-in basis if they meet other eligibility requirements for being enrolled in Medicaid Managed Care. Members of Exempt Populations are allowed to opt into Medicaid Managed Care or into NC Medicaid Direct at any time, upon request to the Enrollment Broker.
  77. **Fee-for-Service:** A payment model in which Providers are paid for each service provided. NC Medicaid and NC Health Choice's Fee-for-Service program is also known as NC Medicaid Direct.
  78. **Foster Care:** Has the same meaning as Foster Care as defined in N.C. Gen. Stat. § 131D-10.2(9).
  79. **Grantee:** The State government entity (i.e., NC DHHS, Division of MHDDSAS) to which a federal grant is awarded, and which is responsible and accountable for the use of the funds provided and for the performance of the grant-supported project or activity.
  80. **Grievance:** As it relates to a Member, has the same meaning as Grievance as defined in 42 C.F.R. § 438.400(b).
  81. **Hardship Payment:** An advanced payment from the PIHP to a provider, the provision and amount of which are in the PIHP's sole discretion, to address a situation in which the provider is experiencing a significant drop in PIHP claims payments due to issues beyond the control of the provider, and which advance the PIHP shall recoup by offset or repayment.
  82. **Health Home:** A designated provider (including a Provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services pursuant to Section 1945 of the Social Security Act In North Carolina's Medicaid Managed Care program, the PIHPs will serve as the Health Homes, pending approval of the federal Centers for Medicare & Medicaid Services (CMS).
  83. **Health Insurance:** A contract that requires a health insurer to pay some or all of a defined beneficiary's health care costs, sometimes in exchange for a premium.
  84. **High Acuity Clinical Setting:** A hospital/Inpatient acute care and long-term acute care, nursing facility, adult care home, inpatient behavioral health services, facility-based crisis services for children, facility-based Crisis services for adults and Alcohol and Drug Abuse Treatment Centers.
  85. **Historically Marginalized Populations:** Individuals, groups, and communities that have historically and systematically been denied access to services, resources, and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression. Longstanding and well documented structural marginalization has resulted in poor health outcomes, economic disadvantage, and increased vulnerability to harm and adverse social, political and economic outcomes. Historically Marginalized Populations are often identified based on their race, ethnicity, social economic status, geography, religion, language, sexual identity and disability status.
  86. **Human Services Organization (HSO):** An organization that offers non-medical services to address unmet health related resource needs within one or more communities. HSOs are also known as community-based organizations or social service agencies.
  87. **Implementation Plan:** Comprehensive schedule of events, tasks, deliverables, and milestones developed and executed by the PIHP to ensure successful implementation and launch of PIHP services

88. **In Lieu of Services (ILOS):** Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.
89. **In-Reach:** The process of identifying individuals residing in an institutional setting or an adult care home whose service needs could potentially be met in a home or community-based setting, engaging them about their desire to transition to a home or community-based setting and referring them for transition, if appropriate.
90. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a).
91. **Indian Health Care Provider Purchased/Referred Care:** any health service that is delivered based on a referral by, or at the expense of, an Indian health program; and provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program
92. **Individual Support Plan (ISP):** A written individualized person-centered plan of care for Members with I/DD, including Members who are receiving Innovations waiver services, that is developed using a collaborative approach led by the Member or their guardian when appropriate, incorporates the results of the care management comprehensive assessment, and identifies the Member’s desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the Member to achieve those outcomes. For individuals enrolled in the Innovations waiver, the ISP also documents the waiver services that a Member is authorized to obtain.
93. **Innovations Waiver:** The Section 1915(c) Home and Community-Based Services (HCBS) waiver for individuals with I/DD who meet Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IDD) level of care criteria that the PIHP operates in the geographic area covered by this Contract.
94. **Institution for Mental Disease (IMD):** Has the same meaning as IMD as defined in 42 C.F.R. § 435.1010.
95. **Interactive Purchasing System (IPS):** The State of North Carolina’s electronic system for advertising solicitations and publishing award notifications, where vendors can view and search for procurement opportunities, which can be found at the following link, accurate as of the date of execution of this Contract: [www.ips.state.nc.us](http://www.ips.state.nc.us).
96. **Interest:** For the purposes of claim payment or encounter submission, an amount from a PIHP that is due to a Participating Provider for failing to timely or correctly pay a Clean Claim.
97. **Level of Care Utilization System (LOCUS):** A level of care assessment tool that measures an individual’s current clinical needs to determine the appropriate intensity of mental health and SUD services for the individual. The Department has authorized the use of the LOCUS for mental health services only.
98. **Limited English Proficient (LEP):** Has the same meaning as LEP as defined in 42 C.F.R. § 438.10(a).
99. **Local Management Entity/Managed Care Organization (LME/MCO):** Has the same meaning as LME/MCO as defined in N.C. Gen. Stat. § 122C-3(20c).
100. **Long Term Service and Supports (LTSS):** LTSS shall include:
  - a. Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
  - b. Care for older adults and people with disabilities who need support because of age, physical cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; and

- c. c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as:
    - i. Eating;
    - ii. Taking baths;
    - iii. Managing Medications;
    - iv. Grooming;
    - v. Walking;
    - vi. Getting up and down from a seated position;
    - vii. Using the toilet;
    - viii. Cooking;
    - ix. Driving;
    - x. Getting dressed; or
    - xi. Managing money;
  - d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities
101. **Maintenance of Effort (MOE):** Federal requirement that grant recipients maintain non-federal funding for activities described in their application at a level which is not less than expenditures for such activities during the fiscal year prior to receiving the grant or cooperative agreement to be eligible for full participation in federal grant funding. Public Health Service Act, Section 797(b).
  102. **Managing Employee:** Has the same meaning as Managing Employee as defined in 42 C.F.R. § 455.101. Managing Employees includes the Key Personnel required under the Contract and voting members of the Contractor’s governing board.
  103. **Mandatory Populations:** Medicaid Beneficiaries who are required to enroll in Medicaid Managed Care with no option to enroll in Medicaid Direct.
  104. **Marketing:** Has the same meaning as Marketing as defined in 42 C.F.R. §438.104(a).
  105. **Marketing Materials:** Has the same meaning as Marketing Materials as defined in 42 C.F.R. §438.104(a).
  106. **Medicaid Direct:** Refers to the Medicaid Fee-For-Service program serving Beneficiaries who are not enrolled in a Prepaid Health Plan (PHP) or the EBCI Tribal Option.
  107. **Medicaid Enterprise System (MES):** The aggregation of technologies and applications required to operate a State Medicaid Agency (SMA).
  108. **Medicaid Managed Care:** North Carolina’s program under which contracted Managed Care Organizations arrange for integrated medical, physical, pharmacy, behavioral, and other services to be delivered to Medicaid and NC Health Choice Beneficiaries. Medicaid Managed Care will include four types of plans: (1) Standard Plans, (2) BH I/DD Tailored Plans, and (3) Children and Families Specialty Plan. The use of Medicaid Managed Care is also inclusive of EBCI Tribal Option, operating as a primary care case management entity (PCCMe).
  109. **Medically Necessary:** Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

110. **Member Service Line:** A service line available to Members for the purposes of providing convenient access to information about benefits or claims, referral assistance and access to treatment or services.
111. **Members:** Medicaid and NC Health Choice Beneficiaries specifically enrolled in and receiving benefits through the PIHP.
112. **National Correct Coding Initiative (NCCI):** The CMS-developed coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
113. **National Provider Identifier (NPI):** Standard unique health identifier for health care Providers adopted by the Secretary of the U.S. Department of Health and Human Services in accordance with HIPAA.
114. **National Quality Forum:** A not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare.
115. **Natural Supports:** Relationships with people that include coworkers, classmates, activity individuals, neighbors, family and others. These relationships are typically developed in the community through associations in schools, the workplace and participation in clubs, organizations and community activities
116. **NCCARE360:** An electronic platform providing: (a) a robust statewide resource repository of community-based organizations and social service agencies and the services they provide, and (b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, and others to refer and connect Members directly to community resources and track the connections and outcomes through “Closed Loop Referral” capacity. The platform is being deployed as part of a public-private partnership with the Foundation for Health Leadership and Innovation.
117. **NCCI Edits:** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) medically unlikely edits, or units-of service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
118. **NCCI Methodologies:** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
119. **NCTracks:** The Department’s multi-payer Medicaid Management Information System (MMIS). NCTracks adjudicates claims for multiple NC DHHS divisions, including DHB, DMH/DD/SAS, Division of Public Health, and Office of Rural Health. NCTracks also serves as a central repository for Medicaid, NC Health Choice and State-funded Services Provider and Member data.
120. **Network:** A group of Providers, including, without limitation, doctors, hospitals, and others contracted by the PIHP to provide health care services to Members.
121. **Non-Participating Provider:** Non-participating or “non-par” Providers are physicians or other health care Providers that have not entered into a contractual agreement with the PIHP and are not part of the PIHP’s Network, unlike participating Providers. They may also be called out-of-network Providers.

Non-participating providers do not include any licensed practitioner or other healthcare provider employed by and delivering services to Members through the Participating Provider.

122. **Non-public Medicaid NCCI Edit Files:** The quarterly Medicaid NCCI Edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure Regional Information Sharing Systems (RISSNET) portal
123. **North Carolina Controlled Substances Reporting System (CSRS):** The Department's database for collecting information on dispensed controlled substance prescriptions. The system is used as a core clinical tool to improve patient care and safety while avoiding potential drug interactions and identifying individuals who may be in need of referral to substance use disorder services.
124. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department's integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
125. **North Carolina Health Choice (NC Health Choice):** The NC Health Choice Health Insurance Program for Low Income Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children and authorized under Social Security Act Title XXI.
126. **North Carolina Healthcare Enterprise Accounts Receivable Tracking System (HEARTS):** The primary Admission, Discharge, and Transfer (ADT) and billing system used by the State's Alcohol and Drug Abuse Treatment Centers (ADATC) and other facilities owned and/or operated by the NC Division of State-Operated Healthcare Facilities (DSOHF).
127. **North Carolina Identity Service (NCID):** The State's centralized identity and access management platform provided by the Department of Information Technology. NCID is a web-based application that provides a secure environment for state agency, local government, business and individual users to log in and gain access to real-time resources, such as customer-based applications and information retrieval. The following link is accurate as of the date of execution of this Contract: <https://www.ncid.nc.gov>
128. **North Carolina Immunization Registry (NCIR):** The Department's secure, web-based clinical tool which is the official source for North Carolina immunization information.
129. **North Carolina Residency:** An established official residence within the state of North Carolina. For the purpose of this Contract and as it relates to Contractor personnel, the NC residency requirement under the Contract is satisfied if the Contractor's personnel lives no more than forty (40) miles from the North Carolina border.
130. **North Carolina Support Needs Assessment Profile (NC-SNAP):** A needs assessment tool that measures an individual's level of intensity of need for intellectual and developmental disabilities supports and services.
131. **Ombudsman Program:** A Department program to provide education, advocacy, and issue resolution for Medicaid Beneficiaries whether they are in the Medicaid Managed Care program or NC Medicaid Direct. This program is separate and distinct from the Long-Term Care Ombudsman Program.
132. **Ongoing Course of Treatment:** As defined in 42 C.F.R. § 438.62(b), When a Member, in the absence of continued services, would suffer significant detriment to their health or be at risk of hospitalization or institutionalization.



133. **Ongoing Special Condition:** Has the same meaning as ongoing special condition defined in N.C. Gen. Stat. § 58-67-88(a)(1).
134. **Outpatient Commitment:** Occurs pursuant to N.C.G.S. § 122C, Article 5, Part 7, when a judge orders a person to receive treatment in the community for their BH condition. Before ordering Outpatient Commitment, the outpatient Provider must agree to accept the patient into treatment and serve as the responsible party for the management and supervision of the Outpatient Commitment order.
135. **Participating Provider:** Participating Provider or “par” Providers are physicians or other health care providers that have a contractual agreement with the PIHP and are included in the PIHP’s Network. Participating Providers may also be called “network providers” or “in-network providers”.
136. **PHP Contract Data Utility (PCDU):** A secure file transfer platform to allow for posting of Department guidance to the PIHPs, and submission of key contract deliverables and reports by the PIHPs for review and approval by the Department.
137. **Performance Incentive Payments:** Payments additional to fee for service and Tailored Care Management payments, that are contingent upon AMH Practices, AMH+ Practices, or CMAs’ reporting of and/or performance against Performance Metrics.
138. **Permanent Supportive Housing (PSH):** A program that has the same meaning as “permanent supportive housing” in 24 C.F.R. § 578.3 and offers safe and stable housing environments with voluntary and flexible supports and services to help people manage serious, chronic issues such as mental and substance use disorders.PSH is based on the following principles: 1) Choice in housing; 2) No prerequisite for housing placement; 3) Functional separation of housing and services; 4) Decent, safe, and affordable housing; 5) Housing is integrated into the community; 6) Rights of tenancy; 7) Housing access and privacy; and 8) Flexible, voluntary recovery-focused services.
139. **Post-stabilization Care Services:** Has the same meaning as post-stabilization care services as defined in 42 C.F.R. § 438.114(a).
140. **Primary Care Case Management (PCCM):** A system under which a primary care case manager contracts with the Department to furnish case management services (which include the location, coordination and monitoring of primary health care services) to members, or a PCCM entity that contracts with the Department to provide a defined set of functions as defined in 42 C.F.R. § 438.2.
141. **Protected Health Information (PHI):** Has the same meaning as PHI as defined by 45 C.F.R. § 160.103.
142. **Potential Member:** A Beneficiary enrolled in Medicaid or NC Health Choice and eligible for enrollment in a PIHP, but not enrolled in that PIHP.
143. **Prepaid Health Plan (PHP):** Has the same meaning as Prepaid Health Plan, as defined in N.C. Gen. Stat. § 108D-1(30). A PHP is an MCO. A PHP may operate a Standard Plan or a BH/IDD Tailored Plan.
144. **Primary Care Provider (PCP):** The participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the Member to provide and coordinate all the Member’s health care needs and to initiate and monitor referrals for specialized services, when required.
145. **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals aged fifty-five (55) and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

146. **Provider:** Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. (42 C.F.R. § 438.2).
147. **Provider (For the purposes of credentialing):** Individual practitioners and facilities, hospitals, health systems, entities, organizations, atypical organizations/providers, and institutions, unless otherwise noted.
148. **Provider-based Care Management:** Care management where the care manager is affiliated with an AMH+ practice or CMA and performs care management at the site of care, in the home, or in the community through in-person and other methods of interaction between Members and Providers.
149. **Provider Contracting:** The process by which the PIHP negotiates and secures a written agreement with credentialed Providers that will be included in the PIHP's Network, or with out-of-network providers.
150. **Provider Enrollment:** The process by which a Provider is enrolled in North Carolina's Medicaid or NC Health Choice programs, with credentialing as a component of enrollment. A Provider enrolled in North Carolina's Medicaid or NC Health Choice programs (or both) shall be referred to as a "Medicaid Enrolled Provider" or an "Enrolled Medicaid Provider."
151. **Provider Grievance:** Any oral or written complaint or dispute by a Provider over any aspects of the operations, activities, or behavior of the PIHP except for any dispute over for which the provider or related Member has appeal rights.
152. **Provider Support Service Line:** A service line available to Medicaid and NC Health Choice Providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries, and complaints.
153. **Qualified Health Plan (QHP):** Means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of Title 45 of the Code of Federal Regulations issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 of Title 45 of the Code of Federal Regulations. 45 C.F.R. § 155.20.
154. **Qualified Interpreter:** Has the same meaning as described in 45 C.F.R. § 92.4.
155. **Readily Accessible:** Has the same meaning as defined in 42 C.F.R. § 438.10(a).
156. **Readiness Review:** Has the same meaning as described in 42 C.F.R. § 438.66(d).
157. **Reasonable Accommodation:** A reasonable accommodation is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with disabilities to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces, or to fulfill their program obligations.
158. **Receiving Entity:** The entity (e.g., PIHP, Standard Plan, NC Medicaid Direct) that is enrolling the transitioning Member and receiving the Member's information.
159. **Recipient Explanation of Medical Benefits (REOMB):** Written document sent to a sampling of recipients to verify services received.
160. **Redeterminations:** The annual review of Beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and/or NC Health Choice.

161. **Remote Patient Monitoring:** Remote patient monitoring is the use of digital devices to measure and transmit personal health information from a patient in one location to a provider in a different location. Remote patient monitoring enables Providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) to make treatment recommendations.
162. **Reprocess:** For the purposes of Claims and Encounters, the activities completed by a PIHP to reconsider the outcome of a previously adjudicated claim.
163. **Safety Net Providers:** Providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid and other vulnerable populations
164. **Security Assertion Markup Language (SAML):** The State's preferred standard for the implementation of identity and access management.
165. **Settlement Agreement:** Means the court-enforceable Settlement Agreement between the United States and the State of North Carolina filed with the United States District Court for the Eastern District of North Carolina on August 23, 2012, and modified in October 2017 and which created the Transitions to Community Living (TCL) program.).
166. **Significant Change:** Means any change in the services, rates, or fees offered by PIHPs, the benefits, covered under the Contract, the geographic service area, the composition of the PIHP's network, and the enrollment of a new population in the PIHP.
167. **Specialized Services:** Has the same meaning as Specialized Services as defined in 42 CFR § 483.120.
168. **Standard Plan or Standard Benefit Plan:** Has the same meaning as Standard Plan as defined in N.C. Gen. Stat. § 108D-1(36).
169. **State:** The State of North Carolina, the Department as an agency or in its capacity as the Using Agency.
170. **State Developmental Center:** State-operated certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) that provides residential, medical, habilitation, and other supports to individuals with intellectual and developmental disabilities who have complex behavioral challenges and/or medical conditions and for whom appropriate community-based services are not available.
171. **State Fair Hearing:** The hearing conducted at the Office of Administrative Hearings (OAH) under N.C. Gen. Stat. § 108D-15 to resolve a dispute between a Member and a PIHP about an Adverse Benefit Determination.
172. **Subcontractor:** An entity having an arrangement with the PIHP, where the PIHP uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the Subcontractor and the Department, only the Contractor. Network Providers are not considered Subcontractors under the Contract.
173. **Subgrantee:** The PIHP or other legal entity to which a sub-grant is awarded or sub-award is made and which is accountable to the grantee for the use of the funds provided. The terms sub grant/subgrantee and sub award/sub recipient are used interchangeably in practice.
174. **Supports Intensity Scale (SIS)<sup>®</sup>:** An assessment tool designed to measure the level of practical supports required for individuals with I/DD.

175. **Tailored Care Management:** The care management model for BH I/DD Tailored Plan Members and PIHP Members who meet eligibility criteria.
176. **Tailored Care Management Payments:** Per Member per month, acuity-tiered payments made to AMH+ practices, CMAs, and PIHPs for the provision of Tailored Care Management. Tailored Care Management Payments will be subject to rates set by the Department, which shall not be placed at risk.
177. **Telehealth:** Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.
178. **Transitions of Care:** The process of assisting a Member to transition; from PIHP to Standard Plans or PIHP to BH I/DD Tailored Plans; between delivery systems; including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between Providers upon a Participating Provider's termination from the PIHP Network.
179. **Transferring Entity:** The entity (e.g., BH I/DD Tailored Plan, Standard Plan, PIHP) that is disenrolling the transitioning Member and transferring the Member's information.
180. **Unmet Health-Related Resource Needs:** Non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, transportation and addressing interpersonal violence/toxic stress.
181. **Value-Added Services:** Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the PIHP's discretion and are not included in capitation rate calculations. Value-added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.
182. **Value-Based Payment (VBP):** Payment arrangements between PIHPs and Providers that fall within Levels 2 and 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework.
183. **Vendor:** A company, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.
184. **Video Remote Interpreting:** Has the same meaning as described in 28 C.F.R. § 35.104.
185. **Virtual Patient Communication:** The use of technologies other than video to enable remote evaluation and consultation support between a Provider and a patient or a Provider and another Provider. Virtual patient communication services include telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).
186. **Warm Handoff:** Time-sensitive, Member-specific planning for Care-Managed Members or other Members identified by either the transferring or receiving entity to ensure continuity of service and care management functions. "Warm Handoffs" require collaborative transition planning between both transferring and receiving entities and, when possible, occur prior to the transition.
187. **Warm Transfer:** Occurs when a call from a Beneficiary, Member, or Provider is transferred directly from the original call center to the appropriate party during business hours without requiring the caller to make an additional call and without the PIHP abandoning the call until the other party answers.

188. **Work First:** North Carolina’s Temporary Assistance for Needy Families (TANF) program that provides parents with short-term training and other services to help them become employed and move toward self-sufficiency.
189. **X12 Transactions:** Any EDI transaction included in the x12.org standard. This includes but is not limited to the 834 Benefit Enrollment and Maintenance, the 837 Health Care Claim, and the 277 Health Care Information Status Notification. The entire transaction set can be found at <http://www.x12.org>.

## B. Abbreviations and Acronyms

1. AAP: American Academy of Pediatrics
2. ACD: Automated Call Distribution System
3. ACA: Patient Protection and Affordable Care Act
4. ACE: Adverse Childhood Experience
5. ADATC: Alcohol and Drug Abuse Treatment Center
6. ADL: Activities of Daily Living
7. ADT: Admission, Discharge, Transfer
8. AMH: Advanced Medical Home
9. AMH+: Advanced Medical Home Plus
10. API: Administrative Provider Identification
11. APM: Alternative Payment Method
12. ASAM: American Society for Addiction Medicine
13. ASC: Accredited Standards Committee
14. AVRS: Automated Voice Response System
15. AWOL: Absence Without Leave
16. BAA: Business Associate Agreement
17. BAHA: Bone Conduction Hearing Aids
18. BCCCP: Breast and Cervical Cancer Control Program
19. BH: Behavioral Health
20. BIP: Behavioral Intervention Plan
21. CAH: Critical Access Hospital
22. CAHPS: Consumer Assessment of Healthcare Providers and Systems Plan Survey
23. CALOCUS: Child and Adolescent Level of Care Utilization System
24. CANS: Children and Adolescents Needs and Strengths
25. CAP: Corrective Action Plan
26. CAP/C: Community Alternatives Program for Children
27. CAP/DA: Community Alternatives Program for Disabled Adults
28. CASP: Cross Area Service Program
29. CBO: Community-Based Organization
30. CCNC: Community Care of North Carolina
31. CCO: Chief Compliance Officer
32. CDC: Centers for Disease Control
33. CDSA: Children's Developmental Services Agency
34. CEO: Chief Executive Officer
35. CFAC: Consumer and Family Advisory Committee
36. CFO: Chief Financial Officer
37. CFT: Child and Family Team

38. CHIP: Children's Health Insurance Program
39. CIN: Clinically Integrated Network.
40. CIO: Chief Information Officer
41. CIP: Community Integration Plan
42. CM: Care Management
43. CMA: Care Management Agency
44. CMC: Children with Medical Complexity
45. CMO: Chief Medical Officer
46. CMP: Civil Monetary Penalty
47. CMS: Centers for Medicare & Medicaid Services
48. COD: Cost of Dispensing
49. CP: Commercial Plan
50. CPT: Current Procedural Terminology
51. CVO: Credentialing Verification Organization
52. DAAS: Division of Aging and Adult Services
53. DHB: Division of Health Benefits
54. DHHS: Department of Health and Human Services
55. DHSR: Division of Health Service Regulation
56. DID: Direct Inward Dialing
57. DIT: Department of Information Technology
58. DME: Durable Medical Equipment
59. DMH/DD/SAS: Division of Mental Health, Developmental Disabilities and Substance Abuse Services
60. DMVA: Department of Military and Veterans Affairs
61. DOI: Department of Insurance
62. DOS: Date of Service
63. DSOHF: Division of State Operated Healthcare Facilities
64. DSS: Division of Social Services
65. DUR: Drug Utilization Review
66. EB: Enrollment Broker
67. EBCI: Eastern Band of Cherokee Indians
68. ECSII: Early Childhood Services Intensity Instrument
69. EDI: Electronic Data Interchange
70. EFT: Electronic Funds Transfer
71. EHR: Electronic Health Record
72. EPS: Episodic Payment System
73. EPSDT: Early and Periodic Screening, Diagnostic and Treatment
74. EQRO: External Quality Review Organization
75. ESRD: End Stage Renal Disease
76. EUP: End User Procedures
77. EVV: Electronic Visit Verification
78. FAR: Federal Acquisition Regulation
79. FDA: Food and Drug Administration
80. FFS: Fee-for-Service
81. FFY: Federal Fiscal Year
82. FQHC: Federally Qualified Health Center
83. HCPCS: Healthcare Common Procedure Coding System
84. HEARTS: Healthcare Enterprise Accounts Receivable Tracking System
85. HHS: U.S. Department of Health and Human Services

86. HIE: Health Information Exchange
87. HIPAA: Health Insurance Portability and Accountability Act
88. HIPP: Health Insurance Premium Payment
89. HIT: Health Information Technology
90. HITECH: Health Information Technology for Economic and Clinical Health Act
91. HIV: Human Immunodeficiency Virus
92. HRSA: Health Resources and Services Administration
93. HSO: Human Service Organizations
94. I/DD: Intellectual/Developmental Disability
95. ICF: Intermediate Care Facility
96. ICF-IID: Intermediate Care Facility for Individuals with Intellectual Disabilities
97. IDG: Interdisciplinary Group
98. IDM: Identity Management
99. IEM: Inborn Errors of Metabolism
100. IEP: Individualized Education Program
101. IFSP: Individual Family Service Plan
102. IHCP: Indian Health Care Provider
103. IHP: Individual Health Plan
104. IHS: Indian Health Services
105. ILOS: In Lieu of Services
106. IMB: Into the Mouth of Babes
107. IMCE: Indian Managed Care Entities
108. IMD: Institution for Mental Disease
109. IPA: Independent Practice Association
110. IPS: Interactive Purchasing System
111. IRF: Inpatient Rehabilitation Facility
112. IRS: Internal Revenue Service
113. ISP: Individual Support Plan
114. ITD: Information Technology Division (DHHS)
115. LAN: Learning and Action Network
116. LCMHC: Licensed Clinical Mental Health Counselor
117. LCSW: Licensed Clinical Social Worker
118. LEA: Local Education Agencies
119. LEIE: List of Excluded Individuals/Entities
120. LEP: Limited English Proficient
121. LGBTQ: Lesbian, Gay, Bisexual, Transgender, Questioning
122. LHD: Local Health Department
123. LP: Licensed Practitioners
124. LME/MCO: Local Management Entities/Managed Care Organizations
125. LMFT: Licensed Marriage and Family Therapist
126. LOCUS: Level of Care Utilization System
127. LPA: Licensed Psychological Associate
128. LPE: Lead Pilot Entity
129. LPN: Licensed Practical Nurse
130. LTSS: Long Term Service and Supports
131. MAC: Maximum Allowable Cost
132. MAO: Medicare Advantage Organization
133. MCAC: Medical Care Advisory Committee

134. MCO: Managed Care Organization
135. MES: Medicaid Enterprise System
136. MHPAEA: Mental Health Parity and Addiction Equity Act
137. MID: North Carolina Attorney General's Medicaid Investigations Division
138. MIMS: Medicaid Integrated Modular Solution
139. MIS: Management Information Systems
140. MLR: Medical Loss Ratio
141. MME: Morphine Milligram Equivalent
142. MMIS: Medicaid Management Information Systems
143. MOA: Memorandum of Agreement
144. NADAC: National Average Drug Acquisition Cost
145. NC: North Carolina
146. NC FAST: North Carolina Families Accessing Services through Technology
147. NCAC: North Carolina Administrative Code
148. NCCI: National Correct Coding Initiative
149. NCDPH: North Carolina Division of Public Health
150. NCGA: North Carolina General Assembly
151. NCHC: North Carolina Health Choice
152. NCID: North Carolina Identity Management Service
153. NCIR: North Carolina Immunization Registry
154. NCPDP: National Council for Prescription Drug Programs
155. NCQA: National Committee for Quality Assurance
156. NDC: National Drug Code
157. NEMT: Non-Emergency Medical Transportation
158. NIEM: National Information Exchange Model
159. NPI: National Provider Identifier
160. NPPES: National Plan and Provider Enumeration System
161. NQF: National Quality Forum
162. OAH: Office of Administrative Hearings
163. OCR: Office of Civil Rights
164. OFAC: Office of Foreign Assets Control
165. OMB: Office of Management and Budget
166. PA: Prior Authorization
167. PACE: Program of All-Inclusive Care for the Elderly
168. PBM: Pharmacy Benefit Managers
169. PCDU: PHP Contract Data Utility
170. PCP: Primary Care Provider
171. PCS: Personal Care Services
172. PDL: Preferred Drug List
173. PDM: Provider Data Management
174. PDN: Private Duty Nursing
175. PDSA: Plan-Do-Study-Act
176. PHA: Public Housing Authorities
177. PHHS: Public Health and Human Services
178. PHI: Protected Health Information
179. PHP: Prepaid Health Plan
180. PI: Program Integrity
181. PIHP: Prepaid Inpatient Health Plans



182. PIP: Performance Improvement Program
183. PLE: Provider-Led Entity
184. PMPM: Per Member Per Month
185. PRC: Purchased/Referred Care
186. PRTF: Psychiatric Residential Treatment Facility
187. PSH: Permanent Supportive Housing
188. PSO: North Carolina Department of Health and Human Services Privacy and Security Office
189. PTA: Privacy Threshold Analysis
190. QAPI: Quality Assurance and Performance Improvement
191. QHP: Qualified Health Plan
192. REOMB: Recipient Explanation of Medical Benefit
193. RHC: Rural Health Clinic
194. RN: Registered Nurse
195. ROI: Return on Investment
196. SAM: System of Award Management
197. SAMHSA: Substance Abuse and Mental Health Services Administration
198. SAML: Security Assertion Markup Language
199. SBI: North Carolina State Bureau of Investigation
200. SBIRT: Screening, Brief Intervention, and Referral to Treatment
201. SED: Serious Emotional Disturbance
202. SFTP: Secure File Transfer Protocol
203. SID: System Integration Design
204. SIP: System Integration Plan
205. SIS: Supports Intensity Scale®
206. SIU: Special Investigations Unit
207. SLA: Service Level Agreement
208. SLPA: Speech/Language Pathology Assistant
209. SMA: State Medicaid Agency
210. SMAC: State Maximum Allowable Cost
211. SMI: Serious Mental Illness
212. SOC: Service Organization Control
213. SP: Standard Plan
214. SPH: State Psychiatric Hospital
215. SSA: Social Security Act
216. SSADMF: Social Security Administration Death Master File
217. SUD: Substance Use Disorder
218. SUPPORT: Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
219. TBI: Traumatic Brain Injury
220. TCL: Transition to Community Living
221. TDD: Telecommunications Device for the Deaf
222. TP: Tailored Plan
223. TPA: Third Party Administrator
224. TPL: Third party liability
225. TTY: Text Telephone
226. UM: Utilization Management
227. VBP: Value-based payments
228. VEO: Visual Evoked Potential

- 229. VFC: Vaccines for Children
- 230. VRI: Video Remote Interpreting
- 231. WCA: Web Content Accessibility Guidelines
- 232. WHCRA: Women's Health and Cancer Rights Act of 1998
- 233. WIC: Women, Infants and Children

### III. Contract Term, General Terms and Conditions, Protections, and Attachments

#### A. Contract Term and Service Commencement

1. The Contract is effective upon execution through June 30, 2026, or as otherwise provided by law, and shall include an implementation period and Contract Years 1 through 4 as follows:

Contract Period	Upon execution through June 30, 2026.
Implementation Period	Upon execution through November 30, 2022
Contract Year 1	December 1, 2022 through June 30, 2023
Contract Year 2	July 1, 2023 through June 30, 2024
Contract Year 3	July 1, 2024 through June 30, 2025
Contract Year 4	July 1, 2025 through June 30, 2026

#### B. General Terms and Conditions

##### 1. **ACCESS TO PERSONS AND RECORDS:**

- a. Pursuant to N.C. Gen. Stat. §§ 147-64.7 and 143-49(9), the Department, the State Auditor, appropriate State or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with **Paragraph 36. RECORDS RETENTION** of this *Section III.B* of this Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or State law and/or regulation, and the Contractor must adhere to such changes or additions.
- b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C. Gen. Stat. § 147-64.7. Nothing in this Section is intended to limit or restrict the State Auditor's rights.
- c. This term shall survive termination or expiration of the Contract.

2. **ADVERTISING:** Contractor agrees not to use the existence of this Contract or the name of the Department or State of North Carolina as part of any commercial advertising or marketing of its products or services to prospective Members, except as permitted under this Contract. A Contractor

may inquire whether the Department is willing to act as a reference by providing information directly to other prospective customers. The Department is under no obligation to serve as a reference. Notwithstanding the foregoing, Contractor may reference the existence of this Contract and the name of the Department or State of North Carolina in communications with other audiences for non-advertising or marketing purposes associated with implementation and performance of this Contract.

3. **AMENDMENTS:** This Contract may not be amended orally or by performance. This Contract may be amended only by written amendments executed by the Department and the Contractor.
4. **ASSIGNMENT:** Except as otherwise required by law or upon written approval of the Department, no assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted.
5. **AVAILABILITY OF FUNDS:** All payments to Contractor are expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the Department for the purposes set forth in the Contract. If the Contract or any purchase order issued hereunder is funded in whole or in part by federal funds, the Department's performance and payment shall be subject to and contingent upon the continuing availability of said federal funds for the purposes of the Contract or purchase order. If the term of the Contract extends into fiscal years after that in which it is approved, such continuation of the Contract is expressly contingent upon the appropriation, allocation, and availability of funds by the N.C. General Assembly for the purposes set forth in this Contract and any resulting Contract. If funds to effect payment are not available, the Department will provide written notification to the Contractor and may terminate the Contract in accordance with **Paragraph 45. TERMINATION** of this *Section III. B.* of this Contract. If the Contract is terminated, the Contractor agrees to take back any affected deliverables and software not yet delivered under the Contract, terminate any services supplied to the Department under the Contract, and relieve the Department of any further obligation thereof. The Department shall remit payment for deliverables and services accepted prior to the date of the previously mentioned notice in conformance with the payment terms.
6. **BACKGROUND CHECKS:** The Department reserves the right to request a criminal background check on any current or prospective employee of Contractor or its Subcontractor. The Contractor is responsible for obtaining from each prospective Contractor employee or Subcontractor employee a signed statement permitting a criminal background check. Where requested by the Department, the Contractor must obtain (at their own expense) and provide the appropriate Departmental Contract Administrator with a North Carolina State Bureau of Investigation (SBI) and/or FBI background check on all new employees prior to assignment. Neither the Contractor nor its Subcontractor may hire an employee who has a criminal record that consists of a felony unless prior written approval is obtained from the appropriate Departmental Contract Administrator. The Contractor shall keep any records related to these verifications for the life of the contract.
7. **BENEFICIARIES:** The Contract shall inure to the benefit and be binding upon the Parties and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of the Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Department and Contractor. Nothing contained in this Contract shall give or allow any claim or right of action whatsoever by any third person. It is the express intention of the Department and Contractor that any such other person or entity receiving services or benefits under the Contract shall be deemed an incidental beneficiary only and not a contractual third-party beneficiary.
8. **CHANGE IN STRUCTURE:** In cases where Contractor(s) are involved in consolidations, acquisition or mergers, the Parties may negotiate agreements for the transfer of contractual obligations and the continuance of contracts within the framework of the new structure, subject to Department approval

and the terms of this Contract.

9. **CMS APPROVAL**: This Contract and subsequent contracts and amendments are subject to approval by the CMS pursuant to 42 C.F.R. § 438.806(a).

10. **COMPLIANCE WITH LAWS**:

- a. Contractor shall comply with all laws, ordinances, codes, rules, regulations, licensing requirements, electronic storage standards concerning privacy, data protection, confidentiality, and security that are applicable to the conduct of its business and performance in accordance with this Contract, including those of federal, State, NC DHHS, and local departments and agencies having jurisdiction and/or authority.
- b. Contractor must include in its Subcontractor agreements an attestation clause that the Subcontractor must comply with all laws, rules, regulations, and licensing requirements applicable to Contractor's performance under this Contract, including but not limited to the applicable provisions of (a) Title XIX of the Social Security Act and Titles 42 and 45 of the Code of Federal Regulations; and (b) those laws, rules, or regulations of federal and State agencies having jurisdiction over the subject matter of this Contract, whether in effect when this Contract is signed, or becoming effective during the term of this Contract.
- c. Clean Air Act
  - i. Contractor agrees to comply to the extent practicable with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.
  - ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.
  - iii. Contractor agrees to include these requirements in each Subcontractor Agreement.
- d. Federal Water Pollution Control Act
  - i. Contractor agrees to comply to the extent practicable with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.
  - ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the federal agency providing funds hereunder, and the appropriate Environmental Protection Agency Regional Office.
  - iii. Contractor agrees that these requirements will be included in each Subcontractor Agreement.
- e. Pandemic, Endemic and Other North Carolina State Emergencies
  - i. Contractor agrees to comply with all applicable standards, Executive Orders and Department issued guidance for pandemics, endemics, and other North Carolina State emergencies.
  - ii. Notice shall be provided by the Department of the standards, orders and Department issued guidance prior to the Effective Date of the requirements, where practical.
  - iii. In the event requirements are announced and made effective immediately, such as Executive Orders, the Contractor shall adhere to such requirements.
  - iv. Contractor agrees to communicate to Subcontractors for compliance with all applicable standards, orders, and Department-issued guidance.

- 11. CONTRACT ADMINISTRATORS:** The Contract Administrators are the persons to whom notices provided for in this Contract shall be given, and to whom matters relating to the administration of this Contract shall be addressed. Either Party may change its administrator or their address and telephone number by written notice to the other Party.

**For the Department**

Contract Administrator for all contractual issues listed herein:

Name & Title	Nkechi Nnenna Olu Senior Contract Specialist, Division of Health Benefits
Address Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7235
Fax Number	919-715-8468
Email Address	<a href="mailto:Nkechi.Olu@dhhs.nc.gov">Nkechi.Olu@dhhs.nc.gov</a> <a href="mailto:Medicaid.Contractadministrator@dhhs.nc.gov">Medicaid.Contractadministrator@dhhs.nc.gov</a>

Contract Administrator regarding day to day activities herein:

Name & Title	Kelsi Knick Deputy Director of BH I/DD Tailored Plans
Physical Address	820 S. Boylan Avenue McBryde Building Raleigh, NC 27603
Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7031
Fax Number	919-832-0225
Email Address	<a href="mailto:kelsi.knick@dhhs.nc.gov">kelsi.knick@dhhs.nc.gov</a> <a href="mailto:Medicaid.Contractadministrator@dhhs.nc.gov">Medicaid.Contractadministrator@dhhs.nc.gov</a>

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

Name & Title	Pyreddy Reddy, DHHS CISO
Address 1	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	<a href="mailto:Pyreddy.Reddy@dhhs.nc.gov">Pyreddy.Reddy@dhhs.nc.gov</a> <a href="mailto:Medicaid.Contractadministrator@dhhs.nc.gov">Medicaid.Contractadministrator@dhhs.nc.gov</a>

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

Name & Title	Ryan Eppenberger, Privacy Officer
Physical Address	1985 Umstead Drive Raleigh, NC 27603
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7747
Email Address	<a href="mailto:Ryan.Eppenberger@dhhs.nc.gov">Ryan.Eppenberger@dhhs.nc.gov</a> <a href="mailto:Medicaid.Contractadministrator@dhhs.nc.gov">Medicaid.Contractadministrator@dhhs.nc.gov</a>

- 12. COOPERATION WITH OTHER STATE VENDORS:** Contractor shall cooperate with applicable Department Vendors that are providing goods or services to or on behalf of the Department in relation to the requirements of this Contract, including those Vendors providing services with respect to managed care, transition of care, system integration, encounter processing, enrollment and eligibility, Ombudsman, data analytics, and those engaged by the Department to monitor, validate, or verify Contractor's performance. Contractor will enter into trade, non-disclosure agreements or other agreements as necessary to allow Vendors access to Contractor's confidential information needed in performance of Vendor's service for the Department.
- 13. COPYRIGHT:** The State shall own all deliverables that the Contractor is required to develop specifically pursuant to the Contract, except as provided herein. Contractor shall not acquire any right, title, and interest in and to the copyrights for goods, all software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products developed by the Contractor and provided to the State under this Contract. The State shall, upon payment for the deliverables in full in accordance with the payment terms of the Contract, own copyrighted works first originated and prepared by the Contractor for delivery to the State. The State hereby grants Contractor a royalty-free, fully paid worldwide, perpetual, nonexclusive, irrevocable license for the Contractor's business use, to non-confidential deliverables first originated and prepared by the Contractor for delivery to the State. Contractor shall maintain ownership of all pre-existing intellectual property that it provides to the State as part of the deliverable(s), and the State shall have a royalty-free, fully paid, worldwide, perpetual, non-exclusive, irrevocable license in all languages to use such intellectual property solely for its operations. The intellectual property terms of this Contract do not: (i) affect Contractor's, or one of its Subcontractor's, ownership of all other intangible intellectual property (e.g., processes, ideas, know how) that Contractor has developed in the course of performance hereunder, (ii) prevent Contractor, or one of its Subcontractor's, from selling similar services elsewhere, (iii) prevent Contractor, or one of its Subcontractor's, from marketing, licensing or selling any and all intellectual property it develops hereunder to other customers, Beneficiaries, Providers, or other persons, provided no State confidential information is used or disclosed in the process or (iv) affect any ownership right, title, and interest in and to the copyrights for goods, software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products provided by a Subcontractor to Contractor for any such Deliverable required hereunder.
- 14. CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY:** Contractor shall make a good faith effort to recruit, train, promote, and retain a culturally and linguistically diverse governance, leadership, and workforce, who are responsive to the population in the service area, or otherwise participate in the State's efforts to promote culturally competent care in accordance with applicable federal and State law and the CMS guidelines.
- To support the Department's vision on diversity, equity and inclusion, Contractor shall make a good faith effort to recruit, develop and retain a diverse workforce and encourage and promote an inclusive and equitable workplace, in accordance with Federal and State law.
- 15. DISCLOSURE OF CONFLICTS OF INTEREST:** The Contractor shall disclose any known Conflicts of interest, or perceived Conflicts of Interest, at the time they arise, as follows:
- a. Disclose any relationship to any business or associate to whom the Contractor is currently doing business that creates or may give the appearance of a Conflict of Interest related to this Contract.
  - b. By signing the Contract, the Contractor certifies that it shall not knowingly take any action or acquire any interest, either directly or indirectly, that will conflict in any manner or degree with the performance of its services during the term of the Contract.

- c. Disclose prior to employment or engagement by the Contractor, any firm principal, staff member or subcontractor, known by the Contractor to have a Conflict of Interest or potential Conflict of Interest related to this Contract.
- d. All notices required by this subsection must be provided to the Department within thirty (30) Calendar Days of Contractor becoming aware of the conflict.

**16. DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION:** The Contractor's failure to fully and timely comply with the terms of this Section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of the Contract and result in Termination for Cause.

- a. The Contractor shall notify the State, if it, or any of its Subcontractors, or their officers, directors, or key personnel who may provide services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception. The Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding involving the Contractor or any subcontractor, or any of the forgoing entities' then current officers or directors during the term of the Contract or any scope statement awarded to the Contractor.
- b. The Contractor shall notify the State of any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its Subcontractors during the three (3) years preceding execution of this Contract, or which may occur during the Contract term that involve (1) services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any Subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any Subcontractor hereunder violated any federal, State or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or Subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or Subcontractor.
- c. In the event the Contractor, or an officer or governing Board member of the Contractor, is convicted of a criminal offense incident to the performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Contractor's business integrity, and such Contractor shall be prohibited from entering into a contract for goods or services with any department, institution, or agency of the State.
- d. The Contractor shall notify the State of any legal action that could adversely affect the PIHP's financial conditions or ability to meet the requirements of the Contract.
- e. All notices under this Section subsections a., b., c., and d. shall be provided in writing to the State within thirty (30) Calendar Days after the Contractor learns about any such criminal, regulatory, or civil matters or financial circumstances or material change to prior disclosures, unless such matters are governed by the other stated terms and conditions annexed to the solicitation. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Contractor may rely on good faith certifications of its Subcontractors addressing the foregoing, which certifications shall be available for inspection at the option of the State.

- 17. DISCLOSURE OF OWNERSHIP INTEREST:** In accordance with 42 C.F.R. § 438.608(c)(2), the Contractor and its Subcontractors shall provide to the Department written disclosures of information on ownership and control as required under 42 C.F.R. § 455.104. The Contractor and its Subcontractors must provide the following information, as applicable, regarding ownership and control as described in 42 C.F.R. § 455.104:
- a. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Contractor (or Subcontractor), including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's (or Subcontractor's) equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor (or Subcontractor) if that interest equals at least five percent (5%) of the value of the Contractor's (or Subcontractor's) assets, is an officer or director of a Contractor (or Subcontractor) organized as a corporation, or is a partner in a Contractor (or Subcontractor) organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. C.F.R. § 455.100-104);
  - b. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Contractor (or Subcontractor), including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's (or Subcontractor's) equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor (or Subcontractor) if that interest equals at least five percent (5%) of the value of the Contractor's (or Subcontractor's) assets, is an officer or director of a Contractor (or Subcontractor) organized as a corporation, or is a partner in a Contractor (or Subcontractor) organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. §§ 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
  - c. Whether the person (individual or corporation) with an ownership or control interest in the Contractor (or Subcontractor) is related to another person with ownership or control interest in the Contractor (or Subcontractor) as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any sub-contractor of the Contractor (or Subcontractor) in which the PIHP has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor (or Subcontractor) as a spouse, parent, child, or sibling;
  - d. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity as those terms are defined in 42 C.F.R. § 455.101 in which an owner of the Contractor (or Subcontractor) has an ownership or control interest; and
  - e. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee of the Contractor (or Subcontractor). The Managing Employees of the Contractor include the Contractor's governing board and Key Personnel as noted in *Section IV.A.6. Staffing and Facilities*. Contractor and Subcontractors must disclose the information on individuals or corporations with an ownership or control interest as described above to the Department as follows:
    - i. Upon effective date of the Contract;
    - ii. Upon renewal or extension of the Contractor's contract; and
    - iii. Within thirty-five (35) Calendar Days after any change in the Contractor's (or Subcontractor's) ownership.



**18. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE:** This Contract consists of the following documents incorporated herein by reference

- a. Any amendments executed by the Parties, in reverse chronological order,
- b. The originally executed Contract.

In the event of a conflict between the Contract documents, the document in the Contract with the highest precedence shall prevail. These documents constitute the entire agreement between the Parties as to this contract and supersede all prior oral or written statements or agreements.

**19. EQUAL EMPLOYMENT OPPORTUNITY:** Contractor shall comply with all federal and State requirements and North Carolina Executive Order 24 dated October 18, 2017, concerning fair employment and employment of the disabled, and concerning the treatment of all employees without regard to discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or veteran status, sexual orientation, gender identity or expression.

**20. 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 because of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, epidemic or public emergencies, pandemic, or other catastrophic natural event or act of God; excluding COVID-19.

**21. GENERAL INDEMNITY & LIMITATION OF LIABILITY:** Subject to any limitations of liability specified in the Contract, the Contractor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or intentionally tortious acts of the Contractor. The Contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Contractor goods and/or services to the State. The representations and warranties in the preceding sentences shall survive the termination or expiration of this Contract. The State, Department, and/or Office of the Attorney General shall have the option to participate at their own expense in the defence of such claim(s) or action(s) filed and the State shall be responsible for its own litigation expenses if it exercises this option.

**22. GOVERNING LAWS:** This Contract is made under and shall be governed, construed, and enforced in accordance with the laws of the State of North Carolina, without regard to its conflict of laws or rules. This term shall survive the termination or expiration of this Contract.

**23. GOVERNMENTAL RESTRICTIONS:**

- a. In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.
- b. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part of the Contract after the effective date of the loss of program authority. The Department

must adjust capitation rates to remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

- 24. HISTORICALLY UNDERUTILIZED BUSINESS (HUBS):** Pursuant to N.C. Gen. Stat. § 143-48 and Executive Order 150 (1999), the Department invites and strongly encourages participation with businesses owned by minorities, women, disabled individuals, disabled business enterprises, and nonprofit work centers for the blind and severely disabled. Contractor agrees to make a good faith effort to seek out and pursue opportunities to utilize HUBs, as defined in N.C. Gen. Stat. 143-128.4, within the scope of services of this Contract, including via the use of Subcontractors owned by HUBs.
- 25. INDEPENDENT CONTRACTORS:** Contractor and its employees, officers and executives, and subcontractors, if any, shall be independent Contractors and not employees or agents of the Department. The Contract shall not operate as a joint venture, partnership, trust, agency, or any other similar business relationship.
- 26. INSURANCE:** During the term of the Contract, the Contractor, at its sole cost and expense, shall provide commercial insurance coverage of such type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:
- a. Worker's Compensation - The Contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of \$500,000.00, covering all of Contractor's employees who are engaged in any work under the Contract. If any work is sublet, the Contractor shall require the subcontractor to provide the same coverage for any of its employees engaged in any work under the Contract.
  - b. Commercial General Liability - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$2,000,000.00 Combined Single Limit.
  - c. Automobile - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used relating to the Contract. The minimum combined single limit shall be \$500,000.00 for bodily injury and property damage; \$500,000.00 for uninsured/under insured motorist; and \$5,000.00 for medical payment.
  - d. Requirements - Providing and maintaining adequate insurance coverage is a material obligation of the Contractor and is of the essence of this Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Contractor shall always comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this Contract. The limits of coverage under each insurance policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. Notwithstanding the foregoing, nothing contained in this section shall be deemed to constitute a waiver of governmental immunity of the Contractor as a political subdivision of the state, which immunity is hereby reserved to the Contractor.

**27. INTELLECTUAL PROPERTY INDEMNITY:** To the extent permitted by law, Contractor shall hold and save the Department, State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or unpatented invention, articles, device, or appliance delivered relating to this Contract. This term shall survive the termination or expiration of this Contract. Notwithstanding the foregoing, nothing contained in this section shall be deemed to constitute a waiver of governmental immunity of the Contractor as a political subdivision of the state, which immunity is hereby reserved to the Contractor as to any third party.

**28. LITIGATION:** If a demand is asserted, or litigation or administrative proceedings, other than those administrative proceedings related to adverse benefit determinations addressed by other provisions of the Contract, are begun against the Contractor or against the Department and Contractor jointly relating to the services being provided under this Contract, the Contractor shall notify the Department within five (5) Business Days of becoming aware of such action. To the extent no conflict of interest exists or arises, Parties may agree to joint defense and agree to cooperate fully in defense of such litigation. Department will cooperate with Contractor fully in the defense of such litigation to the extent there is not conflict of interest.

In the event of litigation against the Department related to the Contract, Contractor's performance, or services provided under the Contract, Contractor will cooperate with Department fully in the defense of such litigation to the extent there is no conflict of interest.

Any civil or administrative settlements between the Contractor, as a delegee of the Department, and any member, or provider related to Medicaid Managed Care are public record to the extent required by law. All settlements must be reported to the Department within thirty (30) Calendar Days of an executed settlement agreement and a copy of the settlement agreement must be provided to the Department upon request.

This provision shall survive expiration or termination of the Contract.

**29. MEDIA CONTACT APPROVAL AND DISCLOSURE:** Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract or a recipient of services under the Contractor shall make immediate contact with the Department as soon as practical after the contact occurs. Contractor must submit any proposed media release to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure. Department may, at its sole discretion, object to its release or require changes to the information before it is released. The requirements of this Section shall not apply to any information the Contractor is required by law or by any court of competent jurisdiction to disclose.

**30. MONITORING OF SUBCONTRACTORS:** Contractor shall perform on-going monitoring of all Subcontractors and shall confirm compliance with subcontract requirements. As part of on-going monitoring, the Contractor shall identify to the Subcontractor(s) deficiencies or areas for improvement and shall require the Subcontractor(s) to take appropriate corrective action. Contractor shall perform a formal performance review of all Subcontractors at least annually. Contractor shall review encounter data of its Subcontractor for quality and accuracy before the data is submitted to the Department.

- 31. NOTICES:** Any notices required under the Contract must be delivered to the appropriate Contract Administrator for each Party. Unless otherwise specified in the Contract, any notices shall be in writing and **delivered by email**. In addition, notices may be delivered by first class U.S. Mail, commercial courier (e.g., FedEx, UPS, DHL), or personally delivered provided the notice is also emailed to the Contract Administrator at approximately the same time.
- 32. OUTSOURCING:** Any Contractor or Subcontractor providing call or contact center services to the State of North Carolina or any of its agencies shall disclose to inbound callers the location from which the call or contact center services are being provided. If, after award of a contract, the Contractor wishes to relocate or outsource any portion of performance to a location outside the United States, or to contract with a Subcontractor for any such performance, which Subcontractor and nature of the work has not previously been disclosed to the State in writing, prior written approval must be obtained from the Department. Contractor shall give notice to the using agency of any relocation of the Contractor, employees of the Contractor, Subcontractors of the Contractor, or other persons providing performance under this Contract to a location outside of the United States.
- 33. PARTICIPATION IN CATCHMENT AREA SERVICE CONTINUITY:** In the event the Department terminates, suspends, or delays a PIHP Contract in another catchment area, the Contractor agrees, contingent upon appropriation of sufficient funding to Contractor from the Department to perform the additional work, to meaningfully participate with the Department, all other active PIHP Contractors, and any other entities as required by the Department in a collaborative process to identify solutions for ensuring service continuity in such catchment area. Solutions identified under the process may include, but are not limited to, expanding the Contractor's service area, leveraging the Contractor's network building capabilities, and Contractor support for other operational activities, as needed.
- 34. PAYMENT AND REIMBURSEMENT:**
- a. **PIHP Payments:** The Department will make the following payments to the Contractor, as applicable:
    - i. Monthly per member per month (PMPM) capitated payments.
    - ii. Tailored Care Management payments.
  - b. **PMPM Capitated Payments**
    - i. The Contractor must accept capitation rates and risk adjustment methodology developed by the Department and its actuary and approved by CMS, as specified in *Attachment P. PIHP Capitation Rates*.
    - ii. Capitated payments shall be made on a PMPM, prospective basis at the first check-write of each month, unless another schedule is set by the Department.
    - iii. The Department will make PMPM capitation payments to the Contractor based on the number of members in each rate cell (as defined in the Rate Book applicable to the rating period and as determined by the monthly cutoff date in Medicaid Eligibility data system). The payment amount will be pro-rated for partial-month enrollment.
    - iv. PMPM capitation payments will be reconciled on a regular schedule to account for enrollment and eligibility changes not reflected in the initial monthly payment to the Contractor and may result in changes to a subsequent monthly capitation payment. Additional details on reconciliation can be found in *Section IV.L. Technical Specifications*.
    - v. The PMPM capitated rates are specified in the Rate Book. However, capitated payments shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements at 42 C.F.R. § 438.730.
  - c. **Tailored Care Management Payments:** The Department will make payments to the Contractor to support Tailored Care Management. The Contractor will make the following payments to certified

AMH+ practices and Care Management Agencies for Tailored Care Management in accordance with *Section IV.H.4. Provider Payments*:

- i. Tailored Care Management payment per member per month in which the AMH+ or CMA performed Tailored Care Management. Payment will be at a fixed rate and acuity-tiered. It will not be placed at risk.
  - ii. Performance incentive payment, if earned, based on the AMH+ and CMA metrics found in the forthcoming Department's Technical Specifications Manual.
- d. **Payment in Full:**
- i. The PIHP shall accept PIHP Payments under this Section as payment in full for the services provided under Contract, unless otherwise specified by the Contract.
  - ii. Members shall be entitled to receive all covered services as provided in *Section IV.F.1. Behavioral Health and I/DD Benefits Package* for the entire period for which payment has been made by the Department.
- e. **Payment Adjustments:** Payment adjustments may be initiated by the Department based on the eligibility and enrollment reconciliation or when keying errors or system errors affecting correct PIHP Payments to the Contractor 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.
- f. **Overpayment and Recoupment:**
- i. If the Contractor erroneously reports (intentionally or unintentionally), fraudulently reports, or knowingly fails to report any information affecting PIHP Payments to the Contractor, and is consequently overpaid, the Department may request a refund of the overpayment or recoup the overpayment by adjusting payments due in any one or more subsequent months.
  - ii. The Department may also recoup erroneous overpayments made to the Contractor 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 member information and the recoupment amount.
  - iii. The Department shall provide at least ten (10) Calendar Days' notice to Contractor of its intent to recoup overpayments and shall offer Contractor the opportunity to contest any such alleged overpayments. If the Parties cannot come to an agreement, the Contractor may utilize the Dispute Resolution process described in this Contract. The Department shall not take any collection action under this Contract, including recoupment while the dispute is pending and unresolved, unless otherwise allowed by law.
- g. **Other PIHP Payment Terms and Conditions:**
- i. Payment will only be made for services provided and is contingent upon satisfactory performance by the Contractor of its responsibilities and obligations under the Contract.
  - ii. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other adjustments as described in *Section IV.I.1. Quality Management and Quality Improvement* and *Section V. Contract Performance* to any payment due to Contractor.
  - iii. The Contractor is responsible for all payments to Subcontractors under the Contract. The Department shall not be liable for any purchases or subcontracts entered into by the Contractor or any subcontracted Provider in anticipation of funding.
  - iv. All payments by the Department shall be made by electronic funds transfer. Contractor shall set up the necessary bank accounts and provide written authorization to Medicaid's Fiscal Agent to generate and process monthly payments.

- v. Contractor shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).
- vi. Contractor shall maintain separate accounting for revenue and expenses for payments under this Contract in accordance with CMS requirements.

h. **Third-Party Resources:**

The capitated rates set forth in this Contract are adjusted to account for the primary liability of third parties for some of the services rendered to Members. As required in *Section IV.C.4. Third Party (Subcontractor) Liability*, the Contractor shall be responsible for actively seeking and identifying the liability of third parties and engaging in third-party resource recovery and cost avoidance to pay for services rendered to members pursuant to this Contract. All funds recovered by the Contractor from third-party resources shall be treated as income to Contractor.

**35. PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES:** Contractor warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for obtaining any Contract or award issued by the State and its Departments and other agencies or entities. The Contractor further warrants that no commission or other payment has been or will be received from or paid to any third-party contingent on the award of any Contract by the State, except as shall have been expressly communicated to the Department in writing prior to acceptance of the Contract or award in question. The Contractor and its authorized signatory further warrant that no officer or employee of the State has any direct or indirect financial or personal beneficial interest, in the subject matter of the Contract; obligation or Contract for future award of compensation as an inducement or consideration for making the Contract. Subsequent discovery by the State of non-compliance with these provisions shall constitute sufficient cause for termination of all outstanding contracts. Violations of this provision may result in debarment of the Contractor as permitted by 09 NCAC 06B.1206, 01 NCAC 05B.1520, or other provision of law.

**36. RECORDS RETENTION:** All records and data held by the Contractor as it relates to this Contract shall be retained and maintained as required by North Carolina law, federal law, State and Department Record Retention requirements and policies.

- a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer or shorter period is required by federal or State law or policy. Federal record retention standards are located in 45 C.F.R. § 74.53. The State policy is mandated by the State Archives of North Carolina and is located at the following link, accurate as of the date of execution of this Contract: <https://archives.ncdcr.gov/government/retention-schedules>.
- b. Records shall not be destroyed, purged, or disposed of without the express written consent of the Department.
- c. If any litigation, claim, negotiation, audit, disallowance action or other action involving this Contract starts before the expiration of the legally required retention period, the records must be retained until completion of the action and resolution of all issues which arise from it.
- d. In the event there are changes in record retention requirements or policies due to North Carolina law, federal law, State or Department record Retention Policies, the Contractor shall make the necessary changes to be in compliance with all Records Retention requirements.
- e. Record Retention requirements included within the body of this Contract, subsequent contracts and amendments are intended to supplement this term. In the event of conflict, the provisions of this term are the controlling requirements.
- f. At the point the Contract terminates/expires, all data must be transitioned to the State in a format prescribed by the Department unless that data has exceeded its archive requirements. The

Department may request verification from the Contractor that archive requirements are being met.

- g. PIHP shall comply with all standards for record retention in 42 C.F.R. 438.3(u) and the standards determined by the Department.
- h. PIHPs shall comply with all standards for record retention in 45 C.F.R. § 74.53 and the standards determined by the Department.
- i. Contractor shall submit its PIHP Policy for Record Retention to the Department for review. The PIHP shall resubmit its PIHP Policy for Record Retention to the Department if there are significant changes.
- j. Financial records and clinical records for the Innovations and TBI waivers shall be maintained by the Contractor in the manner prescribed in the clinical coverage policies for the Innovations and TBI waivers. In the absence of a policy, Contractor shall follow the requirements of this Record Retention clause.
- k. The Contractor shall maintain indirect cost rate proposals and cost allocation plans shall be retained for ten (10) years, unless otherwise required by federal or State law.
- l. This term survives termination or expiration of the Contract.

**37. RESPONSE TO STATE INQUIRIES AND REQUEST FOR INFORMATION:** The Contractor shall prioritize requests from the Department to respond to inquiries from any Departments under the State of North Carolina, the North Carolina General Assembly or other government agencies or bodies. Contractor shall use best efforts to respond to urgent requests from the Department within twenty-four (24) hours and according to the guidance and timelines provided by the Department. Contractor may be required to participate with and respond to inquiries from a consultant contracted with the Department regarding policies and procedures requiring review to determine compliance.

**38. SEVERABILITY:** If a court of competent authority holds that a provision or requirement of the Contract violates any applicable law, each such provision or requirement shall be enforced only to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of the Contract shall remain in full force and effect.

**39. SITUS:** The place of this Contract, its situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in Contract or tort, relating to its validity, construction, interpretation, and enforcement shall be determined.

**40. SOVEREIGN AND GOVERNMENTAL IMMUNITY:** Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the Department and State under applicable law. Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of governmental immunity that otherwise would be available to the Contractor under applicable law against a third party.

**41. STATE CONTRACT REVIEW:** This Contract and subsequent contracts are exempt from the State contract review and approval requirements pursuant to N.C. Gen. Stat. § 143B-216.80(b)(4).

**42. SUBCONTRACTORS:**

- a. Work performed under this Contract by the Contractor or its employees shall not be subcontracted without prior written approval of the Department. Contractor must submit a written request, in the form of completed *Attachment O Subcontractor Identification*, for approval at least sixty (60) Calendar Days prior to the start of services by a Subcontractor not previously approved by the Department in accordance with this **Paragraph 42. SUBCONTRACTORS.** Subcontractor(s) specified

in *Section IV. A. Administration and Management, 7. Subcontractors* are approved effective upon the date of Contract Execution.

- b. Upon request, the Contractor shall provide the Department with complete copies of any contracts made by and between the Contractor and all Subcontractors. The Contractor remains solely responsible for the performance of its Subcontractors. Subcontractors, if any, shall adhere to the same standards required of the Contractor and this Contract. Any contracts made by the Contractor with a Subcontractor shall include an affirmative statement that the Department is an intended third-party beneficiary of the Contract; that the contract with the Subcontractor does not create a contract between the Department and Subcontractor; and that the Department shall be indemnified by the Contractor for any claim presented by the Subcontractor. Notwithstanding any other term herein, Contractor shall timely exercise its contractual remedies against any non-performing Subcontractor.
- c. The Contractor shall neither participate with nor enter into any agreement with any individual or entity that has been excluded from participation in federal health care programs. The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Act. [42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(2); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09]
- d. Any contract(s) between the Contractor and Subcontractor(s) require:
  - i. The Subcontractor to agree that the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect its premises, any books, records, contracts, computer, or other electronic systems of the subcontractor relating to its Medicaid members, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State and in turn will make available to the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees all audit materials as described in this subsection.
  - ii. The Subcontractor to agree that the right to audit by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
  - iii. That if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
  - iv. That the Contractor inform the Subcontractor of the sources of funding for the Contract and of any special compliance or reporting requirements associated with each funding source (e.g., block grants) and the Subcontractor to agree to accurate reporting and appropriate use of State and federal grant funds.
- e. Any contract(s) between the Contractor and Subcontractor(s) described in this section shall include:
  - i. Required activities and obligations, and related reporting responsibilities.
  - ii. Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Department or the Contractor determines that the Subcontractor has not performed satisfactorily. 42 C.F.R. § 438.230(c)(1)(i) - (iii).
  - iii. Requirement to comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance and contract provisions. 42 C.F.R. § 438.230(c)(2).



- 43. SURVIVAL:** The expiration, termination, or cancellation of this Contract will not extinguish the rights of either Party that accrue prior to expiration, termination, or cancellation or any obligations that extend beyond termination, expiration or cancellation, either by their inherent nature or by their express terms.
- 44. TAXES:** Any applicable taxes shall be invoiced as a separate item and in accordance with this paragraph and applicable laws.
- a. N.C. Gen. Stat. § 143-59.1 bars the Department from entering into Contracts with Contractors if the Contractor or its affiliates meet one of the conditions of N.C. Gen. Stat. § 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under N.C. Gen. Stat. § 105-164.8(b) include: (i) Maintenance of a retail establishment or office, (ii) Presence of representatives in the State that solicit sales or transact business on behalf of the Contractor and (iii) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the Contract, the Contractor certifies that it and all its affiliates (if it has affiliates), collect(s) the appropriate taxes.
  - b. Contractor is a local political subdivision of the State of North Carolina and as such is exempt from local, State, and federal taxes, including but not limited to excise and transportation.
  - c. Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.
- 45. TERMINATION:** Any notice or termination made under the Contract shall be provided to Contractor's and Department's respective Contract Administrators.
- a. The Contractor obligations set forth in this Section shall survive the expiration or termination of this Contract and shall remain fully enforceable by Department against Contractor
  - b. Termination without Cause:  
This Contract may be terminated, in whole or in part, without cause by the Department by giving at least one hundred and eighty (180) Calendar 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 sixty (60) Calendar Day notice period expires. In the event of termination without cause:
    - i. Department and Contractor shall work together daily in good faith to minimize any disruption of services to NC Medicaid Beneficiaries;
    - ii. Contractor shall perform all the Contractor transition and other obligations specified in the Contract;
    - iii. Department and Contractor shall resolve any outstanding obligations under this Contract; and
    - iv. Contractor shall pay Department in full any refunds or other sums due to Department under this Contract.
  - c. Termination for Cause:
    - i. In accordance with 42 C.F.R. § 438.708, Department shall have the right to terminate this Contract with Contractor and to enroll Contractor's members in other managed Care Plans if Department determines that Contractor has failed to carry out the substantive terms of this Contract or has failed to meet applicable requirements in Sections 1905(t), 1903(m), and/or 1932 of the Social Security Act.
    - ii. Upon written notification to Contractor of Department's intent to terminate this Contract, the Department may give Members written notice of such intent and allow the members to disenroll immediately without cause in accordance with 42 C.F.R. § 438.722.
    - iii. If the Department seeks to terminate this Contract pursuant to 42 C.F.R. § 438.708, the Department shall provide Contractor with a pre-termination hearing as required by 42 C.F.R. § 438.710(b) and as described in this Contract.

- iv. Department shall have the right to terminate this Contract for cause when the performance of Contractor or one of its Subcontractors has systemically or repeatedly threatened to place the health or safety of any Beneficiary in jeopardy, and Contractor knew or should have known of the issue and failed to take appropriate action immediately to correct the problem;
- v. Department shall have the right to terminate this Contract for cause when Contractor 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);
- vi. Department shall have the right to terminate this Contract for cause when Contractor has systemically and fraudulently misled any Beneficiary or has systemically and fraudulently misrepresented the facts or law to any Beneficiary, and Contractor failed to take appropriate action immediately to correct the problem;
- vii. Department shall have the right to terminate this Contract for cause when gratuities of any kind with the intent to influence have been offered or received by a public official, employee, or agent of the State by or from Contractor, its agents or employees;
- viii. Department shall have the right to terminate this Contract for cause if Contractor loses or fails to obtain accreditation with the selected accreditation agency.
- ix. Department shall have the right to terminate this Contract for cause if Contractor declares bankruptcy.
- x. Department shall have the right to terminate this Contract as otherwise set forth in this Contract.

d. Automatic Termination:

This Contract shall immediately and automatically terminate without further Contractor obligation to Department, except as provided below in Subsection e., if:

- i. Either of the two (2) sources of reimbursement for Medical Assistance (appropriations from the North Carolina General Assembly and appropriations from the United States Congress) no longer exists; or
- ii. The sum of all contractual obligations of the Department exceeds the balance of funds available to Department for a contract year in which this Contract is effective.

Written certification from the Department that one or the other or both of the conditions described above has been met shall be conclusive and binding upon the Parties. Department shall attempt to provide Contractor with ten (10) Business Days' prior notice of the possible occurrence of events described above.

In the event of immediate and automatic Contract termination, Contractor shall cooperate fully with the Department in transferring any data and information or providing such other assistance as described in this Section in an expedient manner.

e. Contract Expiration, Termination, and Transition Obligations of Contractor:

Unless otherwise provided by law, at least sixty (60) Calendar Days before Contract expiration, and within thirty (30) Calendar Days of receipt of notice by Contractor of any Contract termination, Contractor shall provide notice of termination to Members. In all cases, Contractor's notification letter must be approved by Department before Contractor mails the notice to Members.

No less than ninety (90) Calendar Days prior to the date of planned expiration or forty-five (45) Calendar Days of planned termination of this Contract, Contractor shall:

- i. Provide Department with Contractor's plan for the transfer of all Members to other appropriate managed care entities, and make all Department required changes to said plan;
- ii. Assist Department in the implementation of the Department-approved plan for Member transition in such a manner as to ensure the continuity of services for Members;

- iii. Promptly provide Department with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;
  - iv. Arrange for the secure maintenance of all Contractor records for audit and inspection by Department, CMS, and other authorized government officials;
  - v. Provide for the transfer of all data, including encounter data and records, to Department or its agents as may be requested by Department; and
  - vi. Provide for the preparation and delivery of all reports, forms and other documents to Department as may be required pursuant to this Contract or any applicable policies and procedures of Department.
- 46. TIME IS OF THE ESSENCE:** Time is of the essence in the performance of this Contract and all provisions that specify a time for performance.
- 47. TITLES AND HEADINGS:** Titles and headings in this Contract, and in any subsequent Contract, are for convenience only and shall have no binding force of effect.
- 48. USE OF THIRD PARTY ADMINISTRATOR:** If Contractor uses the services of a Third Party Administrator (TPA) to adjust or settle claims for members, then the Contractor shall do all of the following:
- a. Have a written agreement with the TPA that at a minimum includes a statement of the duties the TPA is expected to perform on behalf of the Contractor;
  - b. Establish the rules, in accordance with this Contract, pertaining to claims payment and shall provide the TPA with the rules; and
  - c. Submit to the Department with the Technical Response an attestation that the Contractor understands it is solely responsible to provide for competent administration of its claims under the Contract.
- 49. WAIVER:** The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.

## C. Confidentiality, Privacy and Security Protections

1. The requirements of this Section shall survive expiration or termination of the Contract except the requirements to protect the privacy and security of State-owned data, which shall survive so long as Contractor holds State-owned data.
2. Confidential Information
  - a. The Contractor, its agents, and its Subcontractors shall maintain the privacy, security and confidentiality of all data information, working papers, and other documents related to the performance of the Contract, including information obtained through its performance under the Contract, that meets the conditions for confidentiality under NCGS 132-1.2, is otherwise protected by law or applicable policy as confidential, or is identified by the Department as embargoed, confidential, or not for release; i.e. confidential information. Any use, sale, or offer of confidential information associated with the performance of the Contract except as contemplated under the Contract or approved in writing by the Department shall be a violation of the Contract. Any such violation will be considered a material breach of the Contract. Contractor specifically warrants that it, its officers, directors, principals, employees, any Subcontractors, and approved third-party contractors shall hold confidential information received from the Department during performance of the Contract in the strictest confidence and shall not disclose the same to any third party except as contemplated under the Contract or approved in writing by the Department.

- b. Contractor warrants that all its employees Subcontractors, and any approved third-party Contractors are subject to a non-disclosure and/or confidentiality agreement or provisions that is/are enforceable in North Carolina and sufficient in breadth to include and protect confidential information related to the Contract. The Contractor shall, upon request by the Department, verify and produce true copies of any such agreements/provisions. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C. Gen. Stat. § 132-1 et. Seq. The Department may, in its sole discretion, provide a non-disclosure and confidentiality agreement satisfactory to the Department for the Contractor's execution. The Department may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including but not limited to 26 U.S.C. 6103, SSA, and IRS Publication 1075 (Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities), HIPAA, and implementing regulation in the Code of Federal Regulations and any future regulations imposed upon the Department of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.
- c. The Department, State auditors, State Attorney General, federal officials as authorized by federal law or regulations, and State officials as authorized by State law or regulations, as well as the authorized representatives of the foregoing, shall have access to confidential information in accordance with the requirements of State and federal laws and regulations. No other person or entity shall be granted access to confidential information unless State and federal laws and regulations allow such access. The Department has the sole authority to determine if and when any other person or entity has properly obtained the right to have access to any confidential information and whether such access may be granted. Use or disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.
- d. The Contractor warrants that without prior written approval of the Department, the Contractor shall not incorporate confidential or proprietary information of any person or entity not a Party to the Contract into any materials furnished to the Department, nor without such approval shall the Contractor disclose to the Department or induce the Department to use any confidential or proprietary information of any person or entity not a Party to the Contract.
- e. The foregoing confidentiality provisions do not prevent the Contractor from disclosing information that (i) at the time of disclosure by the Department is already known by the Contractor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Contractor other than an act that is authorized by the Department or applicable law, (iii) is rightfully received by Contractor from a third party and Contractor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the Department, (iv) is independently developed by the Contractor without use of the Department's confidential information, (v) is disclosed without similar restrictions to a third party by the Department, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Contractor, to the extent possible, provides the Department with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

3. HIPAA and HITECH

- a. The Department has declared itself to be a hybrid entity under HIPAA with the DHB being a covered health care component. As such, this Contract and related activities are subject to HIPAA and HITECH. Contractor shall comply with HIPAA and HITECH requirements and regulations, as amended, including:
  - i. Compliance with the Privacy Rule, Security Rule, and Notification Rule;
  - ii. The development of and adherence to applicable Privacy and Security Safeguards and Policies;
  - iii. Timely reporting of violations regarding the access, use, and disclosure of PHI; and
  - iv. Timely reporting of privacy and/or security incidents at the following link, accurate as of the date of execution of this Contract: <https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security>
- b. Contractor will be performing functions on behalf of the Department that make Contractor a business associate for purposes of HIPAA regulations. Accordingly, Contractor and this Contract are subject to the terms and conditions of *Section VI. Attachment R: Business Associate Agreement*.
- c. Contractor shall cooperate and coordinate with the Department and its privacy officials and other compliance officers as mandated by HIPAA and HITECH and accompanying regulations, or as requested by the Department, during performance of the Contract so that both Parties are in compliance with HIPAA and HITECH.
- d. In addition to federal law and regulation, Contractor shall comply with State rules and regulation regarding protected information and Department and State policies including State IT Security Policy and standards. State and Department policies may be revised from time to time, with at least 30 days' notice to Contractor and the Contractor shall comply with all such revisions following the notice period as soon as practicable upon written notification of such revision(s).

4. North Carolina Identity Theft Protection Act and Other Protections

Certain data and information received, generated, maintained, or used by Contractor may be classified as "identifying information" within the meaning of N.C. Gen. Stat. § 14-113.20(b) or "personal information" within the meaning of N.C. Gen. Stat. § 75-61(10). Contractor is subject to the North Carolina Identity Theft Protection Act requirements, N.C. Gen. Stat. §§ 132-1.10 and 75-65 and must protect such identifying information and personal information as required by law, Department and State policy, and the terms of this Contract. Contractor shall report security incidents and breaches of all protected information, whether PHI, identifying information, or personal information as required in these Confidentiality, Privacy, and Security provisions.

5. Information Technology

- a. Contractor shall comply with and adhere to all applicable federal and North Carolina laws, regulations, policies, and guidelines, including but not limited to HIPAA, CMS and State IT Security Policy and Standards; Department Privacy and Security Policies, and, the most recent Information Security and Privacy guidance shared by CMS. State and Department policies may be revised periodically, with at least thirty (30) Calendar Days' notice to Contractor. Contractor shall comply with any revisions following the notice period as soon as practicable upon written notification of such revision(s). The State Security Manual is available at the following link, accurate as of the date of execution of this Contract <https://files.nc.gov/ncdit/documents/files/Statewide-Information Security Manual.pdf> and the Department security manual is available at <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>.
- b. Contractor's information technology systems shall meet all State and federal statutes, rules and regulations governing information technology (including but not limited to 26 U.S.C. 6103, SSA, IRS Publication 1075, and HIPAA) and the policies of the NC Department of Information Technology,

including NIST 800-53, as outlined in the State's Information Security Manual which can be found at the following links, accurate as of the date of execution of this Contract. See e.g., <https://it.nc.gov/statewide-resources/policies>; [https://files.nc.gov/ncdit/documents/files/Statewide-Information\\_Security\\_Manual.pdf](https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf) and <https://it.nc.gov/document/statewide-data-classification-and-handling-policy>.

- c. **Enterprise Architecture Standards:** The North Carolina Statewide Technical Architecture standards are located at the following link, accurate as of the date of execution of this Contract <https://it.nc.gov/services/it-architecture/statewide-architecture-framework>. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems.
- d. **Modifications, Updates or Fixes to the Contractor's Information Technology Systems:** The Contractor will adhere to the Department's Change Management and control policies and procedures for all modifications to systems that contain electronic protected health information. The Contractor shall not modify, update, or fix any IT system that shares information with (or interfaces with) the Department's Information Technology systems without the Department's prior written approval, unless Contractor identifies the need to perform a security emergency change. The Contractor's request for approval must be communicated to the Department one hundred twenty (120) Calendar Days prior to the change, or immediately after an emergency change, and contain a detailed description of the changes proposed or taken by the Contractor. The Contractor must supplement its request with all clarifications and additional information requested by the Department. The Contractor shall not place any modification, upgrade, or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade, or fix to ensure that it does not impair the operation of the Department's IT systems. The Department reserves the right to delay Contractor's system implementation if it perceives a risk to its operations.
- e. **Modifications, Updates, and Fixes Requested by the Department:** The Contractor shall promptly modify, upgrade, or fix any part of its Information Technology System that shares information with (or interfaces with) the Department's Information Technology Systems as requested by the Department. The Contractor shall not place any such modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's Information Technology Systems. The Contractor may not unilaterally refuse to make a modification, update or fix requested by the Department. In the event the Contractor disagrees with the Department on modification, update or fix requests, the Contractor must follow the Change Management and control policies and procedures for resolution. If the Parties cannot come to agreement, the Contractor may utilize the Dispute Resolution process described in this Contract.
- f. **Patch Management:** As soon as practicable upon receipt of written notification of the need to do so, the Contractor will apply patches based on State requirements on or to any Information Technology Systems or platforms that share information with (or interfaces with) the Department's Information Technology Systems or which may impact the delivery of services to the Department's members, provided that the patches do not disrupt Contractor operations. The State requirements are located at the following link, accurate as of the date of execution of this Contract: [https://files.nc.gov/ncdit/documents/files/Statewide-Information\\_Security\\_Manual.pdf](https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf)  
The Contractor will coordinate patching activity with the Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with Contractor patching. The requirement to apply the

patch may come from the Contractor, the Department, or an external organization such as <https://www.us-cert.gov/>

- g. Changes to Department Information Technology Systems: The Department anticipates changes to its Information Technology Systems. As soon as practicable upon receipt of written notification of the need to do so, the Contractor will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e., number of records per file or overall file size in bytes). The Department will provide test environments to allow adequate testing time.
  - h. The Department's Rejection of the Contractor's Modifications, Updates or Fixes to the Contractor's IT Systems: The Department reserves the right to reject any modification, update or fix that does not meet the Department's Information Technology standards or could impair the operation of the Department's Information Technology Systems.
  - i. Cost of Modifications, Updates, Fixes, and Patches to the Contractor's IT Systems: The cost of all modifications, updates, fixes, and patches to the Contractor's Information Technology Systems (whether proposed by the Contractor or required by the Department) shall be borne solely by the Contractor.
  - j. State LAN/Wan: The Contractor shall not connect any of its own equipment to a State-owned or operated LAN/WAN without prior written approval by the Department. The Contractor shall complete all necessary paperwork as directed and coordinated by the Department's appropriate Contract Administrator to obtain the required written approval by the Department to connect Contractor-owned equipment to a State LAN/WAN.
  - k. Connectivity: The Contractor shall be responsible for providing connectivity to the Department's network and systems as required by the Department. This includes any network, connectivity, licensing, or hardware associated with complying with the State's and the Department's policy for securing data. This applies to all communication between the Contractor and the Department, and also includes the Department's current and future Contractors' networks.
  - l. Web / Internet Presence: Where necessary, any web presence that is required to complete the terms of this agreement will comply with the Department's, the State's, and federal standards including but not limited to those required for accessibility (Web Content Accessibility Guidelines (WCAG) 2.0 and the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Sec. 508 of the Rehabilitation Act of 1973 as amended January 2017). The Department will make these standards available as needed.
  - m. Architecture Framework: The Contractor shall follow the North Carolina Statewide Information Architecture Framework (located at the following link, accurate as of the date of execution of this Contract: <https://it.nc.gov/services/it-architecture/statewide-architecture-framework>), and any Department derivatives of these documents. The Contractor shall provide documentation as requested by the Department to assess the security of the Contractor's facilities and systems. The security review is part of the overall readiness and noncompliance may be subject to Contract Termination for Cause.
6. Continuous Monitoring
- a. The Contractor shall adhere to the mandate for a Continuous Monitoring Process and work with the Department to implement a risk management program that continuously monitors risk through assessments, risk analysis and data inventory. The requirements are based on, NIST 800-37, Continuous Monitoring Process and originates from N.C. Gen. Stat. § 143B-1376, located online at the following link, accurate as of the date of execution of this Contract:

[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter\\_143B.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_143B.html), which requires the North Carolina State CIO to annually assess each agency and each agency's contractors' compliance with enterprise security standards.

- b. The Contractor shall assist the Department with risk assessment and security assessment of the Contractor's critical systems and infrastructure.
    - i. The Contractor shall perform the required assessments, either through a third-party or a self-assessment, on a three-year cycle (with a third-party assessment mandated every third year).
    - ii. All findings identified in the assessment shall be provided through DHB to the North Carolina Department of Information Technology within thirty (30) Calendar Days of assessment completion and a plan to remediate each finding.
    - iii. The Contractor shall provide a risk assessment for its cloud-hosted providers or off-site hosting service providers. Contractor shall provide all findings identified in these risk assessments to the Department and NC DIT within thirty (30) Calendar Days of assessment completion, also including a corrective action plan documenting how each finding will be remediated.
  - c. Assessment of agency cloud-hosted providers or off-site hosting services.
    - i. The Contractor will provide attestation to their compliance and an industry recognized, third-party assessment report performed annually. Types of these reports include: Federal Risk and Authorization Management Program (FedRAMP) certification, SOC 2 Type II, SSAE 18 or ISO 27001.
    - ii. Departments and their divisions/offices are required to review these reports, assess the risk of each Contractor, and provide annual certification of their compliance to the State CIO.
    - iii. Contractor shall cooperate with the Department in completing a data inventory of all public cloud hosted services as required and performed through completion of a Privacy Threshold Analysis (PTA) documenting the data classification and data fields hosted within the cloud, offsite or vendor hosted environment. The PTA shall be reviewed and updated annually by the Parties and when changes have been made to the data being collected. The Department's PTA form is available at the following link, accurate as of the date of execution of this Contract: <https://it.nc.gov/documents/privacy-threshold-analysis-pta-form>.
7. Secure Integration Services
- a. The Contractor's systems shall be able to transmit, receive and process data in HIPAA-compliant or Department-specific formats and methods, including but not limited to Secure File Transfer Protocol (SFTP) over encrypted connections such as a SSL (Secure Sockets Layer) or SSH (Secure Shell).
  - b. As soon as practicable upon receipt of written notification of the need to do so, the Contractor shall work with the Department and Department vendors to implement data exchanges that comply with the Department, State's security policies, as defined by the North Carolina Department of Information Technology. The State's preferred method of exchanging data with other applications in the Medicaid Enterprise System (MES) is through synchronous real-time web services and/or asynchronous queue-based messaging, when ready.
  - c. The Contractor shall have the ability to exchange files through secure protocols with other systems.
8. Service Organization Control (SOC) reports
- All SOC 1 and SOC 2 Type II reports, and associated SOC 2 corrective action plans, must be submitted annually to the DHHS Privacy and Security Office in a format to be specified by the State. The Department will accept ISO 27001 certification for security controls in lieu of a SOC 2 Type II report.



Reports must be submitted within thirty (30) days of completion unless another timeframe is approved by the Department.

9. Security

a. State of NC Security Standards and DHHS Privacy and Security Standards

- i. Contractor shall comply with all security standards including those published in the State of North Carolina Statewide Information Security Manual, the Department PSO Standards, and any federal regulations and requirements (found at the following link, accurate as of the date of execution of this Contract: <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>). The State of North Carolina Statewide Information Security Manual is available at the following URL, accurate as of the date of execution of this Contract: <https://it.nc.gov/statewide-information-security-policies>. The Department will work with the Contractor to validate compliance with the PSO standards.
- ii. The Contractor's systems and processes shall comply with all current and future federal, State, and Department requirements for privacy and security and data exchange within one hundred twenty (120) Calendar Days of the implementation of that standard.

b. Physical Security

- i. Each person who is an employee or agent of Contractor or Subcontractor must always display an appropriate State badge and his or her company ID badge while on State premises. Upon request of Department personnel, each such employee or agent must also provide additional photo identification.
- ii. At all times at any State facility, Contractor's personnel shall cooperate with State site requirements, including being prepared to be escorted, providing information for badging, and wearing the badge in a visible location.

c. State of NC Data Classification and Handling

The State of North Carolina Data Classifications as published in the North Carolina Department of Information Technology Data Classification and Handling Policy guide and the related handling procedures will apply to all data held in Contractor's IT systems on behalf of the Department, and in the execution of this contract. The guide is available at the following URL, accurate as of the date of execution of this Contract: <https://files.nc.gov/ncdit/documents/files/Statewide-Data-Class-Handling.pdf>

10. Privacy and Security Incidents and Breaches

- a. Contractor shall cooperate with the Department regarding any privacy and security incident or breach.
- b. Contractor shall report significant privacy and security incidents (whether confirmed or suspected) and any breaches to the Department's PSO Incident Website at the following link, accurate as of the date of execution of this Contract: <https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security> within twenty-four (24) hours after the incident is first discovered. If a Social Security number has been compromised, the incident must be reported to the Department's PSO within sixty (60) minutes after the incident is discovered.
- c. Contractor, in coordination with the Department PSO, shall also report any breaches of personal information to the North Carolina Department of Justice Consumer Protection Division as well as to the three major consumer reporting agencies. NCDOJ information is available here: <https://ncdoj.gov/protecting-consumers/protecting-your-identity/protect-your-business-from-id-theft/security-breach-information/>
- d. If any applicable federal, State, or local law, regulation or rule requires the Department or the Contractor to give persons written notice of a privacy and / or security breach arising out of the

Contractor's performance under this Contract, the Contractor shall bear the cost of the notice and any other costs related to or resulting from the breach.

- e. Contractor shall notify the Department's PSO and the appropriate Contract Administrator of any contact by the federal Office for Civil Rights (OCR) received by the Contractor. This term survives termination or expiration of the Contract, as it relates to contact by OCR related to this Contract.

## D. Public Records and Trade Secrets Protections

1. Pursuant to N.C. Gen. Stat. § 132-1, et seq., this Contract and information or documents provided to the Department under the Contract are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute. Any proprietary or confidential information which conforms to exclusions from public records as provided by Chapter 132 of the General Statutes must be clearly marked as such with each page containing the trade secret or confidential information identified with bold face as "**CONFIDENTIAL.**" Any material labeled as confidential constitutes a representation by the Contractor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C. Gen. Stat. § 66-152(3). Under no circumstances shall price information be designated as confidential. Contractor is urged and cautioned to limit the marking of information as trade secret or confidential so far as is possible.
2. Regardless of what Contractor may label as a trade secret, the determination of whether it is or is not entitled to protection will be made in accordance with N.C. Gen. Stat. § 132-1.2 and N.C. Gen. Stat. § 66-152(3). If any challenge, legal or otherwise, is made related to the confidential nature of information redacted by the Contractor, the Department will provide reasonable notice of such action to Contractor, and Contractor shall be responsible for the cost and defense of, or objection to, release of any material. The Department is not obligated to defend any challenges as to the confidential nature of information identified by the Contractor as being trade secret, proprietary, and otherwise confidential. The Department shall have no liability to Contractor with the respect to disclosure of Contractor's confidential information ordered by a court of competent authority pursuant to N.C. Gen. Stat. § 132-9 or other applicable law.
3. A redacted copy of this Contract and any subsequent amendments, documents, or materials relating to or provided as part of this Contract, shall be provided to the Department within thirty (30) Calendar Days of execution. Redacted copies must clearly indicate where information has been redacted. For the purposes of this Contract, redaction means to edit the document by obscuring information that is considered confidential and proprietary **and** meets the definition of Confidential Information set forth in N.C. Gen. Stat. § 132-1.2. In lieu of redacting information by obscuring, Contractor may replace the information, paragraphs or pages with the word "Redacted." By submitting a redacted copy, the Contractor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked Confidential and/or Redacted meet the requirements of Chapter 132 of the General Statutes. Redacted copies provided by Contractor to the Department may be released in response to public record requests without notification to Contractor. Information submitted by Contractor that is not marked "Confidential" or "Trade Secret" will become a public record.

## E. Dispute Resolution for Contract Compliance

1. Disputes that arise out of this Contract shall be promptly investigated by the Department's Contract Administrator. If either Party identifies a dispute or potential problem with contract compliance, the Department's 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.
2. If PIHP alleges the dispute or potential problem is the fault of the Department or any of its Divisions, agents, employees or subcontractors, the Department Contract Administrator shall investigate the PIHP's allegations, take immediate steps to cure the problem if substantiated by the Department and shall notify the PIHP Contract Administrator in writing of its investigative findings and the timeline for resolution, if any, within five (5) Business Days of such determination.
3. If the Department alleges the dispute or potential problem, including but not limited to contested over or under payments, recoupments, penalties or adjustments pursuant to this Contract, is the fault of PIHP or its agents, employees or subcontractors, the PIHP Contract Administrator shall investigate the Department's allegations, take immediate steps to cure the problem if substantiated by PIHP and shall notify the Department Contract Administrator in writing of its investigative findings and the timeline for resolution, if any, within five (5) Business Days of such determination.
4. If the dispute is not resolved pursuant to *Section III. E.2* and is the result of a conflict or lack of clarity within this Contract, the Parties will negotiate in good faith an Amendment to this Contract to resolve the dispute.
5. If the unresolved dispute appears to impact more than one PIHP operating under the 1915 (c) Waiver, the Department Contract Administrator shall notify Department leadership, who will develop a plan of action with multiple PIHPs for resolving the dispute. The goal of the resolution process shall be to resolve all problems before they escalate to the next level. The Department and PIHP Contract Administrators shall schedule telephone or face to face meetings as necessary in order to achieve resolution without conflict where possible.
6. If PIHP or Department is not satisfied with the results of the above-described resolution process decision, PIHP or Department may invoke any legal or administrative remedy available to it under State and Federal law. Pending appeal, both parties shall proceed diligently with the performance of this Contract, unless a court of competent jurisdiction issues a stay.

## IV. Scope of Services

### A. Administration and Management

1. Medicaid Program Administration
  - a. In the State of North Carolina, the Department is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for both the Medicaid and NC Health Choice programs. In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid program through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.
  - b. The Department has the authority to determine North Carolina Medicaid and NC Health Choice eligibility and define the populations excluded or delayed from managed care who are thereby eligible to receive Behavioral Health and I/DD Services for Medicaid Direct through the PIHP consistent with G.S. 108D-60 as amended from time to time.
  - c. The Department has the authority to administer the program in the way outlined in this Contract under the terms of the State's waivers under Section 1915(i) and 1915(c), of the Social Security Act and various Medicaid State Plan Amendments.
  - d. During the term of the Contract, and in future years, the Department will modify its Medicaid and NC Health Choice Programs, including supporting technical and operational infrastructure, to conform with Federal and State requirements or Department policies and goals. Modifications may be communicated through State Plan Amendments, Waiver amendments, and administrative memos and bulletins issued by the Department. The PIHP is obligated to review such memos and bulletins to assist in staying informed of program changes.
  - e. The Department will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs and will delegate the direct management of BH and I/DD services as defined in the Contract (Behavioral Health and I/DD Services for Medicaid Direct). Nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Department to perform any of the duties assigned to the Department or its Secretary by the North Carolina General Statutes, the terms and conditions of the federal funds and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by the PIHP to reimburse the PIHP for any of its duties under this Contract. The PIHP will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the PIHP has an adequate Network, delivers high quality care, and operates a successful program.
  - f. The PIHP shall work cooperatively with the Department to be good stewards of taxpayer funds, and to ensure effective administration of this Contract.
  - g. In partnership with the Department, the PIHP shall develop processes and procedures to ensure the PIHP is soliciting stakeholder input, including, but not limited to, input from Members, as applicable, and Providers, to drive policy development and continual improvement in Behavioral Health and I/DD Services for Medicaid Direct.
  - h. The PIHP shall provide certification by the Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting to either the CEO or CFO duly authorized so submit the certification concurrently with the submission of all data, documentation, or information requiring such certification under federal and State law and under this Contract to the

Department that such information is accurate, complete, and truthful. The PIHP shall provide such certification in accordance with 42 C.F.R. § 438.604 and 42 C.F.R. § 438.606.

- i. The PIHP shall cooperate with the Department in the administration of North Carolina's federal Medicaid waivers (e.g., Section 1115, 1915(b), 1915(c)) including providing reporting and data, and engaging with the Department's external evaluators.
  - j. The PIHP shall also comply with the following Department policies and any other Department policy as directed consistent with this Contract. The Department may amend policies and shall provide updated versions to the PIHP at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The PIHP shall have the opportunity to review and provide feedback for the Department's consideration prior to the effective date of such policy revisions.
    - i. North Carolina Medicaid Direct for BH and I/DD Services Enrollment Policy;
    - ii. AMH+ Practice and CMA Certification Policy
    - iii. Uniform Credentialing and Re-credentialing Policy;
    - iv. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards and;
    - v. Tribal Payment Policy; and
    - vi. Transition of Care Policy.
  - k. The PIHP shall provide to the Department an updated, draft implementation plan thirty (30) Calendar Days after Contract Execution that defines the tasks necessary to develop the following capabilities or milestones for Medicaid as applicable. As long as the Implementation Plan clearly states that it applies to the PIHP, the Vendor Readiness Assessment Report may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract:
    - i. Network development, including provider education, training and contracting;
    - ii. Member and recipient engagement, including educational materials, welcome
    - iii. Service line operations;
    - iv. Utilization management development and implementation;
    - v. Care and case management program development and implementation;
    - vi. PCP assignment;
    - vii. Transition of Care data exchange;
    - viii. Quality management infrastructure;
    - ix. Member, recipient and provider enrollment systems;
    - x. Claims and encounter systems;
    - xi. Required system interfaces;
    - xii. Design, development, and testing activities; and
    - xiii. Other administrative supports.
  - l. To support Medicaid Managed Care and State-funded Services implementation and operations, the BH I/DD Tailored Plan shall perform the following testing and technology operations:
    - i. Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable;
    - ii. End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting; and
    - iii. Production defect resolution and testing of production incidents.
2. Entity Requirements
- a. Operational Authority & Potential Licensure

- i. Except where expressly stated, the PIHP shall be permitted to utilize the same staff committees, advisory boards, Subcontractors, policies, procedures, Call Center service lines, systems, processes, training, training materials, and other business materials and operations for both its PIHP and BH I/DD Tailored Plan Contract.
  - ii. An LME/MCO holding a contract with the Department for the provision of Medicaid-funded behavioral health, and I/DD services must also hold a Contract as a BH I/DD Tailored Plan and be a local political subdivision of the State and operate as an LME/MCO, as that term is defined in N.C. Gen. Stat. § 122C-3(20c), at the time of Contract execution.
- b. PIHP Governance and Operations
- i. The PIHP shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, compensation, and maintenance of the entity's governing board, which governs all aspects of PIHP operations.
  - ii. The PIHP shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, and support of the Consumer and Family Advisory Committee (CFAC), which advises the PIHP on the planning and management of the local public mental health, intellectual/ developmental disabilities, and substance use services system pursuant to N.C.G.S. §122C-170(a).
  - iii. The PIHP shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the establishment and maintenance of any other required advisory boards.
- c. PIHP Operating Plan
- i. The PIHP shall develop and maintain an up-to-date PIHP Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid services operations of the legal entity holding the Contract with the Department to provide Behavioral Health and I/DD Medicaid services. As long as the PIHP Operating Plan clearly states that it applies to the PIHP, the PIHP Operating Plan may apply to other LME/MCO operations, including, without limitation, the BH I/DD Tailored Plan.
    - 1. Core Medicaid operations include:
      - a. Managing member lives including member services and the administration of behavioral health, I/DD, and TBI benefits and services;
      - b. Managing Member services, including utilization management and the administration of benefits and services;
      - c. Managing the closed provider network;
      - d. Performing care management and care coordination functions;
      - e. Performing quality management and data reporting;
      - f. Processing and paying claims; and
      - g. Assuming risk through a capitated contract for a subset of Medicaid services.
    - 2. Entities included in the Operating Plan shall include Subcontractors, business partners, and any other entities involved in core Medicaid operations.
    - 3. The PIHP Operating Plan shall:
      - a. Identify each entity by corporate or other legal entity name, address, and telephone number;
      - b. Describe generally the roles, responsibilities, and functions that the entity performs;
      - c. Describe the PIHP's legal or contractual relationship with each entity;
      - d. Describe how the PIHP trains vendor staff; and
      - e. Describe how the PIHP manages and oversees each entity and ensures compliance with the standards described in the Contract.

4. For Department review and approval, after the first year and annually thereafter, provide a Delegation report for each core Medicaid operations entity, including evidence of the PIHP's oversight activities, and describing entity performance including key operating priorities, key metrics, corrective actions taken, and sanctions.
  5. The PIHP is encouraged to and shall be permitted to combine its oversight activities over a Subcontractor that is common between the BH I/DD Tailored Plan and PIHP.
  6. The PIHP shall respond to any additional requests for information pursuant to this subsection as directed by the Department.
- ii. The PIHP shall submit the PIHP Operating Plan to the Department for review and approval:
    1. Annually, on June 30 of the calendar year; and
    2. Within three (3) Business Days after request from the Department.
  - iii. The PIHP must provide written notice to the Department within ten (10) Business Days of any material changes, as determined by the PIHP to the PIHP Operating Plan.
    1. Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
    2. At the Department's discretion, the PIHP will be subject to a reevaluation and Readiness Review prior to approval of the amended PIHP Operating Plan.
  - iv. The PIHP shall provide the information necessary in response to any additional requests for information pursuant to this subsection as directed by the Department.
3. Readiness Review Requirements
    - a. The Department is committed to ensuring the PIHP is prepared and able to serve as a good administrator of Medicaid BH and I/DD services. The Department will engage in a thorough Readiness Review of the PIHP and shall include all areas identified in 42 C.F.R. § 438.66 and others to be identified by the Department. The Department shall use best efforts to combine to the greatest extent possible, components of the Readiness Review for the PIHP and BH I/DD Tailored Plan.
    - b. The Department and its partners will conduct a Readiness Review to verify the PIHP, its staff, providers, Subcontractors and other individuals and organizations are prepared to provide BH and I/DD services on behalf of the Department, consistent with the terms of the Contract and at the Department's discretion.
    - c. The PIHP shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a Readiness Review; the Department may require multiple rounds of Review.
      - i. The PIHP shall participate in Readiness Review(s) conducted by the Department to review the PIHP's readiness to begin and sustain operations throughout the term of the Contract.
        1. The requirements covered within the Readiness Review shall be determined by the Department and communicated to the PIHP at least fifteen (15) Calendar Days prior to the Readiness Review.
        2. The Department may determine, at its discretion, the frequency and intensity of the Readiness Review requirements and may tailor the particular Readiness Review to a specific issue or PIHP.
        3. The PIHP must meet these Readiness Review requirements and Contract requirements in the time frame specified by the Department.
      - ii. Readiness Reviews may include, but are not limited to, onsite reviews, desktop reviews, policy reviews, financial reviews, system demonstrations, staff interviews and self-audit evaluations.
    - d. The Department maintains the discretion to conduct Readiness Reviews on an ongoing basis as new program requirements are implemented or prior to the PIHP effectuating, for example, a material program, operational or technical change.

- e. Readiness Reviews are different and distinct from program integrity, program audits, quality reviews, routine oversight, or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.
  - f. Based upon results of the Readiness Review(s), the Department reserves the right to:
    - i. Offer acceptance to allow the PIHP to commence full operations;
    - ii. Offer conditional acceptance to allow the PIHP to commence operations if the PIHP is found not to meet certain requirements of the Readiness Review(s), so long as the PIHP develops and executes a Department-approved corrective action plan describing how it will meet Readiness Review criteria within the timeframe specified by the Department;
    - iii. Determine a remedy consistent with the terms of this Contract, including corrective action, liquidated damages or sanctions; or
    - iv. Terminate this Contract in accordance with *Section III.B.45. TERMINATION* of this Contract.
  - g. Prior to allowing a PIHP to be assigned PIHP members under this Contract, the PIHP shall demonstrate compliance with the Department's solvency requirements specified in *Section IV.K.2. Medical Loss Ratio*. If the PIHP uses the services of a Third-Party Administrator (TPA), the TPA shall be licensed. A copy of the TPA license shall be due upon request, but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Third-Party Administrator policies and procedures clearly state they apply to the PIHP, the Third-Party Administrator policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - h. As part of Readiness Review, the PIHP shall submit to the Department all required reports for approval prior to commencing operations or performing services according to the terms of this Contract.
  - i. The PIHP shall submit to the Department all policies and procedures that require review and/or approval or as requested by the Department within this Contract and defined in the Contract.
4. Non-discrimination for Services
- a. The PIHP shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:
    - i. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
    - ii. Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity and national origin;
    - iii. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
    - iv. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
    - v. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
    - vi. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
    - vii. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
    - viii. Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;



- ix. The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;
  - x. The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;
  - xi. The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and
  - xii. Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017 by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression.
- b. The PIHP shall not discriminate against Members, Providers, or employees in the provision of services or administration of the program.
  - c. The PIHP shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3).
  - d. The PIHP shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.
    - i. At a minimum, the Non-Discrimination Policy shall include:
      - 1. The definition of discrimination under federal law and regulation, as amended;
      - 2. How the PIHP will collaborate with all the Department's thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (i.e., Division of Services for the Deaf and Hard of Hearing);
      - 3. How the PIHP's policy will apply to clinical, marketing, and care management programs offered to Members;
      - 4. The PIHP's internal complaint process for Members and employees including penalties;
      - 5. The legal recourse, investigative, and complaint process available for Members through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and
      - 6. Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.
    - ii. The PIHP shall make the Non-discrimination Policy available for Department review, due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution. As long as the Non-discrimination Policy clearly states that it applies to the Non-discrimination Policy may apply to other LME/MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
    - iii. The PIHP shall make updates to its Non-discrimination Policy as necessary, and, at a minimum, the PIHP shall review its Non-discrimination Policy for updates annually.
    - iv. The PIHP shall make the Non-discrimination Policy available to Members and employees of the PIHP. Posting on Contractor's public-facing website shall be considered an acceptable means of making the Non-discrimination Policy available for purposes of the PIHP and the BH I/DD Tailored Plan.
5. Advance Directives
- a. The PIHP shall comply with all State and federal laws and regulations related to Advance Directives (including advance instructions for mental health treatment), including Article 23 of Chapter 90 of the General Statutes and Part 2 of Article 3 of Chapter 122C of the General Statutes.

- b. The PIHP shall maintain and implement written policies and procedures on Advance Directives for all adult members receiving care arranged by the PIHP. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a); Part 2 of Article 3 of Chapter 122C of the General Statutes. As long as the Advance Directives policy and procedures clearly state that they apply to the PIHP, they may apply to other LME/MCO operations, including, without limitation, the BH I/DD Tailored Plan Contract.
  - c. The PIHP shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change. 42 C.F.R. § 438.3(j)(4)
  - d. The PIHP shall be prohibited from conditioning the provision of care or otherwise discriminating against a Member based on whether or not the member has executed an Advance Directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).
  - e. The PIHP shall educate staff concerning their policies and procedures on Advance Directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).
  - f. The PIHP shall provide adult members with written information on Advance Directives (including advance instructions for mental health treatment), including the following:
    - i. Member rights under State law;
    - ii. PIHP policies with respect to the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives;
    - iii. Information on the advance directive policies of the PIHP;
    - iv. Each Member's right to file a grievance with the State Certification and Survey Agency for fully licensed services and the PIHP for unlicensed services concerning any alleged noncompliance with the advance directive law. Each Member has the right to report concerns to other applicable agencies such as Disability Rights North Carolina, licensing boards, etc.; and
    - v. Option to register his or her Advance Directive with the N.C. Secretary of State's Office so the Advance Directive can be available to medical professionals.
    - vi. The state shall supply to the PIHP a model enrollee handbook including provisions for members on how to exercise an Advance Directive. The PIHP's communications to adult members on the topic, as described above, must align with the information contained in the Member Handbook.
6. Staffing and Facilities
- a. Personnel required to perform the functions described in this section are not required to be dedicated solely to either PIHP or Tailored Plan functions and shall be permitted to perform functions for both entities, unless otherwise noted.
  - b. The PIHP shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The PIHP shall provide qualified persons in numbers appropriate to the PIHP's size of enrollment and consistent with the requirements to successfully operate the PIHP.
  - c. Except where expressly stated, the PIHP shall be permitted to utilize the same staff for both its PIHP and BH I/DD Tailored Plan. In such instance, the PIHP shall demonstrate upon request by the Department that responsibilities under this Contract are being met. Similarly, the PIHP may contract with a third-party (Subcontractor) to perform one or more of these responsibilities as outlined in *Section IV.A.3. Readiness Review Requirements*. In a format to be specified by the Department, the PIHP shall identify proportion of responsibilities across Medicaid Services fulfilled by key personnel to allow for appropriate cost allocation across services.
  - d. The PIHP shall be responsible for screening all employees and subcontractors to ensure these individuals have not been excluded from participation in federal health care programs, prior to employment or contract.

- e. The PIHP shall not employ or contract with an individual who has been 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 [42 C.F.R. 438.808(a); 42 C.F.R. 438.808(b)(3)(i); 42 C.F.R. 438.610(a); 1903(i)(2); 42 C.F.R. 1001.1901(c); 42 C.F.R. 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549].
- f. To support the Department’s vision on diversity, equity and inclusion, Contractor shall make a good faith effort to recruit, develop and retain a diverse workforce and encourage and promote an inclusive and equitable workplace, in accordance with Federal and State law.
- g. Key PIHP Personnel
  - i. The PIHP shall hire Key Personnel (defined in *Section IV.A.6. Table 1 Key Personnel Requirements for the PIHP*) and shall ensure these Key Personnel positions are filled for the duration of this Contract. Personnel described in this section may perform functions for both this Contract and the BH I/DD Tailored Plan. Key Personnel shall be identified and mapped to the Staffing Roles provided in *Section IV.A.6. Staffing and Facilities*. The PIHP shall include the name of the proposed individual to perform each role in a format provided by the Department. Any exceptions granted by the Department for Key Personnel for the BH I/DD Tailored Plan shall apply to this Contract, and PIHP shall not be required to resubmit or duplicate any exception requests for Key Personnel.
  - ii. Key Personnel shall be directly employed by the PIHP unless an exception request has been submitted and approved by the Department.
  - iii. Key Personnel that may be shared for both this Contract and the BH/DD Tailored Plan include the following as identified in *Section IV.A.6. Table 1 Key Personnel Requirements for the PIHP*.
  - iv. For Key Personnel positions that require the employee to reside in North Carolina, the Department shall consider the requirement met if the individual resides within forty (40) miles of the North Carolina border.

Section IV.A.6: Table 1. Key Personnel Requirements for the PIHP				
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Position May be Shared Across PIHP and BH I/DD Tailored Plan
1.	Chief Executive Officer (CEO) of North Carolina Medicaid	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Master’s degree from an accredited college or university</li> </ul>	Yes
2.	Chief Financial Officer (CFO) of North Carolina Medicaid	Individual responsible for accounting and finance operations, including financial audit activities	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting</li> </ul>	Yes

			<p>coursework from an appropriately accredited institution</p> <ul style="list-style-type: none"> <li>• Minimum of seven (7) years of progressive accounting experience, of which three (3) years are supervisory</li> </ul>	
3.	Chief Operating Officer (COO) of North Carolina Medicaid	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor's degree from an accredited college or university</li> <li>• Minimum of seven (7) years of experience in a managed care organization</li> </ul>	Yes
4.	Chief Medical Officer or Deputy CMO for the PIHP	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, population health and care management, and quality management.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must be a psychiatrist, fully licensed to practice in NC and in good standing.</li> <li>• Minimum of five (5) years of experience in a health clinical setting and five (5) years' experience in managed care</li> <li>• Clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience)</li> </ul>	<ul style="list-style-type: none"> <li>• May be the same staff member identified as the CMO or Deputy CMO of the BH I/DD Tailored Plan, if that staff member is a psychiatrist fully licensed to practice in NC</li> </ul>
5.	Chief Compliance Officer	Individual who oversees and manages all fraud, waste, and abuse and compliance activities	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor's degree from an accredited college or university</li> </ul>	Yes
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO)	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor's degree in information security or computer science from an accredited college or university</li> <li>• Must hold one of the following certifications: CISSP, CISM, or GSEC</li> </ul>	Yes

			<ul style="list-style-type: none"> <li>• Minimum of five (5) years of experience in health care</li> </ul>	
7.	Quality Director	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries</li> <li>• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO)</li> <li>• Certified Professional in Healthcare Quality (CPHQ) is preferred</li> </ul>	Yes, however, individual should report to the Chief Medical Officer for the PIHP for responsibilities within the scope of this Contract
8.	Utilization Management Director	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and the peer review functions of related member appeals.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Minimum of five (5) years of demonstrated utilization review and management experience in behavioral health and I/DD benefits</li> <li>• Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT)</li> </ul>	Yes; however, individual should report to the Chief Medical Officer for the PIHP for responsibilities within the scope of this Contract
9.	Provider Network Director	Individual responsible for provider services and provider relations, including all network development and management issues. Individual reports to the COO.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Minimum of five (5) years of combined network operations, provider relations, and management experience</li> </ul>	Yes
10.	Director of Population Health and Care Management	Individual responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including oversight of care management	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Minimum of five (5) years of demonstrated care management/population health experience in a healthcare organization serving Medicaid beneficiaries, including experience with BH and I/DD populations</li> </ul>	Yes

		provided by AMH+ practices and CMAs	<ul style="list-style-type: none"> <li>North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT)</li> </ul>	
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- h. The PIHP shall:
- i. Ensure that Key Personnel hold no more than one (1) position that is required by the Contract, with time limited exceptions for vacancies; as specified above all Key Personnel positions may be shared between the PIHP and BH I/DD Tailored Plan. The PIHP shall fill all Key Personnel positions no later than ninety (90) Calendar Days prior to Contract Year 1. As long as the Key Personnel Matrix policies and procedures clearly state they apply to the PIHP, Key Personnel Matrix policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - ii. Ensure all Key Personnel meet the Key Personnel role and minimum certification and/or credentialing requirements.
  - i. Key Personnel shall be available to meet during normal Business Hours at the Department’s requested location within one (1) business day’s notice from the Department unless they are able to provide good cause exceptions.
  - j. The Department may, at its sole discretion, notify Contractor that a Key Personnel providing services under this Contract is not meeting Department expectations, and request that Contractor remove the individual from the Key Personnel position. The notice shall include a detailed basis for the Department’s determination, which must satisfy the definition of “just cause” established under the North Carolina State Human Resources Act, Chapter 126 of the North Carolina General Statutes, and implementing rules at Title 25 of the North Carolina Administrative Code, Subchapter 1I, Service to Local Government. If the Key Personnel is the Chief Executive Officer, the notice shall be directed to the Chair of Contractor’s Board of Directors and the Chief Compliance Officer. Contractor shall have fifteen (15) Calendar Days to respond to the Department’s request and indicate whether it agrees with the just cause determination and accepts or declines to remove the individual from the Key Personnel position. The Department understands, agrees and acknowledges that if Contractor consents to remove the individual from a Key Personnel position, such removal shall constitute a demotion or dismissal as those terms are defined in Title 25 of the North Carolina Administrative Code, Subchapter 1I, and may be appealed by the individual pursuant to N.C.G.S. § 126-35(a). In such case, the Department agrees to cooperate with Contractor if the removed individual challenges the removal by filing a petition at the Office of Administrative Hearings, such cooperation to include, but not be limited to, providing supporting documentation and testimony.
  - k. The PIHP shall not permanently substitute Key Personnel without prior written approval by the Department. The PIHP shall inform the Department in writing within seven (7) Calendar Days of staffing changes in Key Personnel positions, including vacancies and interim staff fulfilling the role. The PIHP shall extend offers of employment to Key Personnel roles with permanent qualified replacements within ninety (90) Calendar Days of the departure of the former staff member. At no time, however, shall a Key Personnel Role be vacant. It is the PIHP’s responsibility to keep the role filled until the Department approves a substitution. The Department shall not withhold or delay such approval without good cause, which it must relay to the PIHP as soon as is practicable.
  - l. Upon contract execution and filling a Key Personnel vacancy, the PIHP shall demonstrate that PIHP staff proposed as Key Personnel have the proper credentials and experience to perform all duties

and responsibilities of that role. The PIHP shall provide the following to the Department for each position:

- i. Name;
  - ii. Role;
  - iii. Experience relevant to the services to be provided under this Contract;
  - iv. Resume;
  - v. North Carolina Residency; and
  - vi. Any certifications, licenses or credentials for the role where requested by the Department.
- m. Key Personnel resume and qualifications shall be due to the Department upon request, but no sooner than one hundred eighty (180) Calendar Days after contract execution.
- n. If the PIHP is unable to find a candidate for a Key Personnel Position that meets the required credentials or a permanent qualified replacement, the PIHP may submit an exception request for the Department's approval. The exception request shall include the proposed candidate and mitigation and reporting strategy to fulfill the full requirements of the Contract. The Department reserves the right to provide input on the mitigation and reporting strategy, specify conditions for approval, and request documentation and provide feedback on performance of the candidate.
- o. Organization Roles and Positions
- i. Personnel required to perform the functions described in this section are not required to be dedicated solely to the PIHP functions and shall be permitted to perform functions for the BH I/DD Tailored Plan unless otherwise noted and if said personnel complies with requirements imposed by the BH I/DD Tailored Plan.
  - ii. The PIHP shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Section VI. Attachment A. PIHP Organization Roles and Positions*.
  - iii. Member Services Staffing
    1. The PIHP shall adequately staff and operate its Member Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related to services for the populations covered by the PIHPs.
    2. The PIHP shall ensure that unlicensed Member staff are prohibited from providing health-related advice to members requesting clinical information and instead shall triage/refer such requests to licensed staff with appropriate clinical expertise in treating the member's condition or disease.
    3. Annually, all unlicensed Member services staff and management will submit an attestation that the staff and management understand and adhere to the requirements of the prohibition.
  - iv. Fraud, Waste and Abuse Staffing
    1. The PIHP shall establish a single point of contact to serve as a liaison with DHB and Medical Investigation Division (MID) and to facilitate timely response to Department requests for information, including claims data. This individual may be the same person who serves as the liaison for the BH I/DD Tailored Plan.
    2. The PIHP shall establish a custodian of records, who may be the same person who serves as the custodian of records for the BH I/DD Tailored Plan, to authenticate the business records of the PIHP, provide the business records of the PIHP to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:
      - a. Made at or near the time of the events by a person with knowledge;
      - b. Kept in the normal course of regularly conducted business activity; and

- c. Made in the regular practice of the PIHP's business activity.
- v. The PIHP shall submit resumes for any employee or subcontracted employee upon request by the Department.
- vi. The PIHP shall provide an updated Business Continuity Plan with a detailed staffing contingency plan in the event of public health emergencies, natural disasters, sudden and unexpected increases in enrollment, and service area expansions, with a description on how the plan shall be implemented and coordinated with the Department, upon request by the Department. As long as the Business Continuity Plan clearly states that it applies to the PIHP, the Business Continuity Plan may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan Contract.
- vii. The PIHP shall provide staffing levels, hiring, layoff activity, and plans upon request by the Department.
- viii. PIHP staff with prior professional experience providing diversion, In-reach or transition services under TCL who do not meet the minimum credentials for "Transition Coordinator" or "Diversion Specialist" as defined in *Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions* shall be permitted to fill the "Transition Coordinator" or "Diversion Specialist" role.
- p. Physical Presence in North Carolina
  - i. The PIHP shall have a physical presence in North Carolina by having one or more offices located in the PIHP's catchment area.
  - ii. The PIHP shall establish an office in North Carolina within ninety (90) Calendar Days after Contract Execution that shall be maintained for the duration of the Contract.
  - iii. The Inbound Deliverable to record this shall be due to the Department due upon request but no sooner than one hundred (180) Calendar Days after Contract Execution
  - iv. The PIHP shall begin implementing call center(s) in North Carolina within ninety (90) Calendar Days after Contract execution and ensure call center(s) are established for Readiness Review.
  - v. The Department requires the PIHP establish an office that serves to support care management and care coordination functions and member, provider, and stakeholder engagement requirements of the Contract by PIHP launch within one hundred fifty (150) Calendar Days of Contract execution. This may be the same office as that described in *Section IV.A.6.o.ii.*, above.
  - vi. Additionally, the following personnel and roles, at a minimum, shall reside and/or perform their functions from within the State of North Carolina (as found in *Section VI. Attachment A. PIHP Organization Roles and Positions*). The Department shall consider this requirement to be met if the individual filling the role resides within forty (40) miles of the North Carolina border. All PIHP personnel, regardless of residence must be fully able to fulfill their scope of work as outlined in the contract. All personnel approvals and exceptions issued by the Department to any Tailored Plan for Tailored Plan contract operations shall apply equally to this PIHP Contract.
    1. Readiness Review Staff;
    2. Supervising Care Managers;
    3. Care Managers;
    4. Care Management Housing Specialist(s);
    5. Transition Supervisor(s);
    6. Transition Coordinator(s);
    7. Peer Support Specialist(s);
    8. In-Reach Specialist(s);
    9. System of Care Family Partner(s);
    10. System of Care Coordinator(s);



11. DSOHF Admission Through Discharge Managers;
12. Member Appeal Coordinator;
13. Member Grievance Coordinator;
14. Member Grievance Staff;
15. Member Appeal Staff;
16. Member Services and Service Line Staff;
17. Provider Relations and Service Line Staff;
18. Provider Network Relations Staff;
19. Provider Complaint, Grievance Coordinator;
20. Provider Appeal Coordinator;
21. Utilization Management Staff;
22. I/DD Utilization Management Staff;
23. Tribal Provider Contracting Specialist, if applicable;
24. Liaison between the Department and the MID;
25. Special Investigations Unit Lead;
26. Special Investigations Unit SIU Staff;
27. Liaison to the DSS; and
28. Waiver Contract Manager.

q. Conflict of Interest

- i. The PIHP shall verify that its employees, directors, and Subcontractors comply with all applicable federal and State conflict of interest laws due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C.
- ii. The PIHP shall undertake reasonable actions to verify that employees or Subcontractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, State, or county money under the North Carolina Medicaid or NC Health Choice programs, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.
- iii. The PIHP and its employees and directors shall:
  1. Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee (or such employee's spouse or minor child) if such Department employee participated personally and substantially in the procurement of the PIHP's contract or the oversight of such contract as a Department employee.
  2. Not promise or give a gift to any Department employee or any family member of a Department employee.
  3. Fully and completely disclose to the Department any situation that may present a conflict of interest.
  4. Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.
  5. Not solicit or obtain from the Department any non-public information relating to the Department's criteria or processes for evaluating bids to enter into or renew a PIHP contract.
- iv. The PIHP shall verify that financial considerations do not influence decisions to provide Medically Necessary care.
- v. The PIHP shall validate that all its employees, directors, Subcontractors or owners who are fully licensed providers abide by their professional obligations to their members and shall not take any actions which conflict with such obligations.

- vi. The PIHP shall not serve as a legal guardian or representative payee for any of its Members.
- vii. No official or employee of the PIHP shall acquire any personal interest, direct or indirect, in any provider or vendor contracted with State or federal funds that would be considered a conflict of interest under this Contract.
- viii. The PIHP Board of Directors, advisory committees, employees, volunteers, agents, and contractors shall not participate in clinical or administrative activities or decision in which there is or may be a conflict of interest.
- ix. As required by N.C. Gen. Stat. § 143B-139.6C, the PIHP shall not use a former Department employee, director, or contractor in the administration of its PIHP contract for six (6) months after such person's employment or contract with the Department is terminated, if such person personally participated in the following activities:
  - 1. The award of a contract to the PIHP;
  - 2. An audit, decision, investigation, or other action affecting the PIHP; or
  - 3. Regulatory or licensing decisions that applied to the PIHP.
- x. The PIHP shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices. The PIHP shall submit its written Conflict of Interest Policy for its employees to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution. As long as the Conflict of Interest Policy clearly states that it applies to the PIHP, the Conflict of Interest Policy may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.

7. Subcontractors

PIHP may use Subcontractors to perform the PIHP's obligations under this Contract in accordance with *Section III.B.42. SUBCONTRACTORS*. The following Subcontractors are approved as of the Execution Date of this Contract.

**PIHP specific subcontractor information is found within the individual PIHP's executed contract.**

Subcontractor Name	Summary of Services

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## B. Program Operations

1. Service Lines
  - a. The PIHP may utilize the same staff and service lines as it does for the BH I/DD Tailored Plan to perform the operations described in this Section.
  - b. All service lines shall be staffed with personnel specifically trained on the requirements, policies and procedures of the North Carolina market and can resolve an applicable inquiry or issue in “one-touch.”
  - c. The PIHP shall establish the following service lines as part of its call center:
    - i. **Member Service Line:** To enable Members to conveniently access information about benefits or claims, referral assistance and access to treatment or services.
    - ii. **Provider Support Service Line:** To assist PIHP providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries, and complaints.
    - iii. **Behavioral Health Crisis Line:** To provide Members with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year, which is confidential, toll-free, and provides emergency referral with immediate access to trained, skilled, licensed BH professionals who provide assistance for any type of BH issue the member may be experiencing and offers assistance in linking members to supportive available community resources. In addition to accessing call recordings in real time, the PIHP shall maintain a record of telephonic crisis line calls, including date of the call, type of call, and disposition and make available to the Department upon request.
  - d. The PIHP shall adhere to the Department’s hours of operations, location, and staffing and Member ID requirements for each service line as described in Section IV.B.1. Service Lines. The PIHP shall adhere to hours of operations regardless of holidays.

Section IV.B.1. Table 1: Member and Provider Support Call Center Operations			
Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Date Service Line Required to be Active
1. Member Service Line	<ol style="list-style-type: none"> <li>a. Non-emergency member issues: Monday – Saturday: 7AM – 6PM ET, including State holidays for member questions and additional hours as required by the Department during times of expected high volume (e.g., PIHP and BH I/DD Tailored Plan launch)</li> <li>b. Emergency member issues: open twenty-four (24) hours per day/seven (7) days per week</li> </ol>	Yes	Later of 12/1/2022 or when services begin under the Contract

2. Provider Support Service Line	a. Monday – Saturday: 7AM – 6PM ET including State holidays	Yes	Later of 12/1/2022 or when services begin under the Contract
3. Behavioral Health Crisis Line	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	Yes	Later of 12/1/2022 or when services begin under the Contract

- e. The PIHP service lines shall be accessible via a toll-free telephone line. The PIHP shall establish and maintain a direct inward dialing (DID) number for each required service line to allow for Warm Transfers between the PIHP, the Department and other Department vendors.
- f. The PIHP services lines shall have capacity to handle:
  - i. All inbound and outbound telephone calls during the hours of operation as defined in this Section;
  - ii. Calls from members and providers with limited English proficiency, as well as members and providers with communications impairments, including individuals with hearing and/or speech disabilities;
  - iii. Technology needed to receive calls from deaf, hard of hearing and Deaf-Blind callers to include TTY, captioned phones and amplified phones;
  - iv. After-hours calls for Member Services Line and Provider Support Service Line, including:
    - 1. Accepting, recording or providing instruction in response to incoming calls during non-business hours;
    - 2. Allowing option to leave a message and request for call back for all lines with the exception of the BH Crisis Line;
    - 3. If a request for a call back is made, the return phone call shall be made the following Business Day during normal hours of operations; and
    - 4. Department approval of the after-hours message.
  - v. An Automated Voice Response System (AVRS) which:
    - 1. Interacts with the Member through voice and numeric prompts and allows Members to perform self-service activities and resolve simple inquiries without the need to interact with a live person;
    - 2. May prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the Member prior to the call being distributed to a call center representative;
    - 3. The AVRS must have the capability of allowing non-enrolled individuals and providers to access service line staff;
    - 4. Offers user-friendly options that are easily understood by members and authorized representatives (including a decision tree illustrating AVRS system);
    - 5. Works in conjunction with an Automated Call Distributor (ACD) which intelligently routes and effectively manages all calls to appropriate and available staff:
      - i. When a Member desires to speak with a live person; and
      - ii. Based on unique member needs (i.e., caller language needs).
  - vi. Ensures adequate staffing and capacity to meet the service line performance standards defined in the Contract.

- g. The PIHP shall be permitted to use a surge staffing pattern or contract with secondary call centers to meet capacity requirements or to augment services provided as defined in this Section. All call centers shall be held to the same service line performance standards as defined within the Contract, unless the Department has approved an exception as provided in this Section.
- h. The PIHP shall be permitted to provide educational messages or other messages that improve the customer experience (e.g., announcement of new program changes or reminders) while callers are on hold, as directed or approved by the Department. Callers to the Behavioral Health Crisis Line shall not be placed on hold.
- i. All PIHP service lines shall be able to transfer calls via Warm Transfer to the Department's NC Medicaid Direct provider and beneficiary call centers, Enrollment Broker, Ombudsman, county DSS or EBCI Public Health & Human Service (PHHS) offices, Standard Plans, BH I/DD Tailored Plans, Child and Families Specialty Plan, EBCI Tribal Option, Community Care of North Carolina, and PIHPs when appropriate and without impacting the capacity to handle inbound calls simultaneously.
  - i. The Warm Transfer is required only during the operational hours of the entities listed above in Section IV.B.1. Service Lines.
  - ii. If the service line is attempting to connect a member to another entity that is closed, the PIHP shall provide the information on how the caller may contact the entity directly during their operating hours.
- j. All PIHP services lines shall be able to transfer calls via Warm Transfer to all other PIHP service lines, when appropriate.
- k. The PIHP shall digitally record and store and make available one hundred percent (100%) of incoming and outgoing Member Service Line, Provider Service Line and Behavioral Health Crisis Line calls for quality assurance purposes for a period of no less than twelve (12) months from the date of the call including subcontractors. These calls must be searchable via call recording metadata including at least service line, caller phone number, time, and date.
- l. The PIHP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge, as defined in Section IV.B.3. Staff Training, on North Carolina Medicaid, and NC Health Choice as defined within this Contract.
- m. The PIHP shall acquire the necessary phone number(s) to support the requirements of this section due upon request, but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Service Line Phone Numbers policies and procedures clearly state they apply to the PIHP, the Service Line Phone Numbers policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plans Plan contract.
  - i. The PIHP shall relinquish ownership of the toll-free number(s) upon Contract termination or expiration, at which time the Department shall take title of these telephone numbers.
  - ii. All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the PIHP and shall be paid prior to the Department taking title.
- n. The PIHP shall develop service line scripts for use by PIHP staff when talking with members, authorized representatives, and providers.
  - i. All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies, and procedures of the North Carolina market.
  - ii. The PIHP shall submit to the Department for approval a listing of topics which scripts will address and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
    - 1. Member resources, education and assistance to understand Medicaid and NC Health Choice benefits and benefits available through the PIHP and physical health services in NC Medicaid Direct;

2. Resources, education, and assistance to understand State-funded services;
  3. PIHP benefits;
  4. PIHP Network;
  5. Service prior authorization process and status;
  6. Member Grievances, Complaints and Appeals processes, including information on available member supports;
  7. Care Management and Care Coordination services;
  8. Unmet Health-Related Resource Needs and the NCCARE360 resources;
  9. Provider contracting;
  10. Provider claim submission and adjudication issues;
  11. Ombudsman program;
  12. Transitions of Care; and
  13. Other topics as identified by the Department.
- iii. All Member Service Line, Provider Service Line and Behavioral Health Crisis Line scripts are due no sooner than ninety (90) Calendar Days after launch, and they shall be approved by the Department. All service line scripts are due to the Department upon request and when any Significant Changes are made.
- o. The PIHP shall document all call center interactions with members authorized representative and providers. The record of contact must include:
- i. Current or potential member's name;
  - ii. Medicaid/NC Health Choice identification number (preferred);
  - iii. Channel of interaction/Service Line;
  - iv. Phone number; and emergency or alternative number, if needed
  - v. Notes summary of current or potential member interaction (e.g., summary of issue, if issue was resolved or addressed, what information was provided by the PIHP's representative);
  - vi. Record of the time and date of interaction;
  - vii. Contact agent;
  - viii. Resolution and/or if additional follow-up is or was required; and
  - ix. Interpreter requests and the language requested.
- p. The PIHP shall develop and maintain a Call Center and Service Line Policy that defines how the PIHP will meet and maintain the requirements of the Contract. The Call Center and Service Line Policy shall be made available and due, upon request, but no sooner than one hundred eighty (180) Calendar Days after contract execution to the Department. As long as the Call Center and Service Line Policy clearly states that it applies to the PIHP, the Call Center and Service Line Policy may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract. The Call Center and Service Line Policy shall include at a minimum:
- i. Service line process flows and call-tree routing options;
  - ii. Service line script topics;
  - iii. Staffing and licensure requirements;
  - iv. Quality assurance and monitoring approach;
  - v. Member and Provider issue tracking and resolution process; and
  - vi. Incorporation of member and provider issues into broader PIHP QI activities.
- q. Member Service Line:
- i. Emergency member issues shall be defined as a Member having an Emergency Medical Condition or in need of emergency services.
  - ii. The Member Services Line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined

in Section IV.E.3. Member Engagement. Notwithstanding the preceding Warm Transfer requirements in Section IV.B.1. Service Lines, the PIHP Member Service Line must be able to connect to the PIHP Behavioral Health Crisis Line via a Warm Transfer twenty-four (24) hours per day, seven (7) days per week.

- r. Behavioral Health Crisis Line:
    - i. Must be staffed with licensed BH professionals.
    - ii. Must be able to address mental health, SUD, and I/DD-related crisis events.
    - iii. Must immediately connect to the crisis response systems.
    - iv. Must have patch capabilities to 911 emergency services. In instances where there is immediate danger to self or others, the PIHP shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
    - v. Must follow up with the Member's care manager, as relevant, to share relevant clinical and follow up information.
    - vi. Must not:
      - 1. Allow Members to receive a busy signal;
      - 2. Allow Member calls to be answered by an automated response;
      - 3. Allow Members to leave messages and receive a call back;
      - 4. Shift calls to an overflow system during high volume call times; or
      - 5. Allow maximum call duration limits.
  - s. In all communications with Members, and their families, the PIHP shall comply with HIPAA and all other applicable confidentiality provisions set forth in State and federal law. The PIHP shall:
    - i. Respond appropriately to inquiries by Members, and their family members (including those with limited English proficiency);
    - ii. Connect Members, family members, and stakeholders to crisis services, when clinically appropriate, twenty-four hours (24) per day, seven (7) days per week, 365 days per year;
    - iii. Provide information to members and their family members on where and how to access BH services; and
    - iv. Train its staff to recognize third-party insurance issues and member, grievances and appeals and to route these issues to the appropriate individual or PIHP department.
    - v. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers, if applicable. The PIHP is required to submit a request to the Department for review and approval for a call center used by the PIHP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract. The PIHP shall not be allowed to request, for Department review and approval, any exceptions for overflow call centers.
    - vi. Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the three (3) service lines specified in the Contract.
2. Staff Training
- a. The PIHP shall meet the Department's goals and objectives of providing support and services to meet Member and provider needs by training and educating PIHP staff and contractors on the requirements, policies and procedures of PIHP and the unique needs of Members, or by contracting with a qualified training entity (as described in this section and in other sections in the contract). The PIHP and BH I/DD Tailored Plan may combine its training modules to the extent the training goals and objectives are substantially similar.

- b. As long as the training clearly states that it applies to the PIHP, any such training described in this Section may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
- c. The PIHP shall require all staff to complete implicit bias training, inclusive of race, ethnicity, and religion in health care, gender and class bias.
- d. The PIHP shall participate in Department initiatives to educate staff and providers about implementation activities, including but not limited to:
  - i. Assistance with the development of call center scripts;
  - ii. Participation in Department-sponsored educational activities; and
  - iii. Integration of Department developed implementation-related content into Member- and Provider-facing educational materials.
- e. The PIHP shall ensure that staff and contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under the Contract. Staff having contact with Members, Providers, the Department or the county Departments of Social Services staff shall receive training regarding the appropriate identification and handling of questions and concerns.
- f. The PIHP shall begin training new staff to the PIHP within seven (7) Calendar Days of their start date and complete within sixty (60) Calendar Days, unless otherwise approved by the Department.
- g. The PIHP shall conduct due process training at least annually for all relevant staff.
- h. The training program shall include distinct training for:
  - i. Member services staff and contractors;
  - ii. Provider relations staff and contractors;
  - iii. Staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators; and
  - iv. Staff and contractors whose work integrates with the Department.
- i. The PIHP shall be responsible for ensuring training directed toward member staff and contractors include, but are not limited to:
  - i. Overall understanding of PIHP services and functions, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
  - ii. Services which the PIHP is required to make available to all Members;
  - iii. Services that are not covered by the PIHP that are covered by NC Medicaid Direct
  - iv. Differences between NC Medicaid Direct and Medicaid Managed Care
  - v. Differences between the PIHP and BH I/DD Tailored Plan, including who is eligible for each
  - vi. State-funded services
  - vii. Awareness of:
    - 1. All supports and services that may be appropriate for the Member;
    - 2. Unique needs of the Member populations;
    - 3. Stakeholders who may interact with Members;
    - 4. Other programs that serve distinct populations;
    - 5. The role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to members' health and health care needs; and
    - 6. Benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI.
  - viii. Awareness of and sensitivity to:
    - 1. Different cultural health beliefs and practices;
    - 2. Low-socioeconomic individuals and/or families;



3. Individuals with disabilities;
  4. Learning preferences to receiving information;
  5. Health disparities for Historically Marginalized Populations; and
  6. Individuals with trauma.
- ix. Ability to communicate appropriately with individuals in need of communication and language assistance. Use of interpreters, sign language interpreters both in-person and through video remote interpreting, Relay Video Conferencing Captioning, video relay services, 711 relay services, TTY machines, or assertive communication devices;
  - x. Member rights and responsibilities;
  - xi. Member Grievances and Appeals processes, including State Fair Hearing Process;
  - xii. The PIHP's Provider networks;
  - xiii. Overcoming barriers to accessing medical care (to the degree those resources are available and known by the PIHP);
  - xiv. Linking Members to other state and local programs or assistance, including but not limited to social services, State-funded BH services, law enforcement and the criminal justice system;
  - xv. Fraud, waste, and abuse detection, investigation, and prevention;
  - xvi. Process for offering suggestions to improve the Member or Provider experience;
  - xvii. Unique needs, experiences of Members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:
    1. The significance of extended families including an understanding that the definition of extended families is different than non-native families;
    2. The potential services available for family members of enrolled members in EBCI or other federally recognized tribes;
    3. Some blended families may be trilingual (English, Cherokee or other American Indian languages, and Spanish); and
    4. Respect for traditions where gender and age may play an important role;
    5. Elders have a highly respected status due to their life experiences;
    6. Elders tend to be non-verbal;
    7. Pregnant individuals; and
    8. Veterans.
  - xviii. The different service types and benefit plans available through the EBCI Tribal Option; and
  - xix. HIPAA and the Department's privacy and security requirements.
- j. The PIHP shall be responsible for training care managers and supervising care managers as described in *Section IV.B.3. Staff Training*.
  - k. The PIHP shall be responsible for ensuring training directed towards provider relations staff and contractors include, but are not limited to:
    - i. Understanding of:
      1. PIHP, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
      2. Unique needs of member populations; and
      3. Learning preferences to receiving information.
    - ii. Services that are not covered by the PIHP that are covered by NC Medicaid Direct;
    - iii. Differences between NC Medicaid Direct and Medicaid Managed Care;
    - iv. Differences between the PIHP and BH I/DD Tailored Plan, including who is eligible for each;
    - v. State-funded services;
    - vi. Awareness of:
      1. All supports and services that enhance the provider experience;

- 2. Stakeholders who may interact with providers; and
  - 3. Other programs that serve distinct populations.
- vii. Awareness and sensitivity to:
    - 1. Different cultural health beliefs and practices; and
    - 2. Individuals with trauma.
  - viii. EPSDT criteria for Members, within the scope of the PIHP's responsibilities;
  - ix. Provider rights and responsibilities;
  - x. Fraud, waste, and abuse detection, investigation, and prevention;
  - xi. Use of interpreters, sign language interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, or assistive communication devices;
  - xii. Unique needs and requirements of Indian Health Care Providers; and
  - xiii. HIPAA and the Department's privacy and security requirements.
- l. The PIHP shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators include, but are not limited to:
    - i. Overall understanding of the PIHP's core functions and responsibilities, including program eligibility, benefits, services, cost sharing, key initiatives and priorities, and program goals;
    - ii. Overall understanding of the unique needs of member populations;
    - iii. Awareness of member supports and services;
    - iv. Member rights and responsibilities;
    - v. Member Grievances, and Appeals processes;
    - vi. Awareness of other programs that serve distinct populations;
    - vii. Fraud, waste, and abuse detection, investigation, and prevention; and
    - viii. HIPAA and the Department's privacy and security requirements.
    - ix. Overall understanding of the Innovations waiver
    - x. Tailored Care Management eligibility criteria
    - xi. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.
  - m. The PIHP shall be responsible for ensuring training directed towards staff and Subcontractors whose work integrates with the Department includes topics identified for all other training programs as described above, including, but not limited to an overall understanding of PIHP, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals
  - n. Submission and Approval
    - i. Upon request, but no sooner than one hundred eighty (180) Calendar Days after Contract Execution, the PIHP shall submit a Staff Training and Evaluation Program to the Department.
      - 1. The training program shall comply with all state and federal provisions and should utilize Department resources where available.
      - 2. Each training program shall be approved by the Department before use with PIHP staff and contractors.
      - 3. The PIHP shall initiate training within five (5) Calendar Days of approval by the Department.
      - 4. As long as the Staff Training and Evaluation Program and its related policies and procedures clearly state they apply to the PIHP, they may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

- ii. Training materials shall include, but are not limited to:
    - 1. Training policies and procedures;
    - 2. Training plan;
    - 3. Training curriculum; and
    - 4. Evaluation methodology.
  - iii. The PIHP shall update the training materials and conduct training of its staff and contractors annually, as changes are made to PIHP, in response to improving the member experience, improving the provider experience, improving staff and contractor performance, and/or as requested by the Department.
  - iv. The PIHP shall submit material updates and changes to the Department for review and approval before use with PIHP staff and contractors.
  - o. The PIHP must collaborate with the Department on providing training to the Department, county DSS staff, the EBCI, and the Ombudsman program.
    - i. Training must:
      - 1. Be completed at least ninety (90) Calendar Days prior to PIHP launch;
      - 2. Be hosted at multiple locations as defined by the Department or be held virtually;
      - 3. Contain information on the role of the PIHP;
      - 4. Describe the relationship and integration of the PIHP with the Department, county DSS staff, the EBCI PHHS, and the Ombudsman program; and
      - 5. Describe how to navigate the public facing websites.
    - ii. Materials for the training must be provided to the Department no later than thirty (30) Calendar Days prior to scheduled events for review. Training events may take place in person, virtually, using an on-demand recorded webinar, through distributed materials, or any other vehicle in which the PIHP is able to communicate its content to staff and contractors.
  - p. No later than fourteen (14) Calendar Days after identification, the PIHP shall update any materials publicly posted on the PIHP's website that are inconsistent with the terms of this subsection or inconsistent with any trainings provided by the Department.
  - q. In support of the Department's health equity goals, the PIHP shall establish and maintain a Health Equity Council that reports to the CEO no less than quarterly. The council members shall be reflective of the diverse populations served by the PIHP and at a minimum:
    - i. Identify and analyze health disparities through review of utilization and quality data,
    - ii. Address stakeholder representation and engagement improvements,
    - iii. Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid members,
    - iv. Develop new initiatives that would address health disparities, and
    - v. Examine existing policies that can be amended to improve health equity and reduce health disparities,
    - vi. As long as the Health Equity Council clearly covers PIHP operations, the Council may also be used to meet requirements for other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
3. Reporting
- a. The PIHP shall comply with all the reporting requirements established by the Contract.
  - b. The Department shall provide the PIHP with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in Section VI. Attachment I. Reporting Requirements.
  - c. The Department may, at its discretion, change the content, format or frequency of reports or require the PIHP to submit additional reports both ad hoc and recurring. The Department shall provide written notice of the proposed change at least thirty (30) Calendar Days in advance of the

change's effective date through posting on the PCDU. As applicable, all notices should include the updated reporting template and any sample data requests for the PIHP to send to its staff, contractors, contracted providers, or any other entity as appropriate.

- d. If the Department requests any revisions to the reports already submitted, the PIHP shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.
  - e. The PIHP shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.
  - f. The PIHP shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.
  - g. Except as otherwise specified, all reports shall be specific to each catchment area covered by this Contract.
  - h. The PIHP shall provide all necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements including in the administration of North Carolina's 1915(b), 1915(c), and 1115 waivers, 1915(i) option, and SPAs by supporting the Department in monitoring PIHP progress towards clinical quality and outcomes goals and maximizing federal match of state funds.
  - i. Upon request, the PIHP shall provide the Department with all underlying data required to produce reports required under the Contract.
4. PIHP Policies
- a. The PIHP shall develop policy documents outlining key business processes, procedures and staffing requirements as required in this Contract.
  - b. Each policy document shall include:
    - i. Processes and procedures;
    - ii. Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
    - iii. Define required PIHP and Department systems;
    - iv. Role of Subcontractors; and
    - v. Describe PIHP's continuous improvement approach to update policies.
  - c. All required PIHP policies are outlined in the Contract. The PIHP shall submit policy documents to the Department for review and approval as defined in the Contract.
  - d. After initial approval, the PIHP shall submit any material modifications, additions, or deletions of all Medicaid policies to the Department at least thirty (30) Calendar Days prior to implementation, unless another time frame has been specified in the Contract.
5. Business Continuity
- a. The PIHP shall develop and maintain a Business Continuity Plan that is acceptable to the Department and demonstrates the adequacy of the Plan at the Department's request. The PIHP shall adhere to all applicable published Department privacy and security policies, (located at <https://it.nc.gov/documents/statewide-information-security-manual> and <https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals/security-manual>), and all other requirements set forth in the Contract.
  - b. As long as the Business Continuity Plan clearly states it applies to Medicaid Direct, the Business Continuity Plan may apply to other PIHP operations, including without limited the BH I/DD Tailored Plan Contract.
  - c. The PIHP shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following the occurrence of a natural or manmade disaster or state of emergency. The PIHP shall meet recognized industry standards for security and disaster recovery requirements.

- d. The PIHP shall identify disaster or emergency situations that can result in a major failure or disruption in care, including but not limited to fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic.
- e. As part of the PIHP's business continuity planning, the PIHP shall identify and review all federal or State disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Execution to inform future disaster or emergency planning.
- f. The PIHP shall provide disaster or emergency-related care coordination for high-risk Medicaid members, defined as members who would have otherwise been eligible for BH I/DD Tailored Plan if they were not part of a group delayed or excluded from Medicaid managed care or members with a behavioral health transitional care need, as described in Section IV.G.4. Care Coordination for Members with Transition Care Need during three (3) emergency timeframes, as applicable:
  - i. Pre-Emergency:
    - 1. Incorporate disaster planning in the care planning process; and
    - 2. Increase member outreach to ensure that members have adequate shelter, access to support to address their Unmet Health Related Resource Needs, access to back-up equipment and/or caretaker training if equipment fails or refer member to local DSS office to help member arrange NEMT for evacuation if the member is unable to safely shelter in place.
  - ii. During an Emergency:
 

Continue to check-in on high-risk members to ensure safety, and access to supports to address their Unmet Health-Related Resource Needs; and
  - iii. Post-Emergency:
 

Check-in on high-risk members to ensure they were able to shelter safely and identify additional behavioral or medical needs, or Unmet Health-Related Resource Needs.
- g. The PIHP shall comply with any additional requirements released by the Department to ensure continuity of care during a public health emergency, epidemic or pandemic, including those related to care coordination, care management, and supports to address their Unmet Health-Related Resource Needs.
- h. PIHPs shall comply with any additional guidance released by the Department during any type of disaster or emergency, including guidance on provider payments.
- i. When directed by the Department during a disaster or emergency, the PIHP shall ensure continuity by:
  - i. Offering extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries.
  - ii. Removing and/or reducing required prior authorizations and concurrent review services;
  - iii. Providing emergency BH services to Medicaid members residing in shelters; and
  - iv. Providing all Medicaid members with access to out-of-network and Telehealth providers.
- j. The PIHP shall support the Department's priorities for state-wide and local disaster or emergency planning and response including:
  - i. Participation in the development of community disaster emergency response plans;
  - ii. Collaboration with other State department vendors to align efforts, as needed;
  - iii. Appointment of at least one representative to the statewide disaster or emergency planning and response efforts; and
  - iv. Recruitment and training for in-network Medicaid BH and I/DD providers to staff disaster shelters; and
  - v. Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.

- k. Upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution, the PIHP shall submit its Business Continuity Plan for all requirements specified in the Contract, including:
  - a. The preventive measures that would be instituted to minimize impact;
  - b. The back-up, off-site storage, and other pre-disaster or emergency safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
    - 1. Descriptions of the controls for back-up processing, including how frequently backups occur;
    - 2. Documented back-up procedures;
    - 3. The location of data that has been backed up (off-site and on-site, as applicable);
    - 4. Identification and description of what is being backed up as part of the back-up plan;
    - 5. Any change in back-up procedures in relation to the PIHP's technology changes;
  - c. A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and
  - d. Approach for providing care coordination activities to high-risk members in accordance with Section IV.B. 6. Business Continuity;
  - e. Approach for ensuring continuity of care during an emergency for members in accordance with Section IV.B. 6. Business Continuity;
  - f. Approach for supporting the Department's priorities for statewide and local disaster or emergency planning in accordance with Section IV.B. 6. Business Continuity;
  - g. Processes to provide information and resources to Medicaid members on how to protect themselves during a disaster or emergency and assist members with understanding how and when to access Medicaid benefits;
  - h. Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a member;
  - i. Processes to ensure that providers deliver all necessary care to Members during a disaster or emergency;
  - j. Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
  - k. Approach to supporting providers in the event of provider revenue disruptions;
  - l. Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
  - m. The tasks that would be involved in implementing the Business Continuity Plan, and identify by job description or title the PIHP's staff and the Department's staff involvement;
  - n. Current contact information for all critical staff and relevant personnel;
  - o. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternate worksite locations;
  - p. The timeframe required to accomplish full recovery from the point of interruption;
  - q. A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
  - r. The procedures for coordinating with the Department in the event of a disaster or emergency;
  - s. Notification procedures (call trees);
  - t. Employee training and awareness detailing activation process;
  - u. Document recovery time results;
  - v. Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results; and

- w. The procedures for notifying the Department, members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.
- l. The Business Continuity Plan should be marked as follows: “Confidential information – Not subject to public disclosure under G.S. §132” to prevent such document from being produced in a response to public record’s request.
- m. The PIHP shall update the Business Continuity Plan as necessary, every six (6) months at minimum.

## C. Compliance

### 1. Compliance Program

- a. The PIHP may utilize the same staff and services as it does for the BH I/DD Tailored Plan to perform the operations described in this Section.
- b. The PIHP shall implement a comprehensive Compliance Program focused on ensuring the PIHP is in compliance with all applicable federal and State laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.
- c. The PIHP’s Compliance Program shall comply with 42 C.F.R. § 438.608, and must include:
  - i. Written policies, procedures, and standards of conduct that articulate the PIHP’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and State requirements, including:
    - i. Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the PIHP, including termination of the provider agreement with the PIHP. 42 C.F.R. § 438.608(a)(4).
    - ii. Retention policies for the treatment of recoveries of all overpayments from the PIHP to a Provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i).
    - iii. Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the PIHP is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii).
    - iv. Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).
    - v. Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5).
    - vi. Process for Providers to report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2).
  - ii. The designation of a Chief Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors.
  - iii. The establishment of a Regulatory Compliance Committee of the Board of Directors at the senior management level charged with overseeing the PIHP's Compliance Program and its compliance with the requirements under the Contract. The Regulatory Compliance Committee may serve as the committee for both the PIHP and the BH I/DD Tailored Plan.

- iv. A system for training and education for the Compliance Officer, the PIHP's senior management, and the PIHP's employees on the federal and State standards and requirements under the Contract.
  - v. Effective lines of communication between the Compliance Officer and the PIHP's employees.
  - vi. Enforcement of standards through well-publicized disciplinary guidelines.
  - vii. Identification of potential and actual compliance risks.
  - viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.
- d. The PIHP shall develop a Compliance Plan which defines the PIHP's Compliance Program. As long as the Compliance Plan clearly states it applies to the PIHP, the Compliance Plan may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- i. The PIHP shall provide the Compliance Plan to the Department:
    - i. As part of the Implementation Plan, during Readiness Review;
    - ii. Due, upon request by the Department, but no sooner than one hundred eighty (180) Calendar Days after Contract Execution; and
    - iii. Annually thereafter.
  - ii. The PIHP shall revise the Compliance Plan as requested by the Department.
  - iii. The PIHP shall submit any requested document within five (5) Calendar Days of the Department's request to review the PIHP's Compliance Plan, and any other policy or procedures governing the PIHP's compliance activities.
    - 1. Annually, the PIHP shall develop monitoring and auditing work plan(s) for the upcoming year. The PIHP shall submit a Compliance Program report describing the work plans for the upcoming year.
      - i. The report shall be submitted upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Compliance Program Report policies and procedures clearly state they apply to the PIHP, Compliance Program Report, policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
    - 2. Following Contract Year 1 of PIHP, the Compliance Program report shall include proposed work plan(s) for the upcoming year and summarize of the status of the previous year's work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.
2. Program Integrity (PI)
- a. The PIHP may utilize the same staff and services as it does for the BH I/DD Tailored Plan to perform the operations described in this Section.
  - b. To ensure the effective use and management of public resources in the delivery of services to members, the PIHP shall also increase awareness within its organization and across its Provider Network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the PIHP shall comply with all applicable federal and State laws and regulations including, but not limited to Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.
  - c. To promote PI, the PIHP shall adhere to the following program standards, at a minimum:



- i. Validation of Exclusion List Status
  1. The PIHP shall, prior to contracting, check the exclusion status of all providers against the Exclusion Lists to ensure that the PIHP does not pay federal funds to excluded persons or entities.
  2. The PIHP shall disclose to the Department within thirty (30) Calendar Days of PIHP's knowledge any disciplinary actions that have been imposed on any licensed providers or entities or their governing body related to fraud, waste, or abuse as defined within the Contract.
  3. The PIHP shall check, at least every month, the exclusion status of persons with an ownership or controlling interest in the PIHP (as applicable), agents and managing employees of the PIHP, network providers, delegated entities, and subcontractors against the Exclusion Lists to ensure that the PIHP does not pay federal funds to excluded persons or entities. The PIHP shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a); 42 C.F.R. 438.808(b)(1); 42 C.F.R. 431.55(h); section 1903(i)(2) of the Act; 42 C.F.R. 1001.1901(c); 42 C.F.R. 1002.3(b)(3).
  4. The PIHP shall take appropriate action upon identification that a person, agent, managing employee, network Provider, delegated entities or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
  5. The PIHP shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
    - a. The name(s) of the Excluded Person(s);
    - b. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
    - c. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.
- ii. Prohibited Relationships
  1. In accordance with 42 C.F.R. § 438.61042 CFR 438.808(a); 42 C.F.R. CFR 438.808(b)(2); 42 C.F.R. CFR 438.610(a); 42 C.F.R. CFR 431.55(h); section 1903(i)(2) of the Act; 42 C.F.R. 1001.1901(c); 42 C.F.R. CFR 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09; Exec. Order No. 12549], the PIHP shall not knowingly have a relationship with any of the following:
    - a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) 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 or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person.
    - c. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
  2. For the purposes of this Section, a "relationship" means any of the following:
    - a. A director, officer, governing board member, or partner of the PIHP;
    - b. A subcontractor of the PIHP, as governed by 42 C.F.R. § 438.230;
    - c. A person with beneficial ownership of five percent (5%) or more of the PIHP's equity; or
    - d. A network provider or person with an employment, consulting or other arrangement with the PIHP for the provision of items and services that are significant and material to the PIHP's obligations under this Contract.
  3. If the Department learns that the PIHP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in

procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the PIHP has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the PIHP unless the United States Secretary of the Department of Health & Human Services directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the PIHP unless the United States Secretary of the Department of Health & Human Services provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

- iii. Suspensions and Withholds for Payments to Providers for Program Integrity
  1. The PIHP shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold for Providers.
  2. The PIHP shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold Providers.
  3. When the Department notifies the PIHP that payments to a Provider have been suspended or are being withheld, the PIHP shall suspend payments to or withhold payments from the provider in accordance with the Department's instructions within one (1) Business Day of receipt of the notice or as otherwise instructed. The PIHP shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
  4. The PIHP shall commence a payment suspension or withhold in accordance with the Department's instructions and such suspension or withhold shall continue until the PIHP receives notice from the Department to lift the suspension or withhold.
  5. The PIHP shall lift the suspension or withhold within three (3) Business Days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
  6. The PIHP shall obtain the Department's written approval of the suspension prior suspending payments to any provider due to suspected fraud or abuse. The PIHP shall initiate such suspension within one (1) Business Day of receipt of the approval if the Department approve the suspension of payment.
  7. The PIHP shall provide the following information to the Department to request a suspension or withhold of payment to any Provider:
    - a. Name of the Network provider or non-contract Provider and NPI;
    - b. The nature of the suspected fraud;
    - c. Basis for the suspension/withhold;
    - d. Desired date for the suspension/withhold to begin;
    - e. Proposed length of the suspension/withhold;
    - f. Proposed percentage of the withhold, if applicable; and
    - g. If applicable, the good cause rationale for imposing a partial payment suspension.
- iv. Coordination of Provider Monitoring and Auditing
  1. The PIHP may conduct an audit of a Provider or accept a self-disclosure from a Provider even when the Department or MID conducted an audit of the same Provider or accepted a self-disclosure from the same Provider on a similar matter or covering a similar time period with prior permission from the Department.
  2. The PIHP shall comply with any Department or MID directive not to conduct an audit of a Provider.

- v. The PIHP shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services, the Inspector General of the US DHHS, and the Comptroller General a description of transactions between the PIHP and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
  - 1. Any sale or exchange, or leasing of any property between the PIHP and such a party;
  - 2. Any furnishing for consideration of goods, services (including management services), or facilities between the PIHP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
  - 3. Any lending of money or other extension of credit between the PIHP and such a party. Section 1903(m)(4)(A) of the Social Security Act.
- vi. Deficit Reduction Act (DRA) Reporting for Medicaid
  - 1. The PIHP shall have a policy and procedure which complies with the requirements of the DRA of 2005, which requires entities that make or receive annual Medicaid payments of five million (\$5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the government or its agents. Section 1902(a)(68) of the Act; 42 C.F.R. 438.608(a)(6).
  - 2. The PIHP shall submit upon request, but no sooner than one hundred eighty (180) Calendar Days after contract execution, and annually thereafter, in the format prescribed by the Department, policies and procedures in accordance with the DRA. As long as the DRA policies and procedures, clearly state they apply to the PIHP, the DRA policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- vii. Providers and Subcontractors
  - 1. The PIHP shall require Subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the DRA of 2005 requirements.
  - 2. The PIHP shall provide its Network Providers and Subcontractors with training materials regarding fraud, waste, and abuse prevention.
  - 3. The PIHP shall annually certify that no payments are made for services or items provided to a Provider, Subcontractor, or financial institution located outside of the United States.
  - 4. In accordance with federal regulations, the PIHP shall require Network Providers and non-contract Providers to have and implement a policy recognizing Medicaid as the payer of last resort.
- viii. Prohibited Payments
  - 1. The PIHP shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
    - a. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
    - b. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
    - c. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible

- allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
  3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.
3. Fraud, Waste, and Abuse Prevention
- a. To promote integrity in all PIHP activities and combat fraud, waste, and abuse, the PIHP shall:
    - i. Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (Members, providers, subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid services
    - ii. Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits for Members;
    - iii. Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
    - iv. Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
    - v. Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
    - vi. Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;
    - vii. Refer all allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department;
    - viii. Define the quality and data integrity standards maintained by the PIHP to produce accurate clinical quality metrics and reporting to the Department; and
    - ix. Have an identified individual(s) testify to the potential financial loss due to fraud, waste, and abuse upon request by the Department.
  - b. Fraud, Waste, and Abuse Investigation Staffing
    - i. The PIHP may utilize the same staff as it does for the BH I/DD Tailored Plan to perform the operations described in this Section.
    - ii. The PIHP shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the PIHP in preventing and detecting fraud, waste and abuse.
    - iii. The PIHP shall establish a Special Investigations Unit (SIU) sixty (60) Calendar Days prior to PIHP launch, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan inclusive of Medicaid funding. The PIHP shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department. The SIU may perform functions for both this PIHP and the BH I/DD Tailored Plan.
      1. The SIU will consist of dedicated staff members who are located in North Carolina.
      2. The PIHP's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
      3. The PIHP shall ensure that SIU staff have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public

administration, auditing, security management, pre-law or criminal justice, or have at least three (3) years of relevant experience.

4. The PIHP shall require that the staff of its SIU, as well as its Chief Compliance Officer, or designee, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training or similar training from the Health Care Compliance Association.

c. Investigation Coordination

- i. The PIHP shall refer allegations of fraud, including instances involving the PIHP's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) Calendar Days of making the determination.
- ii. Once an allegation of fraud has been referred to the Department, until further written notice by the Department, the PIHP shall not take any further action including the following:
  1. Contacting the subject of the investigation about any matters related to the investigation;
  2. Continuing the investigation into the matter;
  3. Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
  4. Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- iii. The PIHP shall cooperate with all appropriate State and federal agencies, including MID and/or federal OIG, in investigating fraud and abuse.
- iv. The PIHP shall provide data or information requested by the Department including the Program Integrity teams or MID, as relevant, in the standardized format within five (5) Calendar Days of receiving the request.
- v. The PIHP shall cooperate with the Department, including the Program Integrity teams and MID, as relevant, to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.
- vi. If the PIHP is directed to complete the investigation into potential instances of fraud, then the PIHP shall report to the Department, including the Program Integrity teams and MID, as relevant, in a specified format, its finding within ten (10) Calendar Days of the conclusion of the investigation.
- vii. The PIHP shall report new information related to a previously referred potential instance of fraud where PI, the Program Integrity teams and MID did not intervene in the investigation to the Department. The PIHP shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) Calendar Days of receiving or identifying the new information.
- viii. The PIHP cannot take action, such as termination or suspension, or withhold of payment, related to potential findings of fraud, waste or abuse without approval of the Department including the Program Integrity teams and/or MID. Any such action taken after PIHP has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.
- ix. Action by the PIHP shall not preclude the Department, including the Program Integrity teams or MID from conducting an audit or accepting a self-disclosure from a Provider even if the PIHP has conducted an audit or accepted a self-disclosure from the same Provider on a similar matter or covering a similar time period.
- x. The PIHP must participate in:
  1. Monthly calls with the Department regarding fraud, waste, and abuse;
  2. Quarterly in-person meetings with the Department, including the Program Integrity teams and MID regarding fraud and abuse; and
  3. Ad hoc calls or meetings as requested by the Department, including the Program Integrity teams and MID.

- d. Whistleblower Protections
  - i. The PIHP shall develop and maintain a Whistleblower Policy related to whistleblower protections and submit to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
  - ii. As long as the Whistleblower policies and procedures clearly state they apply to the PIHP, the Whistleblower policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - iii. The PIHP shall include fraud, waste, and abuse policies and procedure information in the PIHP's employee handbook with reference to and description of the applicable federal and State fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the PIHP's compliance policies and how to access those policies.
- e. Fraud Prevention Plan
  - i. The PIHP shall develop and maintain a Fraud Prevention Plan subject to Department review and approval. The PIHP shall submit the Plan to the Department:
    - 1. Upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution;
    - 2. Annually thereafter;
    - 3. When substantive or material changes are made to the Fraud Prevention Plan; and
    - 4. Upon request by the Department.
  - ii. The PIHP shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the PIHP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the PIHP's Fraud Prevention Plan.
  - iii. As long as the Fraud Prevention Plan clearly states it applies to the PIHP, the Fraud Prevention Plan may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - iv. The Fraud Prevention Plan shall include the following:
    - 1. The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2 and Section II.A. Definitions;
    - 2. Name of the Chief Compliance Officer;
    - 3. The Chief Compliance Officer, or designee, shall be responsible for making the decisions on which fraud, waste, or abuse cases to refer to the Department.
    - 4. Description of the SIU, the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care;
    - 5. Description of other staff assigned to fraud, waste, and abuse functions;
    - 6. Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
    - 7. Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
    - 8. Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
    - 9. Processes and procedures that address network provider and PIHP staff terminations related to suspected or confirmed fraud and abuse;
    - 10. Processes and procedures by which the PIHP avoids fraud, waste and abuse engaged in by out-of-network Medicaid providers;
    - 11. Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by Members;

12. Training procedures for directors, officers, employees, delegated entities, and Subcontractor education on federal and State laws, as well as PIHP practices for detection, identification, reporting and prevention of fraud, waste, and abuse;
13. Processes and procedures for ensuring in and out-of-network Providers, and Members know and understand fraud, waste and abuse obligations;
14. Processes and procedures for putting a Provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate. The policy shall be included in the PIHP's Provider Manual;
15. Description of the PIHP's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
  - a. A list of automated pre-payment claims edits;
  - b. A list of automated post-payment claims edits;
  - c. A list of desk audits on post-processing review of claims planned;
  - d. A list of reports on Medicaid network Provider and out-of-network Provider profiling used to aid program and payment integrity review;
  - e. The methods the PIHP will use to identify high-risk claims and the PIHP's definition of "high-risk claims;"
  - f. Visit verification procedures and practices, including sample sizes and targeted provider types or locations;
  - g. A list of surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Medicaid services, including Waiver services;
  - h. Policies and procedures used by the PIHP designed to prevent, detect, and report known or suspected fraud, waste, and abuse;
  - i. A list of references in Provider and Member material regarding fraud and abuse referrals (e.g., on member EOB);
  - j. Work plans for conducting both announced and unannounced site visits and field audits of network Providers determined to be at high risk to ensure services are rendered and billed correctly; and
  - k. The process by which the SIU shall monitor the PIHP's marketing representative activities to ensure that the PIHP does not engage in inappropriate activities, such as provision of inducements.
16. Assurance that the identities of individuals reporting violations by the PIHP are protected and that there is no retaliation against such persons;
17. Description of criminal background and Exclusion List screening processes for its owners, agents, delegated entities, employees, and Subcontractors; and
18. Process and procedures for working and coordinating with the Department, including its State and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.

4. Third-Party Liability (TPL)
- a. The PIHP may utilize the same TPL resources as it does for the BH I/DD Tailored Plan to perform operations and meet requirements described in this Section.
  - b. The PIHP shall be responsible for actively seeking and identifying third-party resources for the purposes of the following:
    - i. Cost avoidance;
    - ii. Credit balance;
    - iii. Commercial health insurance;
    - iv. Medicare disallowance;
    - v. Casualty insurance; and
    - vi. Liability insurance.
  - c. Cost Avoidance
    - i. The PIHP shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
      1. Policy number;
      2. Policyholder's name;
      3. Group Policy number;
      4. Group Policy name;
      5. Identification of whether the policyholder is the non-custodial parent;
      6. Member Medicaid/NC Health Choice ID;
      7. Member relationship to policy holder;
      8. The begin date of insurance coverage; and
      9. The end date of insurance coverage.
  - d. The PIHP shall engage in third-party resource recovery and cost avoidance for all other types of recovery.
  - e. The PIHP shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless of whether the start date began prior to the Member becoming Medicaid eligible or enrolled with the PIHP.
  - f. The PIHP shall report cost recovery and cost adjustments through the encounter process, including denials.
  - g. The PIHP shall make every reasonable effort to determine the liability of third parties to pay for services rendered to Members and to cost avoid and/or cost recover such liability from the third party.
  - h. The PIHP shall treat all funds recovered by the PIHP from third-party resources as income to the PIHP.
  - i. TPL Recovery
    - i. The PIHP shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
    - ii. The PIHP shall open a new case upon receipt of a TPL Accident Information Report form from the Member's attorney or other reliable leads that indicate third-party recovery might be possible.
    - iii. The PIHP shall be responsible for identifying and communicating with attorneys retained by Members for tort action, through contact with the Members, Participating Providers, and the Department for seeking and identifying third-party resources.
    - iv. The Department shall review the effectiveness of the PIHP's TPL recovery programs annually and may revoke TPL activities from a PIHP if the PIHP's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the PIHP's TPL recovery programs may include:



1. A comparison to annual Medicaid Fee-for-Service recovery averages to PIHP recovery averages per beneficiary.
  2. The percentage of recoveries over total spend.
  3. The percentage of cost avoidance over total spend.
  4. The average turnaround time from the remittance to recovery.
  5. The average number of policy adds in comparison to historical Medicaid Fee-for-Service policy adds on a monthly basis.
  6. Quarterly audits on PIHP encounter data.
- v. The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.
- j. Identification of Other Forms of Insurance
- i. The PIHP shall notify the Department within five (5) Calendar Days if it has identified that a Member has another form of insurance.
  - ii. The PIHP shall load and submit to the Department updates and additions on other forms of insurance into its system within thirty (30) Calendar Days of matching and verification.
  - iii. The PIHP shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been updated in the PIHP's system or submitted by the PIHP to the Department for Managed Care members.
  - iv. The PIHP shall ensure that the information on Member's other forms of insurance is accurately tracked and maintained within the Member record. The PIHP must correct all errors made in its submission of other forms of insurance to the Department within five (5) Business Days of becoming aware of the other forms of insurance and must provide proof of such corrections upon request from the Department.
  - v. The PIHP shall review paid claims to determine which paid claims should have been paid by the Member's other forms of insurance instead of by the PIHP.
  - vi. The PIHP shall notify the Department of overpayments paid to the PIHP from an insurance carrier for recovery claims billed by the PIHP for Members with other forms of coverage.
  - vii. The PIHP shall bill the applicable insurance carriers for Members' major BH or I/DD claims within thirty (30) Calendar Days of matching the claims to TPL segments pertaining to members' active insurance policies for commercial insurance direct billing.
    1. The PIHP shall adhere to the billing requirements of each commercial insurance carrier.
    2. In instances where the carrier will not accept the claim without supporting medical records, the PIHP shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) Calendar Days of becoming aware of the need for medical records by the commercial insurance to bill.
  - viii. Within ten (10) Business Days after receipt of a direct claim billing denial or other types of denials, the PIHP shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the PIHP's IT system; and resubmit the claim to the appropriate insurance carrier.
- k. Subrogation Cases
- i. Pursuant to 42 C.F.R. § 438.608, the PIHP agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
  - ii. The PIHP lien in each subrogation case shall be equal to the payments made by the PIHP.
  - iii. The PIHP shall identify the PIHP paid medical claims amounts for each subrogation case using data from the paid claims file.
  - iv. Relevant information in the subrogation case at the time of closure shall include:
    1. Settlement sheet listing all providers with medical subrogation rights.
    2. Original lien amount of each entity with subrogation right.

3. The PIHP recovered amount.
4. The amount disbursed to each entity involved.
- v. The PIHP shall review the diagnosis code and Member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
- vi. A subrogation case shall be closed with recovery after the PIHP lien has been satisfied to the statutory limits, as referenced in N.C. Gen. Stat. § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery only after the PIHP provides relevant and adequate documentation supporting the reason for case closure without recovery. The PIHP shall obtain and record all relevant information in the subrogation case at the time of closure.
- vii. In accordance with N.C. Gen. Stat. § 108A-57(a1), the PIHP shall collect the amount of the PIHP lien or up to one-third (1/3) of the amount of the Member's gross recovery in the personal injury or wrongful death case, whichever is less.
- viii. The PIHP shall coordinate collection of the settlement amount with the Member or the Member's attorney.
- ix. The PIHP shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the PIHP's claim to any part of the proceeds of any settlement.
- x. The PIHP shall not compromise, waive or reduce the PIHP's lien without written authorization from the Department or its designated legal counsel.
- xi. The PIHP shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.
- xii. The PIHP shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.
- I. The PIHP shall develop and maintain a TPL Policy for review and approval by the Department. As long as the TPL Policy clearly states it applies to the PIHP, the TPL Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - i. The TPL Policy shall include the following:
    1. Cost avoidance activities;
    2. Payment recovery activities;
    3. Identification of other forms of insurance processes and procedures;
    4. Subrogation, including the methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
  - ii. The PIHP shall submit the TPL Policy:
    1. Upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution; and
    2. Annually thereafter.
5. Medicaid Service Recipient Explanation of Medical Benefit (REOMB)
  - a. The PIHP shall create the REOMB using the previous month's claims for North Carolina Medicaid (i.e., February claims comprise March REOMB sample).
  - b. The PIHP shall include the following in the REOMB:
    - i. List of services provided and billed to the PIHP;
    - ii. The name of the Provider administering the service;
    - iii. The date(s) on which the service was administered;
    - iv. The paid and unpaid services; and

- v. The reason a service was not paid.
- c. The PIHP shall exclude those claims that include sensitive information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB. Sensitive information shall be defined as any procedures for allergies, newborn treatment and care, and any treatment for a Member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, sterilization, and substance abuse disorder information protected by 42 C.F.R. Part 2.
- d. The PIHP shall exclude sensitive information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with N.C. Chapter 48A.
- e. The PIHP shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month for both PIHP and BH/IDD Tailored Plan claims, whichever is less. (Excluded claims include those in referenced in this Section).
- f. The PIHP shall send the REOMB via US mail to randomly selected members. The PIHP shall collect responses from the REOMB mailing.
- g. The PIHP shall use a Department approved sampling method to determine the population to receive the REOMB and include it in the PIHP's annual Fraud Prevention Plan.
- h. The PIHP shall follow the Department approved policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.
- i. The PIHP shall provide a REOMB to a member upon request.

## D. Stakeholder Engagement and Community Partnerships

1. Engagement with Tribes
  - a. The PIHP must have a strong understanding of and capability to meet the needs of all tribal members and other individuals eligible to receive Indian Health Services, including North Carolina's federally recognized tribe (the Eastern Band of Cherokee Indians) and State-recognized tribes.
  - b. As specified in N.C. Gen. Stat. § 160-40(a)(5) and (5a), members of federally recognized tribes are exempt from mandatory enrollment in Medicaid Managed Care, and the Department will seek statutory authorization to exempt from mandatory enrollment in Medicaid Managed Care other individuals eligible to receive Indian Health Services, consistent with federal law.
  - c. The Department is collaborating with the EBCI to develop the EBCI Tribal Option that considers and addresses the unique cultural, physical/medical behavioral, and social determinants of health needs of federally recognized tribal members and other individuals eligible to receive Indian Health Services.
  - d. Federally recognized tribal members and other individuals eligible to receive Indian Health Services will be enrolled in the Tribal Option if they live in the five (5) western counties of Swain, Jackson, Haywood, Cherokee, and Graham counties. Individuals enrolled in the Tribal Option will receive services through NC Medicaid Direct for their physical health, pharmacy, and State Plan LTSS, and will be enrolled in the PIHP for their behavioral health and I/DD services. Individuals will have the ability to opt out of the Tribal Option if they reside in those five counties and participate in Medicaid Managed Care (either a Standard Plan or BH I/DD Tailored Plan, as applicable) or NC Medicaid Direct and the PIHP without obtaining care management through the Tribal Option.
  - e. The PIHP shall establish an ongoing meaningful partnership and collaboration with any State and federally recognized Tribes located within the service area of the PIHP. All PIHPs are required to establish a partnership with the Eastern Band of the Cherokee as they manage and operate the IHCPs in NC in which all federally recognized tribal members are entitled to access regardless of location or geography.

- f. The PIHP shall implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health and behavioral and I/DD care and supports for the individual, family, or community members of both State and federally recognized tribes. The Strategy should adapt individual engagement interventions unique to the Tribe's respective culture, address access to programs, and policies that target health and social determinant disparities, demonstrate Cultural and Linguistic Competency, respect and honor and fit the historical and cultural context of the individual, family, or community members of Tribes. The Strategy should clearly articulate differences (e.g., Medicaid enrollment options, federal payment and funding allowances, etc.) for members of State and federally recognized tribes. The engagement strategy should outline the impact of tribal history on the issues facing Native Americans in today's environment as it relates to their health status.
- g. The Tribal Engagement Strategy shall include:
  - i. A proposal of an administrative, clinical, and operating model intended to meet the needs of tribal members in the service area of the PIHP;
  - ii. A proposal to access IHCP services for federally recognized tribal members regardless of location of the PIHP;
  - iii. Culturally and Linguistically Competent, proactive, innovative methods for engaging and communicating with tribal members and tribal leadership;
  - iv. A proposal and strategy to improve communication through the utilization of the State or regional health information exchange (e.g., Health Connex) to improve coordination of care and health outcomes for tribal members and reduce duplication and administration as a result of multiple IT systems;
  - v. A description of how the PIHP's care management and quality strategies take into consideration the needs of tribal members and working with tribal providers, utilizing those quality measures already in place for BH I/DD Tailored Plans;
  - vi. A description of the proposed relationship with the Tribal AMH+/CMA;
  - vii. A description of how the plan will coordinate with the EBCI Family Safety Office, the Tsali Public Health Agency and other programs within EBCI;
  - viii. A description of how the PIHP will integrate with and coordinate with tribal organizations or agencies (e.g., community-based organizations, services, or entities) serving tribal members in the service area of the PIHP or that have the right to access IHCPs;
  - ix. Medicaid education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may lead to health disparities, create barriers to health care, provider access and service delivery; and
  - x. A description of how the PIHP will coordinate with tribal organizations to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities managed and operated by the Tribe. The plan shall address both tribal operated and county operated services that are accessed by Tribal members.
- h. The Tribal Engagement Strategy shall be submitted to the Department for review and approval due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. The Strategy shall be updated annually, with consultation with the Tribe and resubmitted to the Department for review. As long as the Tribal Engagement Strategy clearly states that it applies to Medicaid Direct, the Tribal Engagement Strategy may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plans contract.
- i. The PIHP shall consult with the Indian Tribes and Tribal Organizations, in a manner agreed upon by the individual Tribes regarding PIHP initiatives impacting tribal populations or providers.

- j. The PIHP shall collaborate with the Tribes in the service area of the PIHP to facilitate, in a manner agreed upon by the individual Tribes, meetings and forums with tribal leaders and IHCPs that serve tribal members.
  - k. The PIHP shall collaborate with the Tribes in developing any member education and training materials. The manner for such collaboration shall be outlined in the Tribal Engagement Strategy and must be approved by the Tribes.
  - l. The PIHP shall make member education and training material available to licensed and unlicensed BH personnel who work with Tribal members, upon request by such personnel.
  - m. The PIHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract, to the extent such requirements are applicable and the DHHS Tribal Payment Policy.
  - n. The PIHP shall provide and maintain a single point of contact for IHCP billing issues to the Department and with the Tribe.
  - o. The PIHP shall ensure its staff, materials, and resources adhere to the requirements described in Section IV.E.3. Member Engagement.
  - p. Annually, the PIHP shall train its staff regarding the PIHP's Tribal Engagement Strategy and in providing Culturally and Linguistically Competent and consumer-specific supports to the tribal population as referenced in Section IV.B.3. Staff Training. Training materials referencing federally recognized tribes shall be reviewed by the EBCI prior to training. Reasonable time for review shall be established as part of the Tribal Engagement Strategy.
2. Engagement with Community and County Organizations
- a. The PIHP must have a strong understanding of and capability to meet the needs of North Carolina's local communities to help guide and support the delivery of services to members and their families in their catchment area, including engagement with:
    - 1. County agencies (e.g., county mental health associations, local Department of Social Services, Area Agency on Aging, Local Education Agencies, housing authorities, county commissioners, children's developmental services agencies, local systems of care programs, law enforcement, justice and judicial agencies such as sheriff departments, police departments, pre and post-trial release programs, reentry councils, county magistrates)
  - b. County and community based organizations (e.g., homeless shelters, continuums of care, homelessness and housing providers, faith-based organizations, food pantries, domestic violence agencies, consumer and peer run organizations).
  - c. The PIHP shall engage with CFACs as required by N.C.G.S. 122-C-170 and -171, non-profits, county and community-based organizations (CBOs) to understand the potentially unique resources and needs of each community.
  - d. The PIHP shall:
    - i. Include strategies within the Local Community Collaboration and Engagement Strategy to effectively integrate its model of care and eliminate service access barriers within the local communities it serves; and
    - ii. Establish an ongoing partnership with the Department and North Carolina County Agencies ("County Agencies"), CFACs, nonprofits, and CBOs in the catchment area that the PIHP is contracted to cover with the primary goals of getting feedback from members, families and advocates to improve service delivery, access, and outcomes. This shall include providing support staff to local or regional CFACs with the goals of assisting CFACs in performing their statutory duties as outlined in N.C.G.S. 122-170 and all relevant statutory provisions with the primary goals of working to address service barriers, identify system gaps, and assess policies impacting service delivery and access.

- e. The PIHP shall develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with County Agencies, CFACs and CBOs and build partnerships at the local level to improve the health of their members. As long as the Local Community Collaboration and Engagement Strategy clearly states that it applies to Medicaid Direct, the Local Community Collaboration and Engagement Strategy may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
    - i. The Local Community Collaboration and Engagement Strategy shall address how the PIHP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member engagement, unmet resource needs (e.g., transportation, food insecurity, housing) and local continuums of care. The strategy shall include:
      1. An approach to understand the unique needs of the counties and communities the PIHP serves;
      2. Methods of collaborative outreach and engagement with county agencies, CBOs, and other community partners;
      3. Measures of successful engagement and collaboration;
      4. Measures to foster community inclusion supporting PIHP members;
      5. Reporting of outcomes to County Agencies, CFACs, CBOs, and other community partners;
      6. Contracting status with each provider identified in each local area crisis services plan and other key crisis providers identified by the Department within their regions; and
      7. Information on how the PIHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.
    - ii. The PIHP shall submit the Local Community Collaboration and Engagement Strategy to the Department for review and approval due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution. The Strategy shall be updated annually and resubmitted to the Department for review.
  - f. The PIHP shall consult with the County Agencies, county executives and/or the county commissioners' association quarterly regarding Medicaid initiatives impacting counties and community organizations.
  - g. The PIHP shall facilitate, at least semi-annually, meetings and forums with the County Agencies, county executives and/or the county associations to report on progress of Local Community Collaboration and Engagement Strategy.
  - h. The PIHP shall support local collaboratives that are focused on addressing the unique needs of the populations they serve.
    - i. The PIHP shall staff city or county Community Collaboratives, work to address service barriers, identify system gaps, and develop cross system training plans for children receiving services in their areas as referenced in *Section IV.G.10. System of Care*; and
    - ii. The PIHP shall participate in local crisis collaboratives as detailed in *Section IV.D.5. Community Crisis Services Plan*.
  - i. The PIHP is encouraged to organize and participate in other local and regional collaboratives, including those focused on the adult and juvenile justice-involved populations, seniors and aging adults.
3. Integration with Other Department Partners
- a. The Department seeks a PIHP with the ability to seamlessly integrate with key Medicaid services partners, including, but not limited to: Department divisions, Standard Plans, BH I/DD Tailored Plans, the Foster Care Plan upon launch, the Enrollment Broker, Ombudsman Program and local county DSS offices to support beneficiaries through on-going implementation of PIHPs. To achieve this goal, the PIHP shall:

- i. Engage in joint community-based education events and activities with the staff of the Enrollment Broker, Ombudsman Program and other key Department partners as requested by the Department, including but not limited to health education and promotion fairs, forums, town halls and other community events.
  - ii. Provide educational materials described in *Section IV.E.3. Member Engagement* in hard copy and electronic format for distribution to local DSS offices and to members who may utilize the Ombudsman Program for assistance.
  - iii. Coordinate efforts with the Department, the Enrollment Broker, the Ombudsman Program, and other key Department partners to improve the Member experience by incorporating Member feedback into the PIHP education campaign strategy by modifying, updating, removing, changing, or adding materials, call center scripts, website content, education materials, presentations, or other administrative or operational processes.
  - iv. Collaborate with county DSS offices, DHHS offices, community-based and advocacy organizations and the Ombudsman Program to understand and incorporate the needs of Members into the PIHP's members education strategy.
- b. The PIHP shall collaborate with other Department and Division partners to ensure that members' unique needs are met, including the Department of Public Instruction, the Department of Public Safety, the North Carolina Housing Financing Agency, the Division of Health Services Regulation, the Division of Public Health, the Division of Adult and Aging Services and the Division of Social Services.
  - c. The PIHP shall work with the Department and DVRS to improve employment outcomes for Members and consumers aligning with Employment First principles and best practices for recovery, self-determination, and full community inclusion.
  - d. The PIHP shall also foster relationships with its local VR offices, Workforce Development boards, Department of Public of Instruction (DPI) post-secondary transition partners, and the NC Business Leadership Network to increase access to employment opportunities for Members.
4. Development of Housing Opportunities for Members
- a. The PIHP may utilize the same staff and services as it does for the BH I/DD Tailored Plan to perform the operations described in this Section.
  - b. The Department expects that PIHPs will play an integral role in the Department's supportive housing approach and community integration for individuals with mental illness, I/DD, TBI, and/or SUDs.
  - c. The PIHP shall work in collaboration with the Department and with other public agencies, local, regional and statewide housing and homeless populations' service providers and Department housing staff to support the expansion of supportive housing opportunities available to persons with mental illness, I/DD, TBI, and/or SUDs.
  - d. The PIHP shall employ care management housing specialists to act as experts on supportive housing for Members and organizations providing Tailored Care Management as referenced in *Section IV.G.9. Care Management and Care Coordination Policy*.
  - e. The housing staff shall have the knowledge, expertise, and experience to support and oversee affordable and supportive housing programs in local municipalities and local geographic areas including census tracts.
  - f. The PIHP's care management housing specialist(s) shall attend the four (4) quarterly meetings and any ad hoc meetings of Housing Specialists that are facilitated by the Department.
  - g. Education and Outreach
    - i. The PIHP shall provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable and supportive housing, and on negotiating reasonable accommodations.

- ii. The PIHP shall:
    1. Collaborate with Department professionals and their vendors along with other stakeholders to identify and secure housing as referenced in *Section IV.G.9. Care Management and Care Coordination Policy*.
    2. Make available in multiple venues where service providers convene information to identify housing resources, expand knowledge of eligibility requirements for different housing programs, how to access affordable housing resources, including information on, for example: the Fair Housing Act, Landlord and Tenant Rights, barriers associated with Not In My Back Yard (NIMBY), and information to reduce stigma associated with mental illness, I/DD, TBI, and SUDs.
  - iii. Provide technical support to service providers on accessing housing, landlord engagement, and the process of making a Reasonable Accommodation request.
  - iv. Provide and/or appropriately link consumers to additional supports when housing is at risk of becoming destabilized.
- h. Collaborative Relationships
- i. The PIHP shall develop a memorandum of understanding establishing a working relationship with each local public housing authority (PHA), and HUD Section 8/Housing Choice Voucher administrating agency, local and state-wide Continuum of Care committees as defined in *Section II.A. Definitions*. Topics covered must include local coordinated entry processes, and any other pertinent local, regional, or statewide homeless/housing organizations, to improve access and increase the supply of these resources, through the following means:
    1. Regularly, strategically seek out means of establishing/formalizing partnerships with PHAs and other relevant housing assistance organizations.
    2. Gain knowledge of and seek out ways to support PHAs' administrative plans and collaborate on preferences for individuals with BH, I/DD, and TBI needs.
    3. Stay abreast of and attend at least one (1) public meeting annually at a PHA in the catchment area with a particular focus on increasing affordable and supportive housing opportunities for individuals with BH, I/DD, and TBI needs.
    4. Participate in local, regional and statewide housing and homelessness planning and plan creation.
  - ii. The PIHP shall also use best efforts to establish partnerships with other local, affordable housing and BH, I/DD, and TBI advocates and stakeholders to improve access to supportive housing, increase the supply of resources, coordinate supportive services for eligible populations, identify and secure housing, and support/collaborate on service funding opportunities from private, city/county, State, and federal sources through the following means:
    1. Meet with property managers and provide training opportunity for landlords on supportive housing for members with BH, I/DD, and TBI needs.
    2. Employ landlord engagement strategies to create more landlord partnerships for Members.
    3. Maintain regular communication with area housing agencies and supportive housing advocates.
    4. Gain knowledge of and strive to work collaboratively with local non-profits, developers, Departmental stakeholders such as NC Oxford House to encourage and support development of new supportive housing for members with BH, I/DD, and TBI needs.
    5. Gain knowledge of and strive to work collaboratively with local advocates and stakeholders to encourage and support development of new supportive housing (participating jurisdiction, affordable housing providers, local Coalition, the Center for Independent Living, etc.).



6. Work with partners and stakeholders to establish additional resources for supportive housing (i.e., additional vouchers, housing opportunities, and programs).
  7. Identify potential housing development partners (e.g., DSS, city officials, faith community, public housing agencies, jails, prisons, psychiatric hospitals, homeless shelters, mental health, substance abuse, I/DD and TBI professionals and advocates) and collaborate to creating opportunities for supportive housing.
  8. Strive to enhance working knowledge of funding sources and how to successfully secure and utilize to increase the supply of supportive housing.
  9. Provide technical assistance and support to identified agencies applying for state and federal funding opportunities for supportive housing (e.g., justification of need, providing data and information as it relates to available support services) as resources allow.
5. Community Crisis Services Plan
- a. The PIHP shall implement the community crisis services plan as defined in N.C. General Statute § 122c-202.2. As long as the community crisis service plan clearly states that it applies to Medicaid Direct, the community crisis service plan may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
  - b. The community crisis services plan defined in the statute shall cover the PIHP's entire catchment area and shall be comprised of one or more local area crisis plans.
  - c. The PIHP shall submit an updated community crisis services plan to the Department at least every two (2) years and when there are Significant Changes as defined by the Department. Initial submission for review shall be due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution.
  - d. The PIHP shall include in the Crisis Planning Committee all affected agencies, including all Standard Plans that cover any of the counties covered in the local area crisis plan when updating the community crisis services plan.
  - e. The community crisis services plan shall not be considered complete by the Department unless all affected agencies have signed and agreed to each local area crisis plan.
  - f. The PIHP shall coordinate with Standard Plans, BH I/DD Tailored Plan, and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each community crisis services plan and alternatives to involving law enforcement in behavioral health crisis response.
  - g. The PIHP shall participate in local or regional crisis collaboratives with local magistrates, law enforcement, county commissioners, crisis providers, and hospitals, to meet and regularly share information on improvements to the crisis continuum.

## E. Members

1. Eligibility and Enrollment for PIHPs
  - a. Department Roles and Responsibilities
    - i. The Department has authority to determine North Carolina Medicaid and NC Health Choice eligibility and define the populations excluded or delayed from managed care who are thereby eligible for a PIHP consistent with N.C. General Statute § 108D-60 as amended by S.L. 2021-64, s. 3.4A.
    - ii. The Department shall maintain sole authority for performing, managing, and maintaining all Medicaid eligibility, PIHP eligibility, enrollment, including but not limited to the following populations who are excluded or delayed from Medicaid Managed Care shall be eligible for enrollment in PIHP upon their launch:

1. Beneficiaries who reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer.
  2. Beneficiaries who are in one of the following categories will be enrolled in the PIHP until the launch of the Foster Care Plan:
    - a. Enrolled in the foster care system;
    - b. Receiving adoption assistance; or
    - c. Under the age of twenty-six (26) and formerly were in the foster care system.
  3. Beneficiaries who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, except for beneficiaries enrolled in the Innovations waiver.
  4. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations waivers excluding federally recognized tribal members
  5. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the TBI waivers excluding federally recognized tribal members<sup>1</sup>.
  6. Presumptively eligible beneficiaries, during the period of presumptive eligibility, excluding presumptive eligibility for pregnant women.
  7. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations and TBI waivers.
  8. Beneficiaries being served through CAP/C and
  9. Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice).
  10. Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).
- iii. In accordance with N.C. Gen. Stat. § 108D-40(a)(5) and (5a), beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are eligible for the PIHP.
1. These beneficiaries will default to the Tribal Option for care management if they reside in a county where the Tribal Option is offered and will default to the PIHP for BH I/DD and TBI services and NC Medicaid Direct for physical health services, pharmacy, and State Plan LTSS.
  2. These beneficiaries will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible).
  3. More details of these options can be found in Section IV.H.1. Provider Network.
- b. PIHP Enrollment and Disenrollment
- i. PIHP Roles and Responsibilities
    1. The PIHP must adhere to PIHP eligibility decisions made by the Department and enroll or disenroll beneficiaries in accordance with those decisions and this Contract.
    2. The PIHP shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1).
    3. The PIHP shall have staff with sufficient knowledge about the North Carolina Medicaid and NC Health Choice programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.
    4. The PIHP shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect

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<sup>1</sup> Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

the member's Medicaid or NC Health Choice eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).

5. The PIHP shall ensure automatic reenrollment of a member who is disenrolled solely because they lose North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).
6. The PIHP shall only process enrollment for beneficiaries who are eligible for PIHP coverage.
7. The PIHP shall notify the Department in a format defined by the Department of the receipt of enrollment information for any beneficiary who is ineligible for PIHP within five (5) Business Days.
8. The PIHP shall direct the member to the NC FAST online portal or perform a Warm Transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.).
9. The PIHP shall ensure as outlined in Section IV.B. Program Operations that its telephone system will have the functionality to transfer beneficiaries and authorized representatives from the call center to the local DSS office without disconnecting the call.
10. If a member's demographic information is not updated during the next member reconciliation cycle with the PIHP and the Department, the PIHP shall follow up with members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.

ii. Beneficiary Disenrollment

1. The PIHP shall adhere to the Department's disenrollment approach as defined in Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
  - i. Member disenrollment requests; and
  - ii. Department disenrollment requests.
2. The PIHP shall accept and initiate all PIHP enrollments and disenrollments within twenty-four (24) hours of receipt of the complete standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
3. The PIHP shall comply with the Department's membership reconciliation process as defined in Section IV.L. Technical Specifications.
4. The PIHP shall develop and maintain a Member Enrollment and Disenrollment policy. Due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution the policy shall be submitted to the Department for review and approval. The PIHP shall submit to the Department for review any updates to the policy at least ninety (90) days prior to implementation. As long as the Member Enrollment and Disenrollment policy clearly states it apply to the PIHP, the Member Enrollment and Disenrollment policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

2. Transitions of Care

a. Ongoing Requirements

- i. The PIHP shall develop policies, processes, and procedures to support members transitioning between PIHPs, from BH I/DD Tailored Plans to PIHPs, PIHPs to BH I/DD Tailored Plans, Standard Plans to PIHPs, PIHPs to Standard Plans, other types of plans established by the Department (e.g., Tribal Option or Children and Families Specialty Plan, upon launch) or between delivery systems, including a Transition of Care Policy and Provider Transition of Care Policy.

- ii. As long as the policies, processes, and procedures for transition of care clearly states they apply to the PIHP, they may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- iii. Sixty (60) Calendar Days following Contract Execution, the PIHP shall provide the Department with a contact person who will coordinate Transitions of Care for newly enrolling members on behalf of the PIHP, including for the initial transition to the PIHP. This may be the same individual identified as the contact person for Transitions of Care for the BH I/DD Tailored Plan.
- iv. The PIHP shall accept and transfer member's claims/encounter history, prior authorizations, and transition file content, as described in *Section IV.E.2. Transitions of Care*, between PIHPs, Standard Plans, BH I/DD Tailored Plans, and other authorized Department Business Associates in accordance with the Department's data transfer protocols and related privacy and security requirements. The PIHP shall adhere to the Department's Transition of Care Policy for newly enrolling members, for members transitioning from a Standard Plan or BH I/DD Tailored Plan to the PIHP, or from the PIHP to a Standard Plan or BH I/DD Tailored Plan. The PIHP shall at a minimum:
  - 1. Identify enrolling or disenrolling members, as defined in Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities, who are transitioning from another PIHP, BH I/DD Tailored Plan, Standard Plan, other plan established by the Department, or other delivery system such as NC Medicaid Direct. Protocols shall be made available to the Department, upon request.
  - 2. Provide for the transfer and receipt of relevant member information, including a summary page narrative of member-specific circumstances that are time-sensitive or potentially impact continuity of care, a summary listing of the member's providers, treatment records that would encompass BH and I/DD, care management or care coordination records, open service authorizations, prescheduled appointments historic claims and encounter data, and other pertinent materials, to the transitioning member's receiving entity (the entity, such as the PIHP, BH I/DD Tailored Plan, Standard Plan, other type of plan established by the Department, or NC Medicaid Direct, that is enrolling the transitioning member and receiving the member's information) upon notification of the transition collectively referred to as the "Transition File".
    - a. The PIHP shall facilitate the transfer of a Member's claims/encounter history and Prior Authorization data between PIHPs and other authorized Transition Entities and Department Business Associates following requirements established and published by the Department, hereinafter together referred to as the "Transfer Data File".
    - b. If the PIHP is contacted by another PIHP or other receiving entity, such as a BH I/DD Tailored Plan, Standard Plan, other plan established by the Department, or designated entity within NC Medicaid Direct, requesting relevant member information, the PIHP shall provide such data to the entity within five (5) Business Days of receiving the request, unless otherwise governed by established technical requirements
    - c. The PIHP shall engage in pre-transition planning discussions and knowledge transfer with other Transition Entities as required in the NC DHHS Transition of Care Policy or as reasonably requested by another Transition Entity.
    - d. If the PIHP receives notice of an enrollment and has not received the applicable Transfer Data File or Enrollee's Transition File within five (5) Business Days of the transition notice date, the PIHP will contact the applicable Transition Entity on the following business day to request such files, as needed.

3. Within five (5) Business Days of the PIHP receiving notice that a member will disenroll, the PIHP shall ensure the Member's Transfer Data File and Transition File are transferred to the Receiving Entity utilizing the Department's process and schedule established in applicable technical requirements, including the TOC PA Requirements documents, the Claims Requirements document or the Care Plans Requirements document maintained on PCDU.
4. The PIHP shall ensure that any Member enrolling in the PIHP is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.
5. The PIHP shall allow a Member to complete an existing service authorization period for a Medicaid-covered State Plan service, within the scope of services in this Contract, or service that was previously covered as an In Lieu of Service established by their previous PIHP, Standard Plan, BH I/DD Tailored Plan, or another plan established by the Department. If the service was offered as an In Lieu of Service ("ILOS") by the previous health plan, the PIHP shall not be required to submit a request for approval of the ILOS for the Member to complete the existing service authorization period. The service will not continue beyond the existing service authorization period, if the PIHP does not submit the ILOS to the Department or if the submission is not approved by the Department.
6. If applicable, the PIHP shall assist the Member in transitioning to an in-network provider at the end of the service authorization period established by their previous Standard Plan, PIHP, BH I/DD Tailored Plan or NC Medicaid Direct.
7. In instances in which a Member transitions into a PIHP from a BH I/DD Tailored Plan, Standard Plan, another PIHP, another type of plan established by the Department or another type of health insurance coverage, and the Member is in an ongoing course of treatment or has an Ongoing Special Condition, within the scope of services of this contract, the PIHP shall permit the Member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status as required by the Contract. A Member's I/DD, mental health diagnosis, substance use disorder, or TBI shall be considered a special condition. The PIHP shall honor a transitional period of a minimum of ninety (90) Calendar Days for all out-of-network providers serving a transitioning PIHP Member at the time of transition, treating out-of-network providers the same as in-network providers regarding both reimbursement and prior authorization requirements. If the ongoing course of treatment includes inpatient care, the transitional period shall extend through post-discharge follow-up care related to the inpatient care.
8. The PIHP shall allow pregnant Members to continue to receive services from their BH treatment provider, without any form of prior authorization, until the birth of the child, the end of the pregnancy, or loss of Medicaid eligibility during the pregnancy, whichever is later.
9. For facilities paid a per diem rate, the PIHP shall only be responsible for the days the member resides in the facility and is also enrolled with the PIHP.
  - a. The PIHP's financial responsibility shall not extend beyond the date of disenrollment.
  - b. Post-discharge care shall be coordinated prior to discharge in accordance with *Section IV.G.9. Care Management and Care Coordination Policy*.
10. The PIHP shall establish a written Transition of Care Policy. The PIHP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and include processes and procedures for coordinating care for:
  - a. Members who have an Ongoing Special Condition;
  - b. Members transitioning to the PIHP from another PIHP, BH I/DD Tailored Plan, Standard Plan, other types of plans established by the Department or NC Medicaid Direct, as detailed in Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities;

- c. Members transitioning from the PIHP into another PIHP, BH I/DD Tailored Plan, Standard Plan, or other type of plan established by the Department;
  - d. Services delivered through other delivery systems including NC Medicaid Direct; and
  - e. Other requirements as defined in this Section and the Department's Transition of Care Policy as revised.
11. Transition of Care Requirements for Members Actively Engaged in Care Management and Members Disenrolling from the PIHP:
- a. The PIHP's Transition of Care Policy shall integrate processes and procedures for managing the transition of Members actively engaged in care management and of members transitioning between delivery systems.
  - b. Processes and procedures shall be consistent with the Department's Transition of Care Policy and ensure:
    - i. Timely Warm Handoffs as defined in *Section II.A. Definitions* with the other transition entity;
    - ii. Proactive communication with the other transition entity (e.g., BH I/DD Tailored Plans, Standard Plan, other PIHPs, Foster Care Plan upon launch, PCCM vendor) throughout the transition process; and
    - iii. Population and service-specific coordination with other entities to ensure the member's continuity of care.
12. The PIHP shall submit the PIHP Transition of Care Policy to the Department for review and approval one hundred fifty (150) Calendar Days after Contract Execution.
- v. Transition of Care with Change of Providers
- 1. The PIHP shall establish a written Provider Transition of Care Policy that includes supporting Members transitioning between providers when a provider is terminated from or otherwise leaves the PIHP's network. The PIHP Provider Transition of Care Policy shall include, at a minimum, the requirements of this Section E.2.v.
    - a. In instances in which a provider is terminated or leaves the PIHP's network for expiration or nonrenewal of the contract and the Member is in an ongoing course of treatment or has an ongoing special condition, the PIHP shall permit the Member to continue seeing their provider, regardless of the provider's network status. The PIHP shall honor a transitional period of one hundred eighty (180) Calendar Days. If the ongoing course of treatment includes hospital inpatient care, the transitional period shall extend through post-discharge follow-up care related to the inpatient care.
    - b. In instances in which a provider is terminated or leaves the PIHP's network for reasons related to quality of care or Program Integrity, the PIHP shall notify the Member in accordance with this Section's requirements and shall assist the Member in transitioning to an appropriate in-network provider that can meet the Member's needs.
  - 2. Member Notification of Provider Termination
    - a. Within fifteen (15) Calendar Days of providing notice of termination to the provider, the PIHP shall provide written notice of termination of a network provider to all members who have received or are scheduled to receive services consistent with *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts* from the terminated provider within the twelve (12) month period immediately preceding the date of notice of termination, except if a terminated provider is an AMH+ or CMA for a member. 42 C.F.R. § 438.10(f)(1).

- b. If a terminated provider is an AMH+ or a CMA for a Member, the PIHP shall notify the Member by the later of thirty (30) Calendar Days prior to the effective date of the termination or fifteen (15) Calendar Days after the receipt or issuance of a provider termination notice of the following:
      - i. Procedures for selecting an alternative AMH+ or CMA.
      - ii. That the member will be assigned to an AMH+ or CMA if they do not actively select one within thirty (30) Calendar Days.
    - c. If a terminated provider is a AMH+ or CMA for a member, the PIHP shall ensure that the member selects or is assigned to a new AMH+ or CMA within thirty (30) Calendar Days of the date of notice to the member and notify the member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.
    - d. The PIHP shall use a Member notice consistent with the Department-developed model member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).
  - 3. The PIHP shall hold the member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
  - 4. The Provider Transition of Care Policy shall include processes and procedures for coordinating care for Members who:
    - a. Have an ongoing special condition as defined in the applicable Contract;
    - b. Are discharged from a residential or institutional setting;
    - c. Are obtaining services from a provider that leaves the PIHP's network;
    - d. Other requirements as identified by the Department; and
    - e. The PIHP shall submit the Provider Transition of Care Policy to the Department for review and approval upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
  - vi. The PIHP shall provide encounter, provider, and Member data at least monthly, or more frequently in order to support transitions of care requirements or as reasonably requested by the Department.
- b. Crossover Population
  - i. The PIHP shall comply with the requirements listed above in *Section IV.E.2. Transitions of Care* to support Members transitioning during the Cross-over Period.
  - ii. The PIHP shall implement strategies to minimize the disruption of benefits at PIHP implementation by adhering to additional prior authorization requirements, including resetting the number of visits that do not require prior authorization, continuing to honor current authorizations for ongoing benefits and complying with Department protocols for streamlining prior authorization requests.
  - iii. The PIHP shall have the capacity to accept, ingest and utilize claims, encounter, prior authorization data files and care plans from other authorized Department Business Associates related to Crossover activities.
  - iv. The PIHP shall participate in Department led implementation preparation activities including but not limited to:
    - 1. Time-limited "stand up" meetings with the Department on a schedule to be determined by the Department;
    - 2. Testing related to data file transfers on a schedule and under a protocol determined by the Department; and
    - 3. Time-limited, rapid cycle solutions process related to data transfer issues and member disruption in care.

- v. The PIHP shall complete and submit any established crossover status reports and data reconciliation to the Department on a weekly basis.
  - vi. The PIHP shall participate in Warm Handoffs for beneficiaries transitioning to the PIHP who were previously receiving services through the PCCM vendor or Former State-designated Utilization-Review Vendor.
  - vii. The PIHP must honor existing and active medical prior authorizations on file with NC Medicaid Direct, Standard Plans, and BH I/DD Tailored Plans minimally for the first ninety (90) Calendar Days after PIHP implementation or until the end of the authorization period, whichever occurs first to ensure continuity of care for Members. For service authorizations managed by an LME/MCO and impacted by 42 C.F.R. Part 2, the PIHP shall deem authorizations submitted directly by impacted providers as covered under this requirement. For the first ninety (90) Calendar Days after PIHP launch, the PIHP shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network providers equal to that of in network providers to ensure that providers fully understand each PIHP's prior authorization requirements during the transition. The PIHP shall process and pay for services rendered during this Crossover transitional period if:
    - 1. A provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
    - 2. A provider submits for retroactive prior authorizations.
  - viii. Retroactive prior authorization does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period. If a transitioning beneficiary is under an Ongoing Course of Treatment covered under N.C. Gen. Stat., § 58-67-88, the PIHP shall pay claims and authorize services to the beneficiary's out-of-network providers on par with in-network providers for the duration of the applicable transitional period defined in statute.
3. Member Engagement
- a. Members, their families, and caregivers may need support during the initial transition to the PIHP and on an on-going basis. To the extent possible due to law and funding, the PIHP will be responsible, individually and in partnership with the Department and other entities identified by the Department, for assisting Members and their families with understanding the PIHP, navigating the behavioral health, I/DD, and TBI health care system, improving member health through various avenues, including maintaining a Member Services department, conducting member and community outreach, and providing education. The Department strongly encourages the PIHP to develop innovative approaches, including the use of electronic mechanisms for member education and outreach.
  - b. The PIHP shall be responsible for engaging with members and their authorized representatives to help callers understand the PIHP and their rights and responsibilities and accessing available benefits and services in-person, by telephone, by mail, and online/electronically. 42 C.F.R. § 438.10(c)(7).
  - c. The PIHP shall utilize various engagement strategies and communication mediums to engage, educate, and assist Members. The engagement strategy shall include the operation of a dedicated Member Services Department (which may be shared across this product and the BH I/DD Tailored Plan and which may be referred to as the Member and Recipient Services Department) which, at a minimum, shall:
    - i. Maintain a member call center and a publicly-available PIHP website that includes a dedicated Medicaid Direct member webpage;
    - ii. Engage with the Department engagement and customer service offices, as well as local community and county organizations;



- iii. Provide written and verbal educational materials, activities, and programs;
  - iv. Collaborate with other entities operating within the North Carolina Medicaid delivery system; and
  - v. Comply with the requirements of Section IV.A.3. Readiness Review Requirements if PIHP delegates any of the requirements to a Subcontractor.
- d. The PIHP shall use standard managed care terminology in all communications with Members and potential Members as defined in *Section VI. Attachment K. Managed Care Terminology Provided to the PIHP for Use with Members Pursuant to 42 C.F.R. § 438.10.*
- e. Unless otherwise stated, all written communications, call center scripts, websites or other communications directed to Members or potential Members must adhere to the requirements in this Contract and receive prior approval from the Department before the material is disseminated. The Department may require changes to previously approved communications, at its sole discretion.
- f. Member Services Department
- i. The PIHP may utilize the same staff, systems and policies and procedures to perform the operations described in this section for both Medicaid Direct and the BH I/DD Tailored Plan. The PIHP shall have and implement Member Services policies and procedures that address the needs of potential members, members, those individuals who support and care for members and address all Member Services activities.
  - ii. The PIHP shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
  - iii. The Member Services staff shall be responsible, at a minimum, for the following functions:
    1. Explaining PIHP operations, including what to do in an emergency, disaster, or urgent medical situation;
    2. Referring Members to the local DSS office to help members access NEMT;
    3. Helping members select or change their care manager;
    4. Educating Members about services available through the PIHP, including out-of-network services;
    5. Helping Members access services covered by the PIHP, including out-of-network services;
    6. Explaining transition of care requirements, care management and care coordination services offered by the PIHP;
    7. Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
    8. Fielding and responding to Members' questions and complaints;
    9. Clarifying information in the Member Handbook;
    10. Advising Members of and assisting Members with the Appeals, Grievance, and State Fair Hearing processes;
    11. Referring Members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues; and
    12. Guiding Members in how to access State-Funded Services managed by the BH I/DD Tailored Plan.
  - iv. The PIHP shall operate and maintain or utilize the BH I/DD Tailored Plan's infrastructure for the following two (2) member facing Service Lines, which may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract:
    1. Member Service Line (see *Section IV.B.1. Service Lines*);
    2. Behavioral Health Crisis Line (see *Section IV.B.1. Service Lines*);

- v. The PIHP shall conduct ongoing quality assurance of its Member Services Department via Member surveys and internal audits to ensure Member satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
  - 1. Member surveys shall be made available after each web, call center (with exception of Behavioral Health Crisis Line) or in-person interaction. A web interaction would include logging into the Member Portal, having a conversation via live chat, or requesting help or service through the website.
  - 2. Surveys and internal audits are intended to measure a Member's overall ability to access needed services, ease of use of telephone, web services, convenience, and help function effectiveness.
  - 3. Reports, including the results of provider surveys and the PIHP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as reasonably requested.
- g. Member Services Website
  - i. The Department encourages the PIHP to utilize processes, procedures, and technology to improve the member experience and effectively reduce or ease administrative burdens on the member.
  - ii. The PIHP shall develop and maintain an interactive website that is shared across and inclusive of this product and the BH I/DD Tailored Plan, which links to dedicated webpages for the Medicaid Direct health plan and the BH I/DD Tailored Plan. The website must allow the Member to search for in-network providers.
  - iii. The PIHP shall maintain a webpage for this product that is within two (2) "clicks" from the homepage, and shall also include on its website at a minimum:
    - 1. An up-to-date copy of the Member Handbook;
    - 2. Information on hours of operation;
    - 3. How to contact the Member Services staff and care managers;
    - 4. How to access PIHP services;
    - 5. Appeals, Grievances, and State Fair Hearing policies and processes;
    - 6. Information regarding the Ombudsman program;
    - 7. Health promotion and educational materials;
    - 8. Any specific prevention, population health, or care management programs offered by the PIHP;
    - 9. Information relevant to any disasters or states of emergency affecting the PIHP catchment area; and
    - 10. Other information the PIHP believes would support the Member and their caregiver and natural supports, including a link to information on BH I/DD Tailored Plan and State-funded Services.
  - iv. The PIHP shall meet the same literacy standards identified for written materials in any materials made available electronically.
  - v. The PIHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
  - vi. The PIHP website shall be accessible via mobile devices.
  - vii. The PIHP website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled downtime for maintenance or downtime of the State's MMIS that impact the ability for the website to operate correctly.

1. The PIHP shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
  2. The PIHP shall notify the Department of unscheduled downtime within one (1) hour of the PIHP becoming aware and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the PIHP.
- h. Communications with Members and Potential Members
- i. The PIHP shall ensure all contacts with Members or authorized representatives are Culturally and Linguistically Competent and provide effective communication to the Member, with deference to the method requested by the Member, including sign language interpreters, and occur in a timely manner that protects the privacy and independence of the individual with a disability.
  - ii. The PIHP shall ensure that Members and potential Members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and the PIHP's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
  - iii. The PIHP shall address the following in the development of Member materials:
    1. The population size and geographic/regional needs and differences throughout each of the PIHP's catchment area;
    2. Language proficiencies;
    3. Types of disabilities;
    4. Literacy levels;
    5. Cultural needs of the member population;
    6. Age and age-specific or other targeted learning skills or capabilities; and
    7. Ability to access and use technology.
  - iv. The PIHP shall be permitted to provide information required to be communicated to Members and potential Members in the following manner:
    1. Mailing a printed copy of the information to the Member's mailing address is the default absent an explicit preference stated by a Member or their authorized representative;
    2. Emailing the information, after receiving the Member's or potential Member's express consent to receive information via secure email and obtaining a valid, up to date email address. The PIHP may email information unencrypted if the Member or potential Member explicitly requests that emails are not encrypted and signs a waiver acknowledging the risk of unencryption;
    3. Posting the information on the PIHP's website and advising the Member or potential Member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a Member may request communication accommodations; and
    4. Providing the information by any other method that can reasonably be expected to result in the Member receiving the information. 42 C.F.R. § 438.10(g)(3).
  - v. The PIHP shall not construe requirement herein to limit or alleviate the PIHP's obligation to communicate directly with the Member, a member's authorized representative, parent or guardian, or potential Member as required under the Contract or under federal or state law or regulation.
  - vi. The PIHP shall provide information in the Member's preferred format upon request at no cost (e.g., a member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
  - vii. The PIHP shall comply with guidelines promulgated by the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.

- i. Written and Verbal Member Materials
  - i. The PIHP shall provide Member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which address information requirements related to written and verbal information provided to members.
  - ii. The PIHP shall provide all written materials to Members and potential Members consistent with the following:
    - 1. Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).
    - 2. Use a san serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.
    - 3. Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or limited English proficiency.
    - 4. Include a tagline that is sufficiently conspicuous and visible (san serif font type and font size no smaller than 12 points) for Members or potential Members to see and read the information on how to request auxiliary aids and services, including materials in alternative formats. The font type and size shall be appropriate to the audience. 42 C.F.R. § 438.10(d). Taglines are required on materials that are critical for potential Members and Members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d).
    - 5. Written in accordance with the most recent Associated Press Style guidance and NC Medicaid Style Guide or Department provided template.
    - 6. Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
    - 7. Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the PIHP's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:
      - a. Spanish,
      - b. Chinese (Mandarin Simplified),
      - c. Vietnamese,
      - d. Korean,
      - e. French,
      - f. Arabic,
      - g. Hmong,
      - h. Russian,
      - i. Tagalog,
      - j. Gujarati,
      - k. Mon-Khmer (Cambodia),
      - l. German,
      - m. Hindi,
      - n. Laotian, and
      - o. Japanese.
  - iii. The PIHP shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to Members in their original format.

- iv. The PIHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
  - v. The PIHP shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on various platforms, such as website and mobile devices.
- j. Mailing Materials to Members
- i. The PIHP shall verify addresses against a United States Postal Service approved product or service on all Members enrolled in the PIHP prior to mailing materials, at no additional cost to the Department or the Member.
    - 1. The PIHP shall make all reasonable attempts to identify the correct mailing address and mail information to the Member within applicable timeframes, as required under the Contract.
    - 2. The PIHP shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
    - 3. The PIHP shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
  - ii. The PIHP shall notify the Department, or the local DSS office as directed by the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.
  - iii. If the PIHP identifies a new, updated address, the PIHP shall resend only Member specific information at no additional cost to the Department or the Member.
  - iv. All materials mailed to potential Members, Members, and, when applicable, authorized representatives, shall be sent via first class mail, unless otherwise approved by the Department or permitted by the Member Mailing Policy.
  - v. The PIHP shall consider cost-effective methods for controlling postage costs when producing Member materials for mailing.
  - vi. The PIHP shall develop a Member Mailing Policy, subject to Department review and approval. The PIHP shall submit to the Department upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Member Mailing Policy, however named, clearly states that it applies to the PIHP, the Member Mailing Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- k. Translation and Interpretation Services
- i. The PIHP shall make interpretation services available to all potential Members and Members. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).
  - ii. The PIHP shall notify Members of the availability of interpretation services and inform them of how to access such services, including providing the following information:
    - 1. That verbal information is available for any language and written translation is available in prevalent languages free of charge to each member. 42 C.F.R. § 438.10(d)(4); and
    - 2. That auxiliary aids and services are available upon request and at no cost for members with disabilities. 42 C.F.R. § 438.10(d)(5).
  - iii. The PIHP shall offer qualified interpreter services available for verbal contacts with Members and authorized representatives whose primary language is not English.
  - iv. The PIHP shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.

- v. The PIHP shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with Member audiences.
- vi. The PIHP shall staff Member facing service lines with enough fluent Spanish speakers to converse with members who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the member or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department.
- vii. Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:
  - 1. Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
  - 2. Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
- viii. The PIHP shall notify the Department in writing within five (5) Business Days each time the PIHP or its Subcontractor charges a Member, potential Member, authorized representative or guardian for interpreter or translation services.
- ix. The PIHP shall notify the Department of any change in the language preference for Members in an electronic format and frequency as defined by the Department.
- I. Member Welcome Packet
  - i. During Contract Year 1, the PIHP shall send a Welcome Packet to the Member within eight (8) Calendar Days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department. Beginning in Contract Year 2, the PIHP shall send a Welcome Packet to the Member within six (6) Calendar Days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department.
  - ii. The PIHP shall include the following in the initial member Welcome Packet and upon redetermination:
    - 1. A welcome letter that notifies the Member of their enrollment in the PIHP and provides:
      - a. The effective date from which the PIHP shall begin health coverage for the member;
      - b. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
      - c. Information on how the Member can learn more about their health care choices;
      - d. Information on types of services to access through NC Medicaid Direct;
      - e. The toll-free service line numbers which a Member may call for the Member Service Line and Behavioral Health Crisis Line;
      - f. Information on care coordination and care management services, assigned Tailored care management entity, how to change a Tailored care management entity, why a member might be auto assigned to a Tailored care management entity and information on opting out for members who meet Tailored Care Management eligibility criteria;
      - g. Contact information for the Ombudsman Program; and
    - 2. A current Member Handbook.
    - 3. The PIHP may opt to send the Member Handbook separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
  - iii. The PIHP shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within ninety (90) Calendar Days of Contract Execution,

and then annually thereafter. The Department may require changes to the Member Welcome Packet and other communications, at its sole discretion.

m. Member Handbook

- i. The PIHP shall use the Department's model PIHP Member Handbook as guidance in the development of the PIHP's Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii). The Department shall provide a model PIHP Member Handbook to the PIHP at least forty-five (45) Calendar Days before due to be submitted to the Department by the PIHP.
- ii. The PIHP shall ensure that all Member Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
- iii. The PIHP shall ensure that the Member Handbook includes sufficient information that enables a Member to understand how to effectively use the PIHP. This information shall include at a minimum:
  1. Covered benefits provided by the PIHP, including:
    - a. Waiver services and supports where applicable; and
    - b. Care management and care coordination, including, for members engaged in Tailored Care Management, how to select and change care managers or the organization where they are obtaining Tailored Care Management.
  2. Member Enrollment and Disenrollment Policy, including Information on the member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract.
  3. How and where to access any other benefits provided by PIHP or the Department, including State-funded Services, physical health services, pharmacy services and State Plan LTSS services in NC Medicaid Direct.
  4. As applicable to the PIHP as a governmental entity, list of counseling or referral services that the PIHP does not cover because of moral or religious objection instructions for how the member can obtain information from the Department about how to access those services, and notification that the PIHP's failure to cover a service based on moral or religious objection.
  5. The amount, duration, and scope of benefits available under the PIHP in sufficient detail to ensure that Members understand the benefits to which they are entitled.
  6. Procedures for obtaining benefits, including any requirements for service authorizations.
  7. Information on the EPSDT benefits, for members under the age of twenty-one (21), including:
    - a. The benefits of preventive health care;
    - b. Populations eligible for EPSDT;
    - c. Services available under the EPSDT program and where and how to obtain those services;
    - d. That EPSDT services are not subject to cost sharing; and
    - e. That PIHP will provide scheduling and transportation assistance for EPSDT services upon request by the Member.
  8. The extent to which, and how, after-hours and emergency coverage are provided, including:
    - a. What constitutes an emergency medical condition and emergency services;
    - b. The fact that prior authorization is not required for emergency services; and
    - c. The fact that, subject to 42 C.F.R. § 438.10, the Member has a right to use any hospital or other setting for emergency care.
  9. Any restrictions on the Member's freedom of choice among in-network providers and out-of-network providers.

10. The extent to which, and how, Members may obtain benefits, including supplies from out-of-network providers.
11. Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract.
12. Grievance, Appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
  - a. The right to file Grievances and Appeals;
  - b. The requirements and timeframes for filing a Grievance or Appeal or State Fair Hearing;
  - c. The availability of assistance in the filing process;
  - d. The right to request a State Fair Hearing after the PIHP makes a decision on the Member's Appeal which is adverse to the Member; and
  - e. The fact that, when requested by the Member, benefits that the PIHP seeks to reduce or terminate will continue if the member files a request within the timeframes specified for filing and that the Member may be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Member.
13. How to exercise an Advance Directive.
14. An overview of its continuation of benefits policy and define when, why and how a Medicaid Member or their authorized representative may file for continuation of benefits.
15. How to access auxiliary aids and services, including additional information in alternative formats or languages.
16. The toll-free help line numbers for the Member Service Line, Behavioral Health Crisis Line, and Provider Support Service Line.
17. Information on how to report suspected fraud, waste, or abuse.
18. Information on the PIHP Transition of Care Policy.
19. Information about the PIHP's prevention and population health programs.
20. Contact information for beneficiary support systems, including the Ombudsman Program.
- iv. The PIHP shall provide the Department for review any Significant Changes to the Member Handbook, sixty (60) Calendar Days prior to the intended effective date of the change.
- v. The PIHP shall notify each Member, using Department-developed templates, of any Significant Change to the Member Handbook, at least thirty (30) Calendar Days before the intended effective date of the change.
- n. Member Education and Outreach
  - i. PIHP shall provide education and outreach to Members and potential Members, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department or Ombudsman Program may be present. The PIHP may provide education and outreach about other products, including without limitation the BH I/DD Tailored Plan contract, at the same health awareness events, community events, and health fairs.
  - ii. The PIHP shall provide information regarding its planned Member education efforts to the Department for review and approval sixty (60) Calendar Days after Contract Execution and annually thereafter.
  - iii. Any outreach or education related to the proposed Member Incentive Program (as described in *Section IV.E.2. Transitions of Care*) must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not be approved.



- iv. In support of the Department's Health Equity goals, the PIHP shall develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the PIHP's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. The plan shall be submitted no later than November 1, 2022 and annually thereafter to the Department. As long as the Member Engagement and Marketing Plan for Historically Marginalized Populations clearly states it applies to the PIHP, it may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract and annually thereafter to the Department.
  
- o. Engagement with Members
  - i. The PIHP must have a strong understanding of and capability to meet the needs of its members. To that end, the PIHP shall establish and maintain mechanisms to communicate with and obtain advisement from consumer groups which represent Medicaid Direct members served.
  - ii. Stakeholder group(s) described in this Agreement may be shared across and inclusive of both this product and the BH I/DD Tailored Plan and should include those stakeholders/community groups which represent previously carved out Medicaid Direct members, i.e. Refugee Coalitions.
  - iii. Specifically, the PIHP shall continue to support a Consumer and Family Advisory Committee (CFAC) and comply with applicable provisions of N.C. Gen. Stat. Ch. 122C, including any alternative board structure approved by the Secretary, regarding the composition, meeting schedule, training, and support of the governing board, as outlined in *Section IV.A.2. Entity Requirements*.
  - iv. Only one (1) CFAC is statutorily required for the LME/MCO as a whole, but shall serve as the Member Advisory Committee for both the PIHP and BH I/DD Tailored Plan.
  - v. The CFAC shall provide advice on the planning and management of the local public mental health, I/DD, TBI, and substance use services system. Topics for discussion and consultation shall include but should not be limited to:
    - 1. BH and I/DD benefits; and
    - 2. Care management.
  - vi. The PIHP shall help coordinate resolution of concerns within thirty (30) Calendar Days related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's authorized family member(s), the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or Member Advisory Committee as appropriate.
- p. Engagement with Beneficiaries Utilizing Long Term Services and Supports
  - i. The PIHP must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. The PIHP shall, either independently or in coordination with the BH I/DD Tailored Plan, establish a LTSS Member Advisory Committee that garners stakeholder input and advice regarding the LTSS covered under the PIHP contract, and meets all provisions noted in 42 C.F.R. § 438.110. One LTSS Member Advisory Committee may serve as the designated committee for both the PIHP and BH I/DD Tailored Plan provided that members consist of both PIHP and Tailored Plan representatives.
  - ii. The PIHP shall provide reports to the LTSS Member Advisory Committee that will enable the Committee to review Member experience and quality of care to serve as an early warning system for the PIHP on emerging issues.

- iii. The PIHP shall provide quarterly reports quality measure data, appeals and grievance, critical incident reporting, member satisfaction surveys and ad hoc feedback from providers to the LTSS Member Advisory Committee that will enable the LTSS Member Advisory Committee to review member experience and quality of care to serve as an early warning system for the PIHP on emerging issues.
- iv. The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the PIHP or their representatives and include:
  - 1. Members accessing LTSS;
  - 2. Representatives of LTSS members (e.g., authorized representatives);
  - 3. LTSS providers;
  - 4. Care managers from AMH+ practices and CMAs serving members with LTSS needs; and
  - 5. PIHP staff involved in the authorization of LTSS and/or care management of LTSS members.
- v. The PIHP shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.
- vi. The PIHP shall designate a single point of contact who will be responsible for reporting concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to the state's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and Consumer and Family Advisory Committee (CFAC), as applicable.
- vii. The PIHP shall require care managers and other member services and provider relations staff to report concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to a single point of contact designated by the PIHP.
- viii. The PIHP shall help coordinate resolutions to quality of care concerns related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's family, the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or CFAC, as appropriate.
- q. Health Education and Promotion Programs
  - i. The PIHP shall develop member health education and promotion programs that address prevention, wellness, and early intervention of illness and disease.
  - ii. The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.
  - iii. The PIHP shall make the health education and promotion programs available to Members through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
  - iv. The Department may select additional specific educational and health promotion topics for the PIHP to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- r. Member Incentive Program
  - i. The PIHP may offer healthy behavior incentive programs to members, provided that the following criteria are met:
    - 1. The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy;
    - 2. The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
    - 3. The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed seventy five dollars (\$75.00).

- ii. Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
  - iii. Prior to implementation, the PIHP shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the Quality Assurance and Performance Improvement (QAPI) program.
  - iv. As long as the Member Incentive Program policies and procedures clearly state they apply to the PIHP, Member Incentive Program policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract. The Member Incentive Program is due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
  - v. The PIHP shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (i) the program meets the requirements of 1112 of the Social Security Act; and (ii) the program meets the criteria determined by the Department.
4. Marketing
- a. The Department views PIHP marketing activities as a method to help publicize Medicaid services, while ensuring the protection of Members from coercive or misleading practices.
  - b. The PIHP shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the PIHP to ensure that Members receive accurate verbal and written information to make an informed decision on whether to enroll or reenroll in the PIHP.
  - c. The PIHP shall submit its marketing plan to the Department for review and approval on an annual basis.
  - d. The PIHP shall not market or distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i). Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
  - e. The PIHP shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud members or the Department. 42 C.F.R. § 438.104(b)(2).
  - f. The PIHP shall establish and maintain a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed, or presented, shall be the responsibility of the PIHP.
  - g. If the PIHP chooses to market, the PIHP shall distribute marketing materials to the entire catchment area served by the PIHP. 42 C.F.R. 438.104(b)(1)(ii).
  - h. The PIHP shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
  - i. The PIHP shall ensure that all marketing materials and marketing strategies shall abide by the PIHP's Non-discrimination Policy. In addition, the PIHP shall not discriminate against Members or potential Members who may:
    - i. Live or receive health care in rural or underserved areas; or
    - ii. Experience income disparities.
  - j. The PIHP shall assign a unique marketing code provided by the Department to all marketing materials distributed to members.
  - k. Marketing Materials and Activities
    - i. Permissible Marketing Activities

1. The PIHP may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
  2. The PIHP may participate in community-based marketing events or activities (e.g., health fairs, community events).
  3. The PIHP may sponsor outreach activities and events, including as a financial sponsor.
  4. The PIHP may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
  5. The PIHP may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
- ii. Prohibited Statements Claims, and Activities (Written or Verbal)
1. PIHP should ensure that marketing materials are accurate and do not mislead, confuse, or defraud the beneficiaries. However, the PIHP may inform the member that certain benefits are available only through enrollment in a PIHP so that the member may make an informed decision. 42 C.F.R. § 438.104(b)(2)(i).
  2. The PIHP shall not claim that the PIHP is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).
  3. The PIHP shall not use the Department or State logo or other proprietary material in marketing.
  4. The PIHP shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
  5. The PIHP shall not reference other PIHPs, Standard Plans, or other contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department, Standard Plans, or other PIHPs in any of its marketing materials.
  6. The PIHP shall not cross-market with a Standard Plan.
  7. The PIHP shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).
  8. The PIHP shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.
  9. The PIHP shall not market materials or activities that are discriminatory or that target potential members based on health status, geographic residence, location of the provision of possible services or income.
  10. The PIHP shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
  11. The PIHP shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
  12. The PIHP shall not engage in activities that seek to target members currently enrolled in other PIHPs, BH I/DD Tailored Plans, Standard Plans, NC Medicaid Direct, the Tribal Option, or the Statewide Specialized Foster Care Plan, upon launch.
  13. The PIHP shall not offer choice counseling or seek to enroll potential members in the PIHP. This is the sole responsibility of the Department.
  14. The PIHP shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
  15. The PIHP shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
- iii. References to Studies and Statistics

1. The PIHP shall not use irrelevant facts or inaccurate or misleading statistical information in any marketing materials and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
  2. If references to a study or statistics are included in any marketing material, the PIHP shall provide reference information (e.g., publication, date, page number) and information about the PIHP's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.
- iv. Nominal Gifts
1. The PIHP may conduct giveaways and distribute nominal gifts to members and potential members.
  2. The PIHP shall ensure the following for nominal gifts offered by the PIHP:
    - a. The gifts do not exceed ten dollars (\$10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
    - b. The gifts are made available to the public and are not in any way connected to enrollment.
    - c. The gifts are distributed via in-person contacts only (e.g., community events).
- v. Marketing of Multiple Lines of Business
1. The PIHP shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.
  2. The PIHP shall be permitted to co-market QHPs and Medicaid products, to the extent the PIHP is participating in both markets in the State and within the scope authorized for PIHPs under State law.
  3. The PIHP shall be permitted to provide information about a QHP to potential members who could enroll in such a plan as an alternative to NC Medicaid Direct or Medicaid Managed Care due to a loss of Medicaid eligibility.
- l. Department Approval of Marketing Materials
- i. The PIHP shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.
  - ii. If the PIHP makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the PIHP must resubmit the materials, in accordance with this Section, for Department review and approval.
- m. The PIHP may engage in marketing activities beginning one hundred sixty-nine (169) Calendar Days prior to the start of PIHP launch and shall be permitted to market throughout the term of the Contract unless the Department has otherwise restricted the PIHP's marketing activities in accordance with *Section V.A. Contract Compliance and Performance*.
5. Member Rights and Responsibilities
- a. The Department expects the PIHP to treat members with dignity and respect, to protect members' rights, to inform members of their responsibilities as members of the plan, and ensure each member is not subject to any unlawful discrimination in the course of obtaining or receiving services from the PIHP or any Network provider of the PIHP.
  - b. The PIHP shall establish and maintain written policies and procedures that are designed to protect the rights of members and describe the responsibilities of each member. The PIHP shall develop and submit to the Department for review a Member Rights and Responsibilities Policy upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Member Rights and Responsibilities Policy clearly states it applies to the PIHP, the Member Rights and Responsibilities Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

- c. The PIHP shall include a written description of the rights and responsibilities of Members in the Member Welcome Packet and the Member Handbook.
  - d. The PIHP shall provide a copy of its Member Rights and Responsibilities Policy to all PIHP employees and network providers.
  - e. In accordance with 42 CFR 438.10(g)(2)(ix) and 42 C.F.R. § 438.100(b), the PIHP shall ensure its written policies and procedures, at a minimum, afford Members the right to:
    - i. Receive information in accordance with 42 C.F.R. § 438.10;
    - ii. Be treated with respect and with due consideration for his or her dignity and privacy;
    - iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
    - iv. Participate in decisions regarding his or her health care, including the right to refuse treatment and Advance Directives under *Section IV.A.5. Advance Directives*;
    - v. Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
    - vi. If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
    - vii. Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.
  - f. The PIHP shall not attempt to influence, limit, or otherwise interfere with the Member's decision to exercise their rights as provided in this Contract.
  - g. The PIHP shall ensure that Members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the PIHP or its Network providers treat the member. 42 C.F.R. § 438.100(c).
  - h. The PIHP shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against members in the course of obtaining or receiving services from the PIHP or any network provider of the PIHP. 42 C.F.R. § 438.100(d).
  - i. The PIHP shall not avoid costs for services covered in its Contract by referring NC Health Choice beneficiaries to publicly supported health care resources. 42 C.F.R. § 457.1201(p).
6. Member Grievances and Appeals
- a. The Department is committed to ensuring that Members understand and can freely exercise their Appeal and Grievance rights and resolve issues efficiently with minimal burden to the Member or their authorized representative. The PIHP shall educate the Member on their rights and provide reasonable assistance with understanding and navigating the Appeals and Grievances processes.
  - b. Member Grievances and Appeals General Requirements
    - i. The PIHP shall establish and maintain a Grievance and Appeals system for reviewing and resolving member Grievances and Appeals. Components of the system shall include a Grievance process, a plan-level Appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F. The PIHP shall ensure the Grievance and Appeals system aligns with the parameters laid out in *Section IV.A.3. Readiness Review Requirements*, to the degree a Subcontractor relationship applies.
    - ii. The PIHP shall, while adhering to the required Utilization Management Program, employ strategies to resolve Grievance and Appeals at the lowest level of escalation that meets a Member's needs and in a manner that does not discourage Members from exercising their rights.
    - iii. The PIHP shall provide members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section*

*IV.D.3. Integration with other Department Partners, Section IV.B.1. Service Lines, and Section IV.E.3. Member Engagement.*

- iv. The PIHP shall provide members reasonable assistance in completing forms and taking other procedural steps related to a plan Grievance or Appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a); 42 CFR 438.228(a).
  - v. The PIHP shall ensure that the individuals making decisions on Grievances and Appeals:
    - 1. Acknowledge receipt of Grievances and Appeals (including verbal Appeals) unless the Member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
    - 2. Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).
    - 3. If deciding an Appeal of a denial is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).
    - 4. Take into account all comments, documents, records, and other information submitted by the member or their authorized representative for the service authorization request or payment denial at issue without regard to whether such information was submitted or considered in the initial adverse benefit determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).
  - vi. The PIHP shall allow an authorized representative (including providers) or legal guardian, with the Member's written consent, to request an Appeal or file a Grievance on behalf of a member. 42 C.F.R. § 438.402(c)(ii).
  - vii. The PIHP shall not retaliate if a Member, authorized representative, or legal guardian requests an Appeal or files a Grievance.
  - viii. The PIHP shall use Department developed templates for all member notices related to the member Grievance and Appeals processes that meet applicable notification standards, including but not limited to, the Notice of Adverse Benefit Determination, the plan Appeal request form, the State Fair Hearing Appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii). The Department shall provide such templates in a timely fashion and agrees to provide the PIHP with ninety (90) Calendar Days' advance notice of the issuance of new templates before the templates' proposed effective date. The Department shall not issue new templates more than once a year unless required by regulatory changes. The Department shall allow the PIHP the right to provide comment and feedback on proposed template modifications, which the Department shall consider before the templates are finalized.
  - ix. The PIHP shall define an Appeal, adverse benefit determination, and Grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400(b); 42 C.F.R. § 438.10(c)(4)(i).
  - x. The PIHP shall provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) on its Grievance, Appeals, and State Fair Hearing procedures to all providers and applicable subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.
  - xi. The PIHP shall comply with Chapter 108D of the North Carolina General Statutes for all Appeals and Grievance proceedings.
  - xii. The PIHP shall adhere to the NC DHHS Transition of Care Policy's guidance for managing appeals in effect during the Member's transition.
- c. Member Grievance Process
- i. The PIHP shall develop and submit to the Department for review a Member Grievance Policy due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract

Execution. As long as the Member Grievance Policy clearly states it applies to the PIHP, the Member Grievance and Appeals Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

- ii. The PIHP shall allow a member or authorized representative to file a Grievance with the PIHP, verbally or in writing, at any time. 438.402(c)(2)(i) and 438.402(c)(3)(i).
  - iii. The PIHP shall use the Department-developed Notice of Acknowledgement of Receipt of Grievance template to notify the member of receipt of the Grievance.
  - iv. The PIHP's member Grievance process shall include acknowledgement, in writing, within five (5) Calendar Days of receipt of each Grievance. 42 C.F.R. § 438.406(b)(1).
  - v. The PIHP shall provide written notice of resolution of the Grievance to the member and, as applicable, the member's authorized representative within thirty (30) Calendar Days from the date the PIHP receives the Grievance. 42 C.F.R. §§ 438.408(a) and 438.408(b)(1).
  - vi. Consistent with 42 C.F.R. § 438.408(c)(1)(i) - (ii), the PIHP may extend the timeframes for resolution of a Grievance by up to fourteen (14) Calendar Days if:
    1. The Member requests the extension or the PIHP determines that there is a need for additional information and the delay is in the Member's interest.
    2. If the timeframe is extended other than at the Member's request, the PIHP shall do the following:
      - a. Make reasonable efforts to give the Member verbal notice of the delay;
      - b. Within two (2) Calendar Days, provide written notice and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and
      - c. Resolve the Grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. §§ 438.408(b)(1) and 438.408(c)(2).
  - vii. PIHP shall notify Members of their opportunity to submit a complaint with the Department if the member is dissatisfied with the PIHP's resolution of a Grievance.
- d. Notice of Adverse Benefit Determination
- i. The PIHP shall give the Member and provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.404.
  - ii. Each Notice of Adverse Benefit Determination shall conform with 42 C.F.R. § 438.404, contain and explain:
    1. The Adverse Benefit Determination the PIHP has made or intends to make. 42 C.F.R. § 438.404(b)(1);
    2. The reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Notice of Adverse Benefit Determination. 42 C.F.R. § 438.404(b)(2);
    3. The Member's right to file an Appeal, including information on exhausting the PIHP's one (1) level of Appeal and the right to request a State Fair Hearing if the Adverse Benefit Determination is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);
    4. Procedures for exercising the Member's rights to file a Grievance or Appeal. 42 C.F.R. § 438.404(b)(4);
    5. Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
    6. The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).



- iii. The PIHP shall use the Department-developed template for the Notice of Adverse Benefit Determination.
- iv. The PIHP shall provide the member with a Department-developed Appeal request form in conjunction with the Notice of Adverse Benefit Determination.
- v. Timing of the Notice of Adverse Benefit Determination.
  - 1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP shall give written notice to the Member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date of the adverse benefit determination is to take effect, except as provided in this Section. 42 C.F.R. §§ 438.404(c)(1) and 431.211.
  - 2. For termination, suspension, or reduction of previously authorized Medicaid-covered services the PIHP shall provide written notice as expeditiously as possible and no later than five (5) Calendar Days before the date of the Adverse Benefit Determination if:
    - a. The PIHP has facts indicating that action should be taken because of probable fraud by the member; and
    - b. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c)(1).
  - 3. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP shall provide written notice no later than by the date of the action when any of the following occurs:
    - a. The PIHP has factual information confirming the death of the Member;
    - b. The PIHP receives a signed, written statement from the member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
    - c. The Member is admitted to an institution where he or she is ineligible under the plan for further services;
    - d. The Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
    - e. The PIHP establishes that the Member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
    - f. A change in the level of medical care is prescribed by the Member's physician. 42 U.S.C. 1396r(e)(7); 42 C.F.R. §§ 431.213; 438.404(c)(1); 431.231(d).
  - 4. For denial of payment, the PIHP shall give written notice to the Member and, when applicable, an authorized representative at the time of an action affecting the Claim. 42 CFR 438.404(c)(2).
  - 5. For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the PIHP shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).
  - 6. If the member's address is unknown and mail directed to him/her has no forwarding address, the PIHP shall have a contingency plan to provide an Adverse Benefit Determination notification to the member or legally responsible person regarding termination or reduction of previously authorized covered services no later than the date of the benefit determination.
- vi. The PIHP shall develop a written Member Appeals Policy. As long as the Member Appeals Policy clearly states it applies to the PIHP, the Member Appeals Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- vii. Internal Plan Appeals

1. The PIHP shall have an established internal member Appeal process for standard and expedited resolution of Appeals requests.
  2. The PIHP shall have only one level of Appeal for Members. 42 C.F.R. § 438.402(b).
  3. The PIHP shall include the member and his or her representative or the legal representative of a deceased Member's estate as parties to the Appeal. 42 C.F.R. § 438.406(b)(6).
  4. The PIHP shall provide Members a reasonable opportunity, by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the Appeal. For requests for expedited resolution, the PIHP shall inform the Member of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)
  5. The PIHP shall provide Members and his or her authorized representative, to the extent permitted by law, the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PIHP (or at the direction of the PIHP) in connection with the Appeal. The PIHP shall provide the information to the Member free of charge within five (5) Calendar Days for standard appeals and within two (2) Calendar Days for expedited appeals. 42 C.F.R. §§ 438.406(b)(5) and 438.408(b) - (c).
  6. The PIHP shall consider all comments, documents, records, and other information submitted by the member or his or her authorized representative during the appeal without regard to whether such information was submitted or considered in the initial adverse benefit determination.
  7. The PIHP shall require Members to exhaust the internal Appeal process before requesting a State Fair Hearing. However, if the PIHP fails to adhere to the notice and timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, Members will be deemed to have exhausted the PIHP's internal Appeal process and can request a State Fair Hearing. 42 C.F.R. §§ 438.408 and 438.402(c)(1)(i)(A).
- viii. Request for Plan Appeals
1. The PIHP shall allow Members, or an authorized representative, sixty (60) Calendar Days from the date on the Notice of Adverse Benefit Determination to file a request, verbally or in writing, for an Appeal with the PIHP. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).
  2. The PIHP shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard Appeal request, whether received verbally or in writing, within five (5) Calendar Days of receipt of the request. 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
- ix. Standard Resolution of Appeals
1. The PIHP shall provide written notice of resolution of the Appeal to the Member and/or authorized representative as expeditiously as the Member's health condition requires and no later than thirty (30) Calendar Days after receipt of a standard Appeal request. 42 C.F.R. §§ 438.408(a) and 438.408(b)(2).
  2. The PIHP shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing Appeal request form consistent with 42 C.F.R. § 438.408(e).
- x. Extension of Standard Resolution of Appeal
- The PIHP may extend the timeframes for standard resolution of an Appeal request by up to fourteen (14) Calendar Days if:
1. The Member requests the extension, or the PIHP determines that there is a need for additional information and the delay is in the Member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. §§ 438.408(b)(1) and (3).
  2. If the timeframe is extended other than at the Member's request, the PIHP shall do the following:
    - a. Make reasonable efforts to give the Member verbal notice of the delay;

- b. Within two (2) Calendar Days, provide written notice using the Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
    - c. Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(iii); 42 C.F.R. § 438.408(b)(2).
  - 3. The Notice of Extension of Timeframe for Standard Appeal Resolution shall include:
    - a. The timeframe for extension;
    - b. The reason for extension;
    - c. A statement on the Member's right to file a Grievance if he or she disagrees with the extension; and
    - d. A statement regarding the availability of assistance with the Appeals process and the ability to call the PIHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
  - 4. The PIHP shall provide written notice of the resolution of the Appeal, which shall include the date completed and reasons for the determination in easily understood language. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2). The PIHP shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Member may obtain the Utilization Management clinical review or decision-making criteria.
- xi. Expedited Resolution of Plan Appeals
  - 1. The PIHP shall establish, maintain, and communicate to Members an expedited Appeal resolution process for plan Appeals for use when there is an immediate need for health services because a standard Appeal could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).
  - 2. The PIHP shall allow members or an authorized representative to file an expedited Appeal resolution request either verbally or in writing within sixty (60) Calendar Days of the date on the adverse benefit determination notice.
  - 3. The PIHP shall not require any additional written follow-up for verbal requests for expedited Appeal resolution requests. 42 C.F.R. § 438.406(b)(3).
  - 4. In accordance with N.C.G.S. § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited appeal requests made by a network provider acting as an authorized representative of the Member on behalf of a Member, the PIHP shall presume an expedited appeal resolution is necessary and grant the request for expedited resolution. The PIHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).
  - 5. If the PIHP denies the request for an expedited plan Appeal, it shall do the following:
    - a. Immediately transfer the Appeal to the timeframes for standard resolution timeframe; and
    - b. Make reasonable efforts to give the Member or an authorized representative oral notice of the denial and follow up with a written notice, of the denial of the expedited resolution request within two (2) Calendar Days of the denial of the expedited appeal. 42 C.F.R § 438.410(c); 42 C.F.R §§ 438.408 (b)(2) and 438.408(c)(2)(ii).
  - 6. For expedited resolution of Appeals, the PIHP shall make a determination as expeditiously as the Member's health condition requires but shall provide written notice, and make reasonable effort to provide verbal notice, of resolution no later than seventy-two (72) hours of receipt of the expedited Appeal request. 42 C.F.R. § 438.408(a) and 42 C.F.R. § 438.408(b)(3).

7. PIHP shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing Appeal request form.
- xii. Extension of expedited Appeal resolution
  1. The PIHP may extend the timeframes for expedited resolution of an Appeal request by up to fourteen (14) Calendar Days if:
    - a. The Member requests the extension, or the PIHP determines that there is a need for additional information and the delay is in the member's interest.
    - b. If the timeframe is extended other than at the Member's request, the PIHP shall do the following:
      - i. Make reasonable efforts to give the Member verbal notice of the delay;
      - ii. Within two (2) Calendar Days, provide written notice and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and
      - iii. Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(iii); 42 C.F.R. § 438.408(b)(1).
  2. The PIHP shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
    - a. The timeframe for extension;
    - b. The reason for extension;
    - c. A statement on the Member's right to file a Grievance if he or she disagrees with the extension; and
    - d. A statement on the availability of assistance with the Appeals process and the ability to call the PIHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
- e. Continuation of Benefits
  - i. Timely Request for Continuation of Benefits: The PIHP shall continue and pay for the Member's benefits during the pendency of the plan Appeal and State Fair Hearing if all of the following occur:
    1. The Member, or the Member's authorized representative, files the request for an Appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
    2. The plan Appeal involves the termination, suspension, or reduction of previously authorized services;
    3. The services were ordered by an authorized provider;
    4. The period covered by the original authorization has not expired; and
    5. The Member timely files for continuation of benefits within ten (10) Calendar Days of the PIHP sending the notice of the adverse benefit determination (or before), or on the intended effective date of the PIHP's proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(a); 42 C.F.R. § 438.420(b)(1)-(5); and 42 C.F.R. § 438.420(c)(2)(ii).
  - ii. If the PIHP continues the Member's benefits while the Appeal is pending, the benefits must be continued until one (1) of the following occurs:
    1. The Member withdraws the Appeal or State Fair Hearing request, in writing;
    2. The Member does not request a State Fair Hearing and continuation of benefits within ten (10) Calendar Days from when the PIHP mails an adverse PIHP decision regarding the Member's PIHP Appeal; or
    3. A State Fair Hearing decision adverse to the Member is made.
  - iii. The PIHP shall not allow a provider to request continuation of benefits on behalf of a Member. 42 C.F.R. § 438.402(c)(1)(ii).
  - iv. Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
    1. The PIHP shall be permitted to recover the cost of services furnished to the Member during the pendency of the plan Appeal and the State Fair Hearing if:

- a. The PIHP notified the Member of the potential for recovery;
  - b. The PIHP furnished benefits to the member solely because of the requirement for continuation of benefits; and
  - c. The final resolution of the plan Appeal or the State Fair Hearing is adverse to the Member (i.e., upholds the PIHP's adverse benefit determination). 42 C.F.R. § 438.420(d); 42 C.F.R. 431.230(b). For purposes of recovering cost of services furnished during the pendency of the Appeal, the PIHP shall consider a final resolution to be adverse to the Member when all the following occur:
    - i. The member timely requests benefits to continue during the plan appeal or the State Fair Hearing;
    - ii. The PIHP upholds its initial decision in its notice of resolution to the member following the plan appeal; and
    - iii. The Office of Administrative Hearings issues a final decision in accordance with N.C. Gen. Stat. § 150B-34 that upholds the PIHP's Adverse Benefit Determination that gave rise to the appeal.
  - 2. If the PIHP chooses to seek to recover the cost of services provided to Members during the pendency of the plan Appeal or the State Fair Hearing, the PIHP shall do the following:
    - a. Develop a Member hardship exemption process; and
    - b. Obtain prior approval from the Department for each instance in which the PIHP seeks to recover the costs of benefits provided to Members under this Section which includes an explanation of the services provided to the Member, the amount the PIHP is seeking to recover and a detailed explanation for why the PIHP is seeking recovery.
- f. State Fair Hearing Process
- i. PIHP shall comply with Chapter 108D and Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
  - ii. The PIHP shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.
  - iii. The PIHP shall allow Members or their authorized representatives one hundred twenty (120) Calendar Days from the date on the Notice of Resolution issued by the PIHP upholding, in whole or in part, the Adverse Benefit Determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f)(2).
  - iv. The parties to the State Fair Hearing shall include the PIHP and the Member or, when applicable, the Member's authorized representative. 42 C.F.R. § 438.408(f)(3).
  - v. The PIHP shall designate a mailing and email address with the OAH for all Fair Hearing communications from OAH and any party to the State Fair Hearing.
  - vi. Mediation
    - 1. The PIHP shall notify Members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
    - 2. The PIHP shall inform Members that mediation is voluntary and that the member is not required to request a mediation to receive a State Fair Hearing with OAH.
    - 3. The PIHP shall attend and participate in Mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
  - vii. Effectuation of Reversed Appeal Resolutions
    - 1. If the PIHP, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the PIHP shall authorize or provide the disputed services promptly

and as expeditiously as the member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).

2. If the PIHP, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the member received the disputed services while the Appeal was pending, the PIHP shall pay for those services in accordance with the terms of the Contract.

g. Appellate Responsibilities

- i. The PIHP shall notify the Department within five (5) Calendar Days of being served notice of a Member's request for judicial review, or other Appeal, following an adverse ruling in a State Fair Hearing.
- ii. The PIHP is responsible for responding to the request for judicial review, or other Appeal, as well as for PIHP's attorney's fees and costs.
- iii. If Department is also a party, the Department is responsible for its response to the request for judicial review. The PIHP will cooperate fully with Department in its response and defense. To the extent no conflict of interest exists or arises, the PIHP and Department may agree to joint defense.
- iv. The PIHP is responsible for satisfying any judgment, including payment of benefits, that result from a court's ruling or order in favor of the Member and against the PIHP.

h. NC Health Choice Beneficiary Grievances and Appeals

- i. The PIHP shall allow Members who are NC Health Choice beneficiaries enrolled in the PIHP to file Grievances in the same manner as Members who are North Carolina Medicaid beneficiaries as specified in this Contract. 42 C.F.R. § 457.1260(b)(1).
- ii. In accordance with 42 C.F.R. §§ 457.1260 and 457.1130(b), the PIHP shall allow Members who are NC Health Choice beneficiaries enrolled in the plan to file Appeals in the same manner as members who are North Carolina Medicaid beneficiaries as specified in this Contract, except that the PIHP shall not provide continuation of benefits to Members who are NC Health Choice beneficiaries during the pendency of an Appeal. 42 C.F.R. § 457.1260.
- iii. Notwithstanding requirements within this Section, if the sole basis for the PIHP's decision to delay, deny, reduce, suspend, or terminate health services, in whole or in part, is a provision in the NC Health Choice State Plan or in federal or North Carolina law requiring an automatic change in coverage under the health benefits package that affects all Members or a group of members without regard to their individual circumstances, the PIHP shall not be required to provide the member with an opportunity for review of the matter. 42 C.F.R. § 457.1130(c).

i. Appeals and Grievances Recordkeeping and Reporting

- i. The PIHP shall maintain records of all member Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's Quality Strategy. 42 C.F.R. § 438.416(a).
- ii. The record of each Grievance and Appeal shall contain, at a minimum, the following:
  1. The name of the person for whom the Appeal or Grievance was filed;
  2. A general description of the reason for the Appeal or Grievance;
  3. The date received;
  4. The date of each review or, if applicable, review meeting;
  5. Resolution at each level of the Appeal or Grievance, if applicable;
  6. Date of resolution at each level, if applicable;
  7. Date of Appeal decision and mail date of Appeal decision;

8. Whether the Appeal was an expedited request, if applicable;
  9. Who conducted the review of the Appeal or Grievance and made the determination; and
  10. Whether an extension of Appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b)(1)-(6).
- iii. The PIHP shall maintain accurate records in a manner accessible to the Department and available upon request to CMS. 42 C.F.R. § 438.416(c).
  - iv. The PIHP shall retain Appeal and Grievance records consistent with the record retention terms of the Contract following the final decision or the close of the Appeal or Grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the retention 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 period, whichever is later.
  - v. Appeals and Grievance Reporting
    1. In accordance with 42 C.F.R. § 438.416, the Department will monitor the PIHP to ensure compliance with all applicable laws and rules pertaining to member Appeals and Grievances.
    2. To support the Department's monitoring efforts, the PIHP shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
      - a. Each Notice of Adverse Benefit Determination issued by the PIHP; and
      - b. Each Notice of Resolution issued by the PIHP.
    3. The PIHP shall provide a report on all Appeals and Grievances received by the PIHP from members, or an authorized representative, in a form and frequency as described in *Section VI. Attachment I. Reporting Requirements*.

## F. Benefits

1. Behavioral Health and I/DD Benefits Package
  - a. Throughout the term of this Contract, the PIHP shall promptly provide, arrange, purchase, or otherwise make available all medically necessary services required under this Contract to all its Members enrolled in the PIHP. Services shall be delivered within the standard of care and meet Department quality standards set forth in this Contract or otherwise communicated in writing to the PIHP.
    - i. BH benefits are inclusive of mental health and SUD services.
    - ii. I/DD benefits refer to services targeted towards individuals with an I/DD, including intermediate care facilities for individuals with intellectual disabilities (ICF-IID), and other home and community-based services
  - b. The PIHP shall:
    - i. Cover all BH and I/DD services in the North Carolina Medicaid and NC Health Choice State Plans;
    - ii. Use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;
    - iii. Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the Member's diagnosis, type of illness or condition;
    - iv. Furnish covered benefits in an amount, duration, and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2);
    - v. Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i);
    - vi. Develop a comprehensive Utilization Management Program inclusive of a subset of NC Medicaid Direct clinical coverage policies as defined in this Contract; and

- vii. Implement and adhere to all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policies and protocols as defined in *Section IV.F.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members.*
- c. Covered Medicaid and NC Health Choice services:
  - i. Consistent with N.C. Gen. Stat. §§ 108D-60 and 108D-35, the PIHP shall be responsible for covering BH and I/DD services that are defined as *Section IV.F.1. Behavioral Health and I/DD Benefits Package*, as well as any services that the Department obtains authority through a SPA or waiver to cover and adds to the PIHP benefit package.
  - ii. A crosswalk of the SUD services covered under the Medicaid and NC Health Choice State Plans to national clinical standards is provided in *Section IV.F.1. Behavioral Health and I/DD Benefits Package.*
  - iii. The PIHP shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.

<b>Section IV.F.1. Table1: Behavioral Health, I/DD, and TBI Services Covered by PIHP</b>
<ul style="list-style-type: none"> <li>• Inpatient BH services</li> <li>• Outpatient BH emergency room services</li> <li>• Outpatient BH services provided by direct-enrolled providers</li> <li>• Psychological services in health departments and school-based health centers sponsored by health departments</li> <li>• Peer supports</li> <li>• Partial hospitalization</li> <li>• Mobile crisis management</li> <li>• Facility-based crisis services for children and adolescents</li> <li>• Professional treatment services in facility-based crisis program</li> <li>• Outpatient opioid treatment</li> <li>• Ambulatory detoxification</li> <li>• Research-based BH treatment for Autism Spectrum Disorder (ASD)</li> <li>• Diagnostic assessment</li> <li>• Non-hospital medical detoxification</li> <li>• Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization</li> <li>• Residential treatment facility services</li> <li>• Child and adolescent day treatment services</li> <li>• Intensive in-home services</li> <li>• Multi-systemic therapy services</li> <li>• Psychiatric residential treatment facilities (PRTFs)</li> <li>• Assertive community treatment (ACT)</li> <li>• Community support team (CST)<sup>2</sup></li> <li>• Psychosocial rehabilitation</li> <li>• Substance abuse non-medical community residential treatment</li> <li>• Substance abuse medically monitored residential treatment</li> <li>• Substance abuse intensive outpatient program (SAIOP)</li> <li>• Substance abuse comprehensive outpatient treatment program (SACOT)</li> <li>• Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)</li> <li>• Early and periodic screening, diagnostic and treatment (EPSDT) services</li> <li>• Supported employment*</li> </ul>

<sup>2</sup> CST includes tenancy supports.



**Section IV.F.1. Table1: Behavioral Health, I/DD, and TBI Services Covered by PIHP**

- Individual transition and support\*
- Respite\*
- Community living and supports\*
- Community transition\*

*\*North Carolina is currently in the process of developing a SPA to CMS to cover these services through 1915(i) authority.*

**Section IV.F.1. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services**

ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Inpatient BH services
Office-based opioid treatment	Office-based opioid treatment	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

- iv. The PIHP shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).
- v. Changes to Covered Benefits
  - 1. The PIHP shall cover BH and I/DD benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans and consistent with any approved Medicaid waivers, except to the extent the service is carved out of the PIHP.
- vi. Institutions for mental disease (IMD) SUD Services
  - 1. Under North Carolina's 1115 waiver authority, the PIHP shall provide coverage for substance use disorder services for Medicaid Members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.
  - 2. The PIHP shall provide the Department with a weekly report on Medicaid Members who are residing or have resided in an IMD for SUD treatment as defined in Section VI. Attachment I. Reporting Requirements to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.
- d. Medical Necessity
  - i. The PIHP shall cover all medically necessary services for its enrolled Members in accordance with *Section IV.F. Benefits*.
  - ii. The PIHP shall provide medically necessary services to all enrolled Medicaid Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or BH, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section IV.F.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.
  - iii. The PIHP may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section IV.F.1 Behavioral Health and I/DD Benefits Package* below and as permitted by 42 C.F.R. § 438.210(a)(4)(i)-(ii), provided the services furnished can be reasonably expected to achieve their purpose.
  - iv. The PIHP shall work with providers to ensure that providers identify an appropriate new level of care for a Member who no longer meets the medical necessity criteria for an existing service.
  - v. The PIHP shall determine whether a service is medically necessary on a case by case basis.
  - vi. For Members under the age of twenty-one (21), the PIHP shall not issue adverse determinations on requests for a medical service coverable under 42 U.S.C. § 1396d(a), (§1905(a) of the Social Security Act) unless the decision is made following a medical necessity review per EPSDT federal standards.
  - vii. Consistent with 42 C.F.R. 438.210(a)(5)(ii), the PIHP shall provide medically necessary services that address:
    - 1. The prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder that results in health impairments and/or disability.
    - 2. The ability for a Member to achieve age-appropriate growth and development.
    - 3. The ability for a Member to attain, maintain, or regain functional capacity.
- e. Utilization Management
  - i. The PIHP shall develop a utilization management (UM) program for BH and I/DD services that is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies. The PIHP shall ensure the UM program aligns

with the parameters laid out in *Section IV.A.3. Readiness Review Requirements*, to the degree a subcontractor relationship applies.

ii. UM Program Policy

1. The PIHP shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the UM Program Policy, clearly states it applies to the PIHP, the UM Program Policy PIHP may have a single set of UM for the PIHP and BH I/DD Tailored Plan contracts.
2. The UM Program Policy, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
  - a. Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
  - b. Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
  - c. Mechanisms to assess whether Members are receiving the appropriate level of care corresponding to their clinical information;
  - d. Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
  - e. Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
  - f. Protecting Members from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to Appeal the denial or reduction or termination of a service;
  - g. Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization;
  - h. Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the PIHP;
  - i. Dissemination of guidelines to all affected providers and, upon request, to Members and potential Members; and
  - j. Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member.
  - k. The PIHP shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the PIHP shall submit the attestation required by this Section annually, by June 30th, unless otherwise directed by the Department.
3. Nothing in this section shall be construed to limit or interfere with the Department's right to individually review and approve any PIHP UM or clinical coverage policy to ensure compliance with the Contract.
4. The PIHP shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.
5. The PIHP shall post the UM Program Policy on their publicly available website for providers and members, or in other forms as requested by the provider or member, at no cost. The PIHP shall include a prominent reference to the web address of the UM Program Policy in both its Provider Manual and Member Handbook.

6. The PIHP shall provide training and education to providers on changes to the UM Program prior to the effective date of the change as part of the Provider Training Plan as described in *Section IV.H.3. Provider Relations and Engagement*. As long as the training and education applies to the PIHP, the training and education may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- iii. The UM process must support a holistic look at an enrollee’s BH and I/DD needs, noting that alternative treatments or supports may be appropriate in light of a Member’s complete clinical and other support needs.
- iv. The Clinical Practice Guidelines shall:
  1. Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
  2. Consider the needs of Members;
  3. Be adopted in consultation with contracting health professionals;
  4. Be reviewed and updated periodically as appropriate; and
  5. Be utilized for decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply.
- v. The Department will allow “proprietary” UM policies under reasonable circumstances, with prior approval by the Department.
- vi. The Department reserves the right to require the PIHP to follow additional NC Medicaid Direct clinical coverage policies developed by the Department after the effective date of this Contract.
- vii. The PIHP shall incorporate existing NC Medicaid Direct clinical coverage policies into the UM Program as described in *Section IV.F.1. Table 6: Required Clinical Coverage Policies*.

<b>Section IV.F.1 Table 6: Required Clinical Coverage Policies</b>	
<b>Service</b>	<b>Scope</b>
<i><b>PIHP Services</b> Note: For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.</i>	
Medicaid State Plan BH Services	8A: Enhanced Mental Health and Substance Abuse Services: <ul style="list-style-type: none"> <li>• Ambulatory Detoxification</li> <li>• Child and Adolescent Day Treatment services</li> <li>• Diagnostic Assessment</li> <li>• Intensive In-Home Services</li> <li>• Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization</li> <li>• Mobile Crisis Management</li> <li>• Multi-systemic Therapy Services</li> <li>• Non-hospital Medical Detoxification</li> <li>• Outpatient Opioid Treatment</li> <li>• Partial Hospitalization</li> <li>• Professional Treatment Services in Facility-Based Crisis Program</li> <li>• Psychosocial Rehabilitation (PSR)</li> <li>• Substance abuse comprehensive outpatient treatment program (SACOT)</li> <li>• Substance Abuse Non-Medical Community Residential Treatment</li> <li>• Substance Abuse Medically Monitored Residential Treatment</li> <li>• Substance Abuse Intensive Outpatient Program (SAIOP)</li> </ul>

Section IV.F.1 Table 6: Required Clinical Coverage Policies	
Service	Scope
<b>PIHP Services</b> Note: For these policies, PIHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.	
	8A-1: Assertive Community Treatment 8A-2: Facility-Based Crisis Services for Children and Adolescents 8A-6: Community Support Team (CST)  8B: Inpatient Behavioral Health Services  8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers  8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21  8D-2: Residential Treatment Services  8F: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder 8G: Peer Supports 8I: Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population
Medicaid State Plan I/DD Services	8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
Medicaid State Plan HCBS	Supported Employment (IDD and MH/SUD)  Individual Transition and Supports  Community Transition  Community Living and Supports  Respite
Telehealth (for services within the scope of this contract)	1-H, Telehealth, Virtual Communications and Remote Patient Monitoring

- viii. The PIHP shall make the Chief Medical Officer for the PIHP or designee available to discuss and report on the UM Program, as requested by the Department.
- ix. The PIHP shall use a standardized prior authorization request form developed by the Department.
- x. The PIHP shall, prior to the decision on a request for prior approval, limit PIHP-initiated contacts with the requesting provider or Member (including telephone and email contacts) to those

needed to obtain more information about the service request and/or to provide education about covered services.

1. Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (Supports Needs Assessment Profile) or SIS® score or other clinical assessment.
2. Material misinformation to or intimidation of providers or Members who has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH Appeals is prohibited. The care management process shall not be used to improperly influence, change, or prevent a request for a prior approval.
3. Nothing in this paragraph should be construed to prevent clinical or treatment discussions.
- xi. The PIHP shall not terminate a service authorization after the services, supplies, or other items have been provided, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or the provider of the service, supply, or other item.
- xii. The PIHP shall not terminate a prior authorization for emergency services after the services have been provided, unless the authorization was based on a material misrepresentation about the Member's health condition made by the provider of the emergency services or the Member.
- xiii. Any decision to deny a service authorization request or to authorize a service, within the scope of this contract, in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the member's BH or I/DD or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).
- xiv. As part of the UM program, the PIHP shall adhere to the following prior authorization requirements.
  1. The PIHP shall conduct prior authorization reviews using current clinical documentation and must consider the comprehensive range of the member's BH and I/DD needs, noting that alternative treatments or supports may be appropriate in light of a Member's complete clinical and other support needs.
  2. The PIHP may require a referral for any BH or I/DD services except where specifically prohibited in this Contract and in federal or State laws, rules, or regulations.
  3. The PIHP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the LEA. However, PIHP may consider the IEP to contain evidence to support a determination that a Member may require active treatment.
  4. Consistent with 42 C.F.R. § 438.206, the PIHP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
    - i. Emergency services
      - i. In accordance with 42 C.F.R. § 438.114, the PIHP shall not require members to obtain a referral or prior authorization before receiving emergency services.
      - ii. The PIHP shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
      - iii. The PIHP shall not refuse to cover emergency services based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's PIHP of the Member's screening and treatment within ten (10) Calendar Days of presentation for emergency services.

- iv. The PIHP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the PIHP's Network.
  - v. The PIHP shall not hold a Member with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
  - vi. The PIHP shall not deny payment for treatment obtained due to an emergency medical condition or as a result of the Member having been instructed by a representative of the PIHP to seek emergency services. For purposes of this section, the term "representative" shall not include a contracted provider of the PIHP.
- ii. BH services
- i. For Medicaid State Plan BH services, the PIHP shall require providers to use the following BH or other Department approved level-of-care determination and screening as part of the PIHP's UM program. The Department reserves the right to change, in writing, these required screening tools:
    - 1. Substance Use:
      - a. American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through six (6); and
      - b. The PIHP shall use EPSDT criteria when evaluating requests for services for all children.
    - 2. Mental Health:
      - a. Level of Care Utilization System (LOCUS) scores for adults ages eighteen (18) and older;
      - b. Child and Adolescent Level of Care Utilization System (CALOCUS) scores for children and adolescents ages six (6) through seventeen (17); and
      - c. Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.
  - ii. The PIHP shall not require members to obtain a referral or prior authorization for the first mental health or substance use assessment completed in a twelve (12) month period.
- iii. UM for children and youth under age 21
- i. Screening services for children and youth under age 21: The PIHP shall not require members to obtain a referral or prior authorization for children's screening services.
  - ii. School-based clinic services: The PIHP shall not require members to obtain a referral or prior authorization for behavioral health services rendered at school-based clinics.
5. The PIHP shall ensure members have and are aware of having direct access to services for which the Department does not allow the PIHP to require referral or prior authorization, as defined in this Section.

xv. Service Authorization and Noticing Requirements

1. The PIHP shall provide written notice, using the Department-developed template, to members on adverse decisions related to authorization of services. The written notice shall include the following:
  - i. The basis for such decisions; and
  - ii. Sufficient details that inform members of the decision, which will provide them with information necessary to determine if they wish to Appeal as noted in *Section IV.E.6. Member Grievances and Appeals*.
2. For standard authorization decisions, the PIHP shall provide notice as expeditiously as the Member's condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).
3. The PIHP may receive a possible extension of service authorization decision of up to fourteen (14) Calendar Days if the member requests the extension or the PIHP justifies a need for additional information and how the extension is in the Member's interest.
4. If the PIHP extends the timeframe beyond fourteen (14) Calendar Days, the PIHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.
5. For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the PIHP shall provide notice no later than seventy-two (72) hours after receipt of the request for service.
6. The PIHP may extend the seventy-two (72) hour time period for service authorization decisions by up to fourteen (14) Calendar Days if the Member requests the extension or the PIHP justifies a need for additional information and how the extension is in the member's interest.
7. If the PIHP extends the timeframe beyond seventy-two (72) hours, the PIHP shall provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.

xvi. UM Policy for DSOHF facilities

1. The PIHP shall comply with the authorization and admission requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the PIHP shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with I/DD or dementia.
2. Prior to referral or authorization of any Member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the PIHP must verify that the referral is in accordance with the requirements of N.C. Gen. Stat. § 122C-261 and any other applicable North Carolina law governing the admission of Members with intellectual disabilities to a State psychiatric hospital.
3. For Members who have multiple disorders and medical fragility or have multiple disorders and deafness, the PIHP shall be designated by the Department to determine whether Members have a high level of disability that alternative care is inappropriate, consistent with N.C. Gen. Stat. § 122C-261(e)(4).
4. In determining whether Members are eligible for referral and/or authorization for admission to a State psychiatric hospital, the PIHP must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose



in order to determine that any less restrictive and less costly options in the community have been exhausted.

- f. Telehealth and Virtual Patient Communications
  - i. The PIHP shall provide services within the scope of this contract via Telehealth and Virtual Patient Communications to members as an alternative service delivery model where clinically appropriate in compliance with all state and federal laws, including HIPAA and record retention requirements.
  - ii. The services provided via Telehealth and Virtual Patient Communications shall be provided in an amount, duration, and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).
  - iii. The PIHP may use Telehealth and Virtual Patient Communications as tools for facilitating access to needed services in a clinically appropriate manner that are not available within the PIHP's network.
  - iv. The PIHP shall not require a member to seek the services through Telehealth and must allow the member to access an in-person service through an out-of-network provider, if the member requests.
  - v. The PIHP shall develop and submit a Telehealth and Virtual Patient Communications Coverage Policy to the Department. The Telehealth and Virtual Patient Communications Coverage Policy shall include:
    - 1. Eligible providers who may perform Telehealth and Virtual Patient Communications;
    - 2. Modalities covered by the PIHP;
    - 3. Modalities not covered by the PIHP;
    - 4. Requirements for and limitations on coverage;
    - 5. Description of each covered modality, including:
    - 6. Compliance with local, state and federal laws, including HIPAA; and
    - 7. Process to ensure security of protected health information.
    - 8. Reimbursement mechanism (i.e. flow of funds from PIHP to all relevant providers and facilities) for each covered modality; and
    - 9. Billing guidance for providers.
  - vi. The PIHP shall submit a revised Telehealth and Virtual Patient Communications Policy to the Department upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution or whenever there is a material change to the Policy.
    - 1. The PIHP shall pay at least the in-person rate for the same service delivered via Telehealth (i.e. payment parity).
    - 2. For all services provided through Telehealth, the PIHP shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.
  - vii. As long as the Telehealth and Virtual Patient Communications Coverage Policy applies to the PIHP, the Telehealth and Virtual Patient Communications Coverage Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - viii. The PIHP shall pilot new approaches to Telehealth and Virtual Patient Communications and Value-Based Payment and shall support providers in optimizing the use of these services in their practices. For purposes of any pilot, the PIHP may propose, for the Department's review and approval, a waiver of payment parity requirements.
- g. In Lieu of Services (ILOS)
  - i. The PIHP may use ILOS, services or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plan, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)(2)(i)-(iii).

- ii. The PIHP shall submit the Department's standardized ILOS Service Request Form, prior to implementation to the Department for approval.
  - 1. In no instance shall the PIHP reduce or remove ILOS service without approval by the Department within a contract year.
  - 2. If changes, reduction, or removal of ILOS services is approved, the PIHP shall notify all members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.
  - 3. The PIHP shall notify the Department of the transition plan for current members receiving the terminated ILOS and notify all members of other approved service options.
  - 4. If the PIHP wishes to offer an ILOS the PIHP must still submit the Department's standardized ILOS Service Request Form for approval.
  - 5. Upon approval by the Department, the PIHP shall post ILOS policies on its publicly available member and provider websites no later than thirty (30) Calendar Days prior to the effective date of change.
  - 6. The PIHP shall monitor the cost-effectiveness of each approved ILOS by tracking utilization and expenditures on an annual basis or more frequently upon reasonable request of the Department (see Section VI. Attachment I. Reporting Requirements for more detailed requirements).
  - 7. The PIHP shall not require the member to utilize an ILOS.
- iii. The PIHP may offer Value-Added Services as approved by the Department. For each value-added service, the PIHP shall submit to the Department for approval, in the Department developed standardized template, the following information:
  - 1. Definition and description of the value-added service, including if prior authorization is required;
  - 2. Definition of the criteria to be eligible for proposed value-added service;
  - 3. Types of providers eligible to provide the Value-Added Services;
  - 4. Description of how and when providers and Members will be notified about the availability of the proposed value-added service;
  - 5. Duration for which Value-Added Services will be provided; and
  - 6. Description of if, and how, the services will be identified in encounter data.
- iv. The PIHP shall submit to the Department for approval any changes to Value-Added Services.
- v. In no instance may the PIHP reduce or remove Value-Added Services without approval by the Department during a Contract Year.
- vi. If changes, reduction, or removal of Value-Added Services is approved, the PIHP shall notify all members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.
- vii. Value-Added Services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e)(1)(i).
- h. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements
  - i. The PIHP shall work with the Department and the member's nursing facility to coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120 for members admitted to nursing facilities.
  - ii. The PIHP shall ensure the provision of Specialized Services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this contract as listed in *Section IV.F.1. Behavioral Health and I/DD Benefits Package*.
- i. The PIHP shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.

- j. Cost Sharing
    - i. The PIHP shall not impose cost sharing on Medicaid and NC Health Choice BH and I/DD services, as defined by the Department.
  - k. Electronic Verification System Requirements.
    - i. The PIHP must utilize an Electronic Visit Verification (EVV) system to verify personal care services, including all waiver and 1915(i) services that provide assistance with ADLs that are provided in the Member's home and are not provided as a per diem service, prior to releasing payment.
    - ii. The PIHP must utilize an EVV system to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:
      - 1. Type of service performed;
      - 2. Individual receiving the service;
      - 3. Date of the service;
      - 4. Time that the service begins;
      - 5. Location of service delivery;
      - 6. Individual providing the service; and
      - 7. Time that service ends.
    - iii. If the PIHP utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.
    - iv. The PIHP shall ensure that utilization of an EVV system for Innovations waiver services and the services covered under the 1915(i) State Plan option are in effect by PIHP launch.
    - v. At time of PIHP implementation, the PIHP shall deliver the EVV data elements to the Encounter Processing System (EPS) for personal Care Services or services that provide support with activities of daily living in a Member's home that are not daily rate services.
    - vi. The PIHP shall permit providers to continue using their existing EVV system provided that the system is compliant with state and federal regulations.
  - l. Moral and Religious Objection
    - i. The PIHP is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R. § 438.102(b) have been met.
2. If the PIHP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PIHP shall furnish information about the services it does not cover to the Department, and to any other Department partner as directed by the Department, whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2). Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Members.
- a. The PIHP shall cover services within its scope of responsibility for a Medicaid Member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination. This includes any evaluation by a physician or other licensed practitioner.
  - b. The PIHP shall ensure EPSDT services are furnished in an amount, duration, and scope no less than the amount, duration, and scope for the same services as defined in North Carolina's Medicaid State Plan and as defined in the Department's EPSDT policies.
  - c. The PIHP shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for members under twenty-one (21) years of age.

- d. When adjudicating service authorizations for Members under twenty-one (21) years of age, the PIHP shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the member.
- e. Upon conclusion of an individualized review of medically necessary services, the PIHP shall cover medically necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The PIHP shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this Contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the PIHP responsible for delivery of the referred service, product, or treatment.
- f. The PIHP may provide medically necessary services in the most economic mode possible, if:
  - i. The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;
  - ii. The determination process does not delay the delivery of the needed service; or
  - iii. The determination does not limit the Member's right to a free choice of providers within the PIHP's Network.
- g. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, UM policies, service definitions, or billing codes do not apply to Medicaid members who are less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, or other licensed, enrolled clinicians.
- h. The PIHP shall ensure and verify that network BH providers coordinate with primary care providers and specialists conducting EPSDT screenings.
- i. The PIHP shall not require prior authorization for preventive care within its scope of responsibilities (early and periodic screens) for members less than twenty-one (21) years of age. The PIHP may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.
- j. The PIHP shall comply with the Department's standards for the timely provision of EPSDT services within its scope of responsibilities. For purposes of this Contract, the "timely provision of the EPSDT services" shall mean that a Member shall have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks from the date of the request for an appointment.
- k. The PIHP shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.
- l. The PIHP shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:
  - i. Regular preventive care, and
  - ii. Scope of services, products and treatments available when medically necessary to correct or ameliorate a health condition or problem.

- m. The PIHP shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) Calendar Days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in *Section IV.E.3. Member Engagement*.
- n. The PIHP shall perform outreach to members who are due or overdue for an EPSDT screening service within its scope of responsibilities monthly.
- o. The PIHP shall effectively inform Members and/or their parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the *Section IV.E.3. Member Engagement*.
- p. The PIHP shall not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per EPSDT criteria.
- q. While an EPSDT request is under review, the PIHP may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as the PIHP makes clear that the Member has the right to request authorization of the services he or she wants to request.
  - i. The PIHP shall not request that providers or Members withdraw or modify a request for EPSDT services to accept a fewer number of hours, or less intensive type of service, or to modify a SNAP (Support Needs Assessment Profile) or other clinical assessment.
  - ii. Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH Appeals is prohibited.
  - iii. Nothing in this Section should be construed to prevent clinical or treatment discussions.
- r. The PIHP shall offer assistance with scheduling appointments for EPSDT services, upon a member's request.
- s. The PIHP shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services) for referrals. The PIHP shall also make referrals to other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.
- t. The PIHP shall develop and maintain an EPSDT Policy. The PIHP shall submit the EPSDT Policy to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution and annually thereafter. As long as the EPSDT Policy clearly states that it applies to the Medicaid Direct, the EPSDT Policy may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
- u. Educational and Training Materials
  - i. The PIHP shall develop written and verbal educational materials on EPSDT, including educational materials for members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
    - 1. The PIHP shall submit the materials to the Department for review and approval as defined in *Section IV.E.3. Member Engagement*.
    - 2. The PIHP may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.
    - 3. As long as the educational materials clearly state that they apply to the PIHP, the educational materials may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.

- ii. As part of the Provider Training Plan defined in *Section IV.H.3. Provider Relations and Engagement*, the PIHP shall provide training to all Network providers where EPSDT is relevant to the providers' area of practice on an annual basis. Training must include information related to:
  1. EPSDT benefits within its scope of responsibilities;
  2. EPSDT medical necessity review per federal criteria: standards and processes;
  3. Required components of an EPSDT screening service;
  4. Outreach activities related to EPSDT provided by the PIHP; and
  5. Necessary documentation required for reimbursement of EPSDT services.

## G. Care Management and Care Coordination

### 1. Overview

- a. The Department believes that care management and care coordination are crucial drivers to help achieve key goals of PIHPs, linking individuals to services and supports that keep them healthy and provide appropriate care and fostering coordination and collaboration among care team members across disciplines and settings.
- b. The Department recognizes that there will be PIHP Members who would have otherwise been eligible for a BH I/DD Tailored Plan, as described in *Section IV.E.1. Eligibility and Enrollment for PIHPs*, if they were not part of a group that is delayed or excluded from Medicaid Managed Care. Most of these Members would benefit from obtaining Tailored Care Management as defined in *Section IV.G.2. e*.
- c. The PIHP shall be responsible for implementing the Tailored Care Management model as described in *Section IV.G.2. Tailored Care Management and engaging its eligible Members in Tailored Care Management* as described in this Section.
- d. Beyond Tailored Care Management, the PIHP shall be responsible for delivering care coordination and managing care transitions for all Members, regardless of whether they are eligible for or participate in Tailored Care Management, as described in *Section IV.G.3. Care Coordination and Care Transitions for all Members*, *Section IV.G.4. Care Coordination for Members with a BH Transitional Care Need*, *Section IV.G.5. Care Coordination Responsibilities for Members with an Unmet BH, I/DD, or TBI-Related Need Who Are Not Enrolled and Tailored Care Management*, and *Section IV.G.6. Care Coordination Responsibilities for Members Obtaining Care Management, Care Coordination, or Case Management Through Another Entity*.
- e. The PIHP must also provide additional care management and care coordination functions as detailed in *Section IV.M. Innovations Waiver Services*, *Section IV.G.7. Other Care Management Programs*, *Section IV.G.9. System of Care*, and *Section IV.G.10. In-reach and Transition from Institutional Settings*.
- f. The PIHP must also meet the requirements set forth in *Section IV.G.8. Care Management and Care Coordination Policy*, *Section IV.E.3. Member Engagement*, and *Section IV.G.10. In-Reach and Transition from Institutional Settings*.

### 2. Tailored Care Management

- a. Model Overview and Objectives
  - i. Tailored Care Management is built on the principle that Provider- and community-based care management is crucial to the success of fully integrated managed care. The PIHP must ensure that care managers delivering Tailored Care Management coordinate across a Member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.

- ii. The Department is committed to the principle that placing care management as close as possible to the Member and the site of care will drive better health outcomes.
  - iii. The PIHP shall ensure that Tailored Care Management is available to all eligible PIHP Members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative care management services as defined in *Section IV.G.2.c. Tailored Care Management*.
  - iv. Tailored Care Management is also designed to align with the North Carolina System of Care framework. The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with BH needs.
  - v. Federal Health Home Structure
    - 1. The Department intends to submit a SPA to add Tailored Care Management as a Health Home State Plan benefit, upon CMS approval.
    - 2. The PIHP shall act as the designated Health Home for its Members.
    - 3. In its role as a Health Home, the PIHP shall ensure that Members have access to Care Management that meet the requirements of this Section and federal Health Home requirements.
    - 4. The PIHP shall cooperate with the Department in the administration of North Carolina's Section 2703 Health Home SPA, including implementation, providing reporting and data, and other requirements.
- b. Delivery of Tailored Care Management
- i. The PIHP must offer the following three approaches for delivering Tailored Care Management:
    - 1. AMH+: To be eligible to become an AMH+, the practice must intend to become a PCP in the BH I/DD Tailored Plan network. Only AMH Tier 3 practices certified as an AMH+ practice may provide Tailored Care Management as defined in Section IV.G.2. Tailored Care Management.
    - 2. Care Management Agency (CMA): To be eligible to become a CMA, an organization must, at the time of certification, have as its primary purpose the delivery of NC Medicaid, NC Health Choice, or State-funded Services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. Provider organizations must be certified as a CMA to provide Tailored Care Management as defined in Section IV.G.2. Tailored Care Management.
    - 3. PIHP-based care managers: The PIHP may provide Tailored Care Management.
  - ii. Provider-based Tailored Care Management
    - 1. The Department considers Tailored Care Management delivered by an AMH+ practice or a CMA to be provider-based.
    - 2. The PIHP must contract with all willing organizations in its catchment area that receive AMH+ or CMA certification to provide Tailored Care Management, with limited exceptions as described in Section IV.G.2. Tailored Care Management.
    - 3. The PIHP shall meet annual requirements established by the Department for the percentage of Members actively engaged in Provider-based Tailored Care Management across both the Medicaid Direct plan and the BH I/DD Tailored Plan, meaning Members who are receiving at least one (1) of the following six (6) core Health Home services in that month:
      - a. Comprehensive care management;
      - b. Care coordination;
      - c. Health promotion;
      - d. Comprehensive transitional care/follow-up;
      - e. Individual and family supports; or

- f. Referral to community and social support services<sup>3</sup>.
  - g. The percentage shall be calculated as:
    - i. Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department; and
    - ii. Denominator: Total number of members actively engaged in Tailored Care Management.
4. Each year, the Department will divide the amount of Tailored Care Management that was delivered by AMH+s and CMAs (and Clinically Integrated Networks (CINs) or Other Partners on their behalf) to Members of both the LME/MCO's PIHP and BH I/DD Tailored Plan products by the amount of all Tailored Care Management delivered to Members of the LME/MCO's PIHP and BH I/DD Tailored Plan products. The annual goal percentages for Provider-based Tailored Care Management delivered to the LME/MCO's PIHP and BH I/DD Tailored Plan members are as follows:
    - i. Contract Year 1: 30 percent (30%);
    - ii. Contract Year 2: 45 percent (45%);
    - iii. Contract Year 3: 60 percent (60%); and
    - iv. Contract Year 4: 80 percent (80%).
  5. The Department will assess compliance with annual percentages for each Contract Year during the first quarter of subsequent Contract Year, beginning in Contract Year Two.
  6. The Department may adjust the annual required percentages at its discretion, and in accordance with the process for amending this Agreement.
  7. As part of its Care Management and Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*), the PIHP shall provide a plan for supporting development of Provider-based Tailored Care Management and oversight of Provider-based Tailored Care Management.
- c. Eligibility for Tailored Care Management
    - i. All Members who would have otherwise been eligible for a BH I/DD Tailored Plan, as described in *Section IV.E.1. Eligibility and Enrollment for PIHPs*, if they were not part of a group delayed or excluded from Medicaid Managed Care, as described in *Section IV.E.1. Eligibility and Enrollment for PIHPs*, including those enrolled in North Carolina's 1915(c) Innovations waiver, are eligible for Tailored Care Management, with the following exceptions for Members participating in services that are duplicative of Tailored Care Management:
      1. Members receiving Assertive Community Treatment (ACT);
      2. Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
      3. Members participating in Care Management for At-Risk Children;
      4. Members obtaining care management from the Department's PCCM vendor;
      5. Members receiving case management through the CAP/C and CAP/DA programs;
      6. Members participating in the High-Fidelity Wraparound program as described in Section IV.G.7 Other Care Management Programs; and
      7. Members who reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer.

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<sup>3</sup> CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf>



- d. Enrollment in Tailored Care Management
  - i. The PIHP shall auto-enroll all Members eligible for Tailored Care Management into Tailored Care Management at PIHP launch.
  - ii. The PIHP shall allow Members to opt out of Tailored Care Management at any time.
    - 1. The PIHP shall permit Members who do not want to participate in Tailored Care Management to opt-out via a Tailored Care Management Opt-out Form, which the PIHP shall submit to the Department for approval as part of its Care Management and Care Coordination Policy. The PIHP shall use the same Tailored Care Management Opt-out Form as the one used for the BH I/DD Tailored Plan contract. The form must include a place to provide the reason for opting out.
    - 2. The PIHP shall permit the Tailored Care Management Opt-out Form to be mailed in, completed online, filled out in person with the care manager, or filled out over the telephone with either the PIHP or organization assigned to provide Tailored Care Management.
    - 3. The PIHP shall permit a Member who has opted out to opt back into Tailored Care Management at any time by contacting the PIHP.
    - 4. The PIHP shall provide care coordination and manage care transitions for Members who opt-out of Tailored Care Management as described in *Section IV.G.3. Care Coordination and Care Transitions for all Members*.
    - 5. In cases where a member enrolled in the Innovations waiver opts out of Tailored Care Management, the PIHP must provide the Innovations waiver care coordination services as stipulated by the Innovations 1915(c) waiver.
    - 6. The PIHP shall submit a sample Tailored Care Management and care coordination enrollment packet to the Department for review and approval as part of its Member Welcome Packet (*Section IV.E.3. Member Engagement*).
- e. Priority Populations for Engagement into Tailored Care Management
  - i. Among populations eligible for Tailored Care Management, as described in *Section IV.G.2. Tailored Care Management*, the PIHP shall prioritize the following populations for engagement into Tailored Care Management:
    - 1. Members who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing;
    - 2. Members who are Medically Needy;
    - 3. Members who participate in the North Carolina Health Insurance Premium Payment Program are targeted for engagement into Tailored Care Management; and
    - 4. Members in foster care/adoption assistance and former foster youth.
- f. Tailored Care Management Assignment
  - i. Beginning December 1, 2022, the PIHP shall assign eligible members to a Tailored Care Management approach and organization providing Tailored Care Management if they fall into one of the populations described in *Section IV.G.2.c. Tailored Care Management*.
  - ii. The PIHP shall ensure that all eligible Members, including those enrolled in the Innovations waiver, have a choice of organization where they obtain Tailored Care Management.
  - iii. The PIHP shall educate Members on the three different care management approaches and provide unbiased counseling on selecting an organization for Tailored Care Management as part of the choice period prior to launch and on an ongoing basis after launch for new members assigned to Tailored Care Management and Members wishing to change the organization where they are obtaining Tailored Care Management.
  - iv. For all Members, the PIHP shall follow the requirements in the Tailored Care Management Auto Assignment Requirements Document, which will be published in the PCDU, as the PIHP

develops the PIHP's Tailored Care Management auto assignment algorithm. The PIHP shall assign the Member to a contracted AMH+ practice, CMA, or PIHP within twenty-four (24) hours of effectuation date of enrollment with the PIHP. The Department will share specific deployment schedule for Tailored Care Management assignment that the PIHP will be required to follow. The algorithm must consider the Member's existing relationships with an AMH+ practice or CMA; the Member's medical, BH, and I/DD complexity; the Member's geographic location; and the capacity at an AMH+ practice or CMA.

- v. The Department will allow PIHPs to submit any proposed changes to the Tailored Care Management Auto Assignment requirements that will be published through the PCDU, for DHHS approval within thirty (30) Calendar Days of Contract Effective Date. Department will review the proposal and provide their response in thirty (30) Calendar Days and align on an implementation plan. If the proposed and approved flexibilities cannot be realistically implemented at launch, then the PIHP will need to implement the functionality per the Department's Tailored Care Management assignment requirements and align on a timeline to implement that post launch.
- vi. The PIHP must assign Members to a mix of the three Tailored Care Management approaches (outlined in *Section IV.G.2. Tailored Care Management*) according to the factors described in *Section IV.G.2. Tailored Care Management*.
- vii. The PIHP shall assign members to the most clinically appropriate care management approach as based on the factors described in *Section IV.G.2. Tailored Care Management*, with the exception of most Members in foster care/adoption assistance and former foster youth, must be defaulted to PIHP-based care management. The PIHP must assign each AMH+ and CMA providing Tailored Care Management a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the model.
- viii. The PIHP must ensure that Tailored Care Management assignment aligns with the annual requirements for Provider-based Tailored Care Management as described in *Section IV.G.2. Tailored Care Management*.
- ix. The PIHP shall consider the following factors when assigning each Member to care management at an AMH+ practice or a CMA, or at the PIHP level:
  1. The PIHP must default Members in foster care/adoption assistance and former foster youth to PIHP-based Tailored Care Management, with the exception of Members who transition from a BH I/DD Tailored Plan and were previously assigned to an AMH+ or CMA who must be auto-assigned to the same AMH+/CMA. However, Members in foster care/adoption assistance and former foster youth must also be given the option to select an AMH+ or CMA.
- x. The PIHP shall permit Members to change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause.
- xii. The Department shall consider the following as appropriate cause for changes in care management approach, assigned organization providing Tailored Care Management, and care manager:
  1. The AMH+, CMA, PIHP or care manager has, as determined by the Member or the PIHP, failed to furnish accessible and appropriate services to which the Member is entitled.
  2. The AMH+, CMA, PIHP or care manager is not able to reasonably accommodate the Member's needs.
  3. There is a change in the accessibility of the AMH+, CMA, PIHP or care manager, including but not limited to the following:

- i. The organization or care manager moves to a location that is not convenient for the Member.
  - ii. There is a change in the hours the AMH+ practice or CMA is open, and the member cannot reasonably meet during the new hours.
  - iii. There is a change in the hours the care manager is available, and the member cannot reasonably meet during the new hours.
- 4. The Member determines that a change would be in the best interest of the Member.
- 5. The Member's assigned AMH+ practice or CMA leaves the PIHP's Network or is no longer certified by the Department.
- 6. The Member's assigned AMH+ practice or CMA becomes excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. 438.808(a); 42 C.F.R. 438.808(b)(2); 42 C.F.R. 438.610(b); 42 C.F.R. 431.55(h); section 1903(i)(2) of the SSA; 42 C.F.R. 1001.1901(c); 42 C.F.R. 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09.
- 7. The care manager is no longer employed by the AMH+, CMA, or PIHP.
- xii. As part of the choice period prior to launch, for new members assigned to the Tailored Care Management, and on an ongoing basis after the launch, the PIHP shall educate members on the three different care management approaches and provide unbiased counseling on selecting an organization for Tailored Care Management.
- xiii. At least thirty (30) Calendar Days prior to PIHP launch, the PIHP shall send Members a Tailored Care Management enrollment packet, with information about their Tailored Care Management assignment and options for changing their assignment as part of the Member Welcome Packet.
- xiv. After the initial launch of the PIHP, on an ongoing basis the PIHP shall complete Tailored Care Management assignment and information to new Members as part of the Member Welcome Packet within eight (8) Calendar Days of the member's enrollment in the PIHP.
- xv. As part of the Member Welcome Packet sent to members within eight (8) Calendar Days following receipt of the 834 enrollment file (*Section IV.E.3. Member Engagement*), the PIHP must include the following information on Tailored Care Management and care coordination:
  - 1. Information on the Tailored Care Management program, including services available for those who have opted out of Tailored Care Management;
  - 2. Information on the PIHP's care coordination program, including services available for members with a BH transitional care need;
  - 3. The nature of the care manager relationship;
  - 4. Information on the choice period for Tailored Care Management assignment;
  - 5. Process and options for changing their Tailored Care Management assignment;
  - 6. The Tailored Care Management Opt-out form;
  - 7. Circumstances under which Member information will be disclosed to third parties; and
  - 8. The availability of the Grievance and Appeals process as described in *Section IV.E.6. Member Grievances and Appeals*.
- xvi. The PIHP must share each Member's Tailored Care Management assignment with the Member's PCP within fourteen (14) Calendar Days of assignment. Upon changes in the Member's assigned PCP, the PIHP must share the Member's Tailored Care Management assignment with the Member's new PCP within fourteen (14) Calendar Days of assignment to the new PCP.
- xvii. The PIHP must share and receive with each AMH+ and CMA all applicable data files elements specified in *Section IV.G.2. Tailored Care Management*.

- xviii. The PIHP must assign and must ensure that AMH+ practices and CMAs assign the Member to a care manager with appropriate qualifications and experience according to the Member's needs within thirty (30) Calendar Days of PIHP enrollment.
  - xix. The PIHP shall submit its policies and procedures for Tailored Care Management assignment as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- g. Outreach and Engagement for Members Enrolled in Tailored Care Management
- i. The PIHP shall require that care managers initiate contact with assigned Members who have recently been enrolled in Tailored Care Management to start the care management comprehensive assessment within thirty (30) Calendar Days of PIHP assignment (see *Section IV.G. Care Management and Care Coordination*). The care manager shall educate the Member about the benefits of care management and work to engage the Member in a care management comprehensive assessment and care planning.
    - 1. The PIHP shall prioritize outreach regarding the care management comprehensive assessment to Members in foster care/adoption assistance and former foster youth prior to beginning outreach to other Members.
    - 2. Contact for the purpose of starting the care management comprehensive assessment may be telephonic, through two-way real time video and audio conferencing, or in-person.
  - ii. The PIHP shall develop and ensure that AMH+ practices and CMAs also develop, policies for communicating and sharing information with Members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning and/or video capture.
  - iii. For Members who do not actively engage in Tailored Care Management after initial outreach, the PIHP shall require that the assigned organization providing Tailored Care Management conduct outreach at least annually to attempt to engage the Member in Tailored Care Management.
  - iv. The PIHP shall submit its policies and procedures for outreach and engagement as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- h. Coordination with County Child Welfare Workers for Members involved in the Child Welfare System Engaged in Tailored Care Management
- i. For Members in foster care/adoption assistance and former foster youth, the PIHP shall ensure that the assigned organization providing Tailored Care Management arranges an initial meeting with the Member's assigned County Child Welfare Worker (in-person, by video, or telephonic).
  - ii. The PIHP shall ensure that initial meetings shall occur on the following timeframes:
    - 1. For Members enrolled upon the initial launch of the PIHP, within sixty (60) Calendar Days of launch, or earlier, if necessary, to appropriately manage the Member's health care needs; and
    - 2. For Members enrolled after the initial launch of the PIHP, within three (3) Calendar Days, or earlier, if necessary, to appropriately manage the Member's health care needs.
  - iii. During the initial meeting, the PIHP shall ensure that the assigned organization providing Tailored Care Management:
    - 1. Confirms that the Member has received or has been scheduled to receive the DSS-required initial seven (7)-day physical examination and thirty (30)-day comprehensive medical appointment. If such assessments have not been scheduled, the care manager shall work with the County Child Welfare Worker to schedule the appropriate appointments.

2. Gathers the following information at minimum:
  - i. DSS Child Health Summary Components, to the extent available;
  - ii. Placement logs;
  - iii. Member's family history and foster care placement status;
  - iv. Immediate health care needs, including BH and Unmet Health-Related Resource Needs;
  - v. Member's medication history;
  - vi. Child Maltreatment Evaluations, as applicable;
  - vii. Key updates on member's permanency planning process;
  - viii. Identification about whether there are any restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
  - ix. Other information necessary for informing the care management comprehensive assessment and care planning processes.
3. Establishes ongoing processes and timeframes for the County Child Welfare Worker to share the DSS Child Health Summary Components, to the extent available, with the assigned organization providing Tailored Care Management.
4. Establishes a schedule of regular check-ins between the care manager and the County Child Welfare Worker, as required below.
5. As necessary and appropriate, identifies health care services and health-related services, including state-funded mental health, substance use services, housing supports, and other supports, that are necessary to support the Member's biological/adoptive parents and promote reunification and develop a plan for the Child Welfare Worker to make necessary referrals.
6. Agrees on explicit next steps and roles and responsibilities to ensure Member needed services are coordinated in a timely fashion. Throughout the Member's involvement with the child welfare system, the assigned organization providing Tailored Care Management shall schedule and attend meetings with the Member's assigned County Child Welfare Worker at least quarterly and more frequently, as appropriate.
- iv. During regular quarterly meetings, the PIHP shall ensure that the assigned organization providing Tailored Care Management gathers updates on the following:
  1. Member's foster care placement status;
  2. Key changes in the Member's health care needs, including BH and Unmet Health-Related Resource Needs;
  3. Key updates on Member's permanency planning process;
  4. Any changes regarding restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
  5. Other information necessary for informing the member's Care Plan/ISP.
- v. The PIHP shall require the assigned organization providing Tailored Care Management to contact the County Child Welfare Worker within one (1) Business Day when any of the following occur, to the extent that information is available, and take necessary measures to ensure coordination of care:
  1. Member is admitted to an inpatient level of care;
  2. Member visits an ED;
  3. Member is admitted to an institutional level of care or other congregate setting;
  4. Member experiences a behavioral health crisis;

5. Member experiences a disruption in school enrollment (e.g., Member is expelled or is required to change schools); or
  6. Member becomes involved with the justice system.
- i. Care Management Comprehensive Assessment for Members Engaged in Tailored Care Management
- i. The PIHP must make available the results of the *Section IV.G.3. Care Coordination and Care Transitions for All Members*, as described in *Section IV.G.3. Care Coordination and Care Transitions for All Members*, to the assigned organization providing Tailored Care Management.
  - ii. The PIHP shall ensure that the assigned organization providing Tailored Care Management is responsible for conducting the care management comprehensive assessment.
  - iii. The PIHP shall ensure that the care management comprehensive assessment is conducted in a location that meets the Member's needs.
  - iv. The PIHP shall ensure that care managers make a best effort attempt to complete the care management comprehensive assessment in person, realizing that in limited instances it will be necessary to complete the care management comprehensive assessment via technology conferencing tools (e.g., audio and/or video tools).
  - v. The PIHP shall verify that care management comprehensive assessments are completed in a timely manner as part of routine monitoring.
  - vi. During Contract Year 1, the assigned organization providing Tailored Care Management shall make its best effort to complete the care management comprehensive assessment within the following timeframes:
    1. Members identified as high acuity: Best efforts to complete it within forty-five (45) Calendar Days of assignment to Tailored Care Management and no longer than sixty (60) Calendar Days after assignment to Tailored Care Management.
    2. Members identified as medium/low acuity: Within ninety (90) Calendar Days of assignment to Tailored Care Management.
    3. For purposes of provisions related to Tailored Care Management, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home or working with a known provider to meet the Member at an appointment, to contact the Member if the first attempt is unsuccessful.
  - vii. During Contract Years after Contract Year 1, the PIHP shall ensure that care managers make best efforts to complete the care management comprehensive assessment for new Members within sixty (60) Calendar Days of assignment to Tailored Care Management.
  - viii. The PIHP shall ensure that the assigned organization providing Tailored Care Management makes the results of the care management comprehensive assessment available to the Member's PCP, BH, I/DD, TBI and LTSS providers, and the PIHP within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, provided that the Member consents to making the results available, if required by law. The PIHP shall not withhold medically necessary services for Members while awaiting completion of the care management comprehensive assessment.
  - ix. The PIHP must attempt a care management comprehensive assessment at least annually for Members eligible for Tailored Care Management:
    1. Who are part of a target population for engagement in Tailored Care Management as described in *Section IV.G.2 Tailored Care Management*;
    2. Have neither opted out nor engaged in Tailored Care Management; and
    3. Are not receiving services duplicative of Tailored Care Management.
  - x. The PIHP shall ensure that a reassessment for Members already engaged in Tailored Care Management is done:

1. At least annually;
2. When the Member's circumstances, needs or health status changes significantly;
3. After Significant Changes in scores on Department-approved level-of-care determination and screening tools (e.g., Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), ASAM, Child and Adolescents Needs and Strengths (CANS), and SIS®;
4. At the Member's request.
5. After triggering events, including:
  - i. Inpatient hospitalization for any reason;
  - ii. Two (2) emergency department (ED) visits since the last care management comprehensive assessment (including reassessment);
  - iii. An involuntary treatment episode;
  - iv. Use of BH crisis services;
  - v. Arrest or other involvement with law enforcement/the criminal justice system, including Division of Juvenile Justice;
  - vi. Becoming pregnant and/or giving birth;
  - vii. A change in Member circumstances that results in an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend/caregiver, or any other circumstance the plan deems to be a change in circumstance;
  - viii. Loss of housing; and
  - ix. Change in foster care placement or living arrangement (including aging out of the child welfare system).
- xi. When a Member requests a reassessment; experiences a Significant Change in circumstances, needs or health status; experiences a Significant Change in level of care score; or experiences a triggering event, the PIHP shall ensure that the Member receives a reassessment within thirty (30) Calendar Days of when the PIHP detects the change or event. Reassessments triggered by pregnancy or childbirth must address pregnancy-specific SUD and mental health screening covering the physical and BH needs of the infant and mother.
- xii. In circumstances in which a care management comprehensive assessment may have been recently performed, reassessment may consist of an addendum or update to a previous care management comprehensive assessment.
- xiii. The PIHP shall develop methodologies and tools for conducting the care management comprehensive assessment, as appropriate for differing member demographics and needs.
- xiv. The PIHP shall incorporate the results of the Section IV.G.3. Care Coordination and Care Transitions for all Members into the care management comprehensive assessment to the extent feasible.
- xv. The care management comprehensive assessment shall address, at a minimum, the following:
  1. Immediate care needs;
  2. Current services and providers across all health needs;
  3. Functional needs, accessibility needs, strengths, and goals;
  4. Other state or local services currently used;
  5. Physical health conditions, including dental conditions;
  6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
  7. Physical, intellectual, or developmental disabilities;
  8. Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;

9. Advanced directives, including advance instructions for mental health treatment;
  10. Available informal, caregiver or social supports;
  11. Standardized Unmet Health-Related Resource Needs questions to be provided by the Department covering four (4) priority domains:
    - i. Housing;
    - ii. Food;
    - iii. Transportation;
    - iv. Interpersonal Violence/Toxic Stress;
  12. Any other ongoing conditions that require a course of treatment or regular care monitoring;
  13. Exposure to adverse childhood experiences (ACEs) or other trauma;
  14. Risks to the health, well-being, and safety of the member and others (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols);
  15. Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
  16. Employment/community involvement;
  17. Education (including individualized education plan and lifelong learning activities);
  18. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
  19. Risk factors that indicate an imminent need for LTSS;
  20. Caregiver's strengths and needs;
  21. Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.);
  22. Self-management and planning skills;
  23. Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare; and
  24. For Members in foster care/adoption assistance and former foster youth, permanency planning goals.
- xvi. For members with an I/DD or TBI diagnosis, the care management comprehensive assessment shall address the elements in *Section IV.G. Care Management* plus the following:
1. Financial resources and money management; and
  2. Alternative guardianship arrangements, as appropriate.
- xvii. For Members ages zero (0) up to age three (3), the care management comprehensive assessment shall address the elements in *Section IV.G. Care Management* and incorporate questions related to Early Intervention (EI) services for children, including:
1. Whether the child is receiving EI services;
  2. Member's current EI services;
  3. Frequency of EI services provided;
  4. Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and
  5. Contact information for the CDSA service coordinator.
- xviii. For PIHP members ages three (3) up to twenty-one (21) with a mental health disorder and/or SUD who are receiving BH or substance abuse services, including members with a dual I/DD and mental health or SUD diagnosis, the care management comprehensive assessment shall incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community.
- xix. The PIHP's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.



- xx. For specific requirements related to care management comprehensive assessments for Innovations waiver enrollees, see *Section IV.M Innovations Waiver Services*.
  - xxi. The PIHP will be required to send a monthly report listing all Members who received the Standardized Unmet Health-Related Resource Needs screening in the form and manner specified by the Department. See *Section VI. Attachment I: Reporting Requirements* for more detail.
  - xxii. The PIHP shall submit its policies and procedures for care management comprehensive assessments as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- j. Development of Care Plan/Individual Support Plan (ISP) for Members Engaged in Tailored Care Management
- i. Using the results of the care management comprehensive assessment, the assigned organization providing Tailored Care Management shall develop a Care Plan for Members with BH needs and an ISP for members with I/DD and TBI needs. 42 C.F.R. § 441.725.
  - ii. The PIHP shall ensure that all Care Plans and ISPs are developed and presented in a manner understandable to the Member, including consideration for the Member's reading level and alternate formats.
  - iii. The PIHP shall ensure that meetings related to the Member's Care Plan/ISP are held at a location, date, and time convenient to the Member and the Member's chosen participants.
  - iv. The PIHP shall ensure that each Care Plan and ISP is individualized and person-centered and is developed using a collaborative approach including Member and family participation where appropriate.
  - v. The PIHP shall make Best Efforts to complete an Initial Care Plan or ISP within thirty (30) Calendar Days of the completion of the care management comprehensive assessment. For purposes of completing an Initial Care Plan, "Best Effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home or working with a known Provider to meet the Member at an appointment, to contact the Member if the first attempt is unsuccessful.
  - vi. The PIHP shall ensure that development of the Care Plan or ISP does not delay the provision of medically needed services to a Member according to the timeline below, even if that Member is waiting for a Care Plan/ISP to be developed.
  - vii. The PIHP shall ensure that the Care Plan or ISP is regularly updated incorporating input from the member and members of the care team, as part of ongoing care management, and that the Care Plan will be comprehensively updated:
    - 1. At minimum every twelve (12) months;
    - 2. When a Member's circumstances or needs change significantly;
    - 3. At the Member's request;
    - 4. Within thirty (30) Calendar Days of (re)assessment; and
    - 5. Following a change in the Member's foster care placement living arrangement or (as appropriate).
  - viii. The PIHP shall ensure that each Care Plan/ISP incorporates results of the care management comprehensive assessment (including Unmet Health-Related Resource Needs questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
    - 1. LOCUS and CALOCUS;
    - 2. CANS;
    - 3. ASAM criteria; and

4. For Innovations waiver enrollees: SIS®.
- ix. The PIHP shall ensure that each Care Plan and ISP contains, at a minimum:
    1. Names and contact information of key Providers, care team members, family members, the County Child Welfare Worker (for Members in foster care/adoption assistance and former foster youth), and others chosen by the Member to be involved in planning and service delivery;
    2. Measurable Member goals;
    3. Clinical BH needs including, but not limited to, any physical health, BH, I/DD-related, TBI-related, or dental needs;
    4. Interventions including addressing medication management, including adherence;
    5. Intended outcomes of interventions and goals;
    6. Social, educational, and other services needed by the Member;
    7. Strategies to increase social interaction, employment, and community integration;
    8. Emergency/natural disaster/crisis plan;
    9. Strategies to mitigate risks to the health, well-being, and safety of the members and of others;
    10. Information about Advance Directives, including advance instructions for mental health treatment, as appropriate;
    11. A life transitions plan to address instances where the Member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving, changing foster care placement, or entering another life transition;
    12. Strategies to improve self-management and planning skills; and
    13. Information on the Member's foster care permanency planning goals (as applicable).
  - x. For members with SED, I/DD, or TBI, the care plan or ISP should also include caregiver supports, including connection to respite services, as necessary.
  - xi. For members ages three (3) up to age twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance use services, the PIHP shall ensure:
    1. A Child and Family Team member is involved in developing the Care Plan/ISP and facilitating the planning process.
    2. The assigned organization providing Tailored Care Management uses the strengths assessment described in *Section IV.G.2. Tailored Care Management* to build strategies included in the Care Plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the Child and Family Team (CFT). These strategies shall be included in the Care Plan or ISP.
    3. The Care Plan or ISP is regularly updated to respond to 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.
  - xii. The PIHP shall ensure that the assigned organization providing Tailored Care Management monitors for completion of Care Plan/ISPs and reviews them for quality control.
  - xiii. The PIHP must conduct regular audits of care management comprehensive assessments, Care Plans, and ISPs to ensure they meet quality expectations.
  - xiv. The PIHP shall ensure that each Care Plan/ISP is documented and stored and made available to the Member and the following representatives within fourteen (14) Calendar Days of completion of the Care Plan or ISP:
    1. Care team members, including the member's PCP, other physical health, BH, I/DD, TBI and LTSS providers, and the assigned County Child Welfare Worker (for Members in foster care/adoption assistance);
    2. Other providers delivering care to the Member;

3. The Member's legal representative (as appropriate);
  4. The Member's caregiver (as appropriate, with consent);
  5. Social service providers (as appropriate, with consent); and
  6. Other individuals identified and authorized by the Member.
- xv. For specific requirements related to ISPs for Innovations waiver enrollees, see *Section IV.M. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver*.
- xvi. The PIHP shall submit its policies and procedures for Care Plan/ISP development with members as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*). As long as the Care Management and Care Coordination Policy clearly states that it applies to the PIHP, the Care Management and Care Coordination Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- k. Care Team Formation for Members Engaged in Tailored Care Management
- i. The PIHP shall ensure that the assigned organization providing Tailored Care Management establishes a multidisciplinary care team for each Member based on the Member's needs.
  - ii. The PIHP shall ensure that the multidisciplinary care team consists of the following members as applicable depending on member needs:
    1. The Member;
    2. Caregiver(s)/legal guardians/foster parents/biological parents/adoptive parents/kinship caregivers (as applicable or appropriate);
    3. The member's care manager;
    4. Supervising care manager;
    5. PCP;
    6. BH provider(s);
    7. I/DD and/or TBI providers;
    8. Other specialists;
    9. Nutritionists;
    10. Pharmacists and pharmacy techs;
    11. The Member's obstetrician/gynecologist;
    12. Peer support specialist;
    13. In-reach and/or transition staff;
    14. County Child Welfare Worker and guardian ad litem (for members in foster care/adoption assistance); and
    15. Other Providers, as determined by the care manager and Member.
  - iii. For Members ages three (3) up age to twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance abuse services, the PIHP shall ensure that the CFT is incorporated into the care team in accordance with *Section IV.G.2. Tailored Care Management*.
    1. The CFT shall be built around the youth and family to meet their unique needs, and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the Care Plan.
    2. The CFT shall be convened at least once every thirty (30) Calendar Days.
  - iv. The PIHP shall require timely communication across the care team.
- l. Ongoing Care Management for Members Engaged in Tailored Care Management
- i. The PIHP shall establish policies and procedures to deliver care to, and coordinate services for, Members in accordance with 42 C.F.R. § 438.208 and N.C. Gen. Stat. § 122C-115.4, regardless of risk or need.

- ii. The PIHP shall ensure that each member who is actively engaged in Tailored Care Management receives care management according to their Care Plan.
- iii. The PIHP shall ensure that care management includes:
  1. Coordinating and providing referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by either the PIHP or otherwise in NC Medicaid Direct:
    - i. Physical health;
    - ii. BH;
    - iii. I/DD;
    - iv. LTSS;
    - v. TBI;
    - vi. Pharmacy;
    - vii. Vision; and
    - viii. Dental.
  2. Coordinating and providing referral, information, and assistance in obtaining and maintaining State-funded Services managed by the BH I/DD Tailored Plan.
  3. Coordinating social services provided by community and social providers to address a Member's Unmet Health-Related Resource Needs.
  4. Coordinating with the County Child Welfare Worker (for members in foster care/adoption assistance).
  5. Coordinating Medicare services for Members dually eligible for Medicare and Medicaid.
  6. Coordinating with other care management supports for members dually eligible for Medicare and Medicaid.
  7. Ensuring that Members have scheduled annual physical exams, or well-child visits based on the appropriate age-related frequency.
  8. Conducting a care management comprehensive assessment at least every twelve (12) months as described in *Section IV.G.2. Tailored Care Management*.
  9. Conducting continuous monitoring of progress toward goals identified in the Care Plan or ISP through in-person and collateral contacts with the Member and the Member's supports, including family, informal, and formal caregivers, and routine care team reviews.
  10. Conducting medication management, including regular medication reconciliation (conducted by appropriate care team member; a community pharmacist at the CIN level may assume this role, in coordination with the AMH+ or CMA), support of medication adherence, and metabolic monitoring (for individuals prescribed antipsychotic medications).
  11. For Members in foster care in the PIHP's plan, the PIHP shall ensure that medication management occurs within seven (7) Calendar Days of initial contact with the member.
  12. Supporting the Member's adherence to prescribed treatment regimens and wellness activities.
  13. Communicating and consulting with other providers and the Member and the Member's supports, including family, informal, and formal caregivers, as appropriate
  14. Following up on referrals.
  15. Conducting transitional care management as described in *Section IV.G.2. Tailored Care Management*.
  16. Facilitating timely communication across the care team, including case conferencing.
- iv. For children and youth receiving BH services, ongoing care management shall also include:

1. Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports.
  2. Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self-determination and enhance self-sufficiency.
  3. Verifiable 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.
  4. Development and implementation of proactive and reactive crisis plans in conjunction with the Care Plan/ISP that anticipate crises and utilize family, team, and community strengths to identify and describe who does what and when; every member of the CFT shall be provided a copy of the plan.
  5. Use family and youth-friendly tools to document and demonstrate for the youth and family their progress over the course of treatment.
- v. The PIHP shall ensure that the assigned organization providing Tailored Care Management provides or arranges for coverage for services, consultation or referral, and treatment for emergency medical conditions, including, but not limited to, BH crisis, twenty-four (24) hours per day, seven (7) days per week.
  - vi. The PIHP shall ensure that the assigned organization providing Tailored Care Management has the ability twenty-four (24) hours per day, seven (7) days per week to (1) share information such as Care Plans/ISPs and Advance Directives, and (2) coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
  - vii. The PIHP shall ensure that Tailored Care Management incorporates individual and family supports including:
    1. Training the Member in self-management;
    2. Providing education and guidance on self-advocacy to the Member, family members and support members;
    3. Connecting the Member and caregivers to education and training to help the Member improve function, develop socialization and adaptive skills, and navigate the service system;
    4. Providing information and connections to needed services and supports including but not limited to self-help services, peer support services and respite services;
    5. Providing information to the Member, family members and support members about the Member's rights, protections, and responsibilities, including the right to change providers, the Grievance and complaint resolution process, and fair hearing processes;
    6. Health promotion, including promoting wellness and prevention programs (see *Section IV.E.3. Member Engagements*);
    7. Providing information on establishing Advance Directives, including advance instructions for mental health treatment, as appropriate, and guardianship options/alternatives, as appropriate;
    8. Connecting Members and family members to resources that support maintaining employment, community integration and success in school, as appropriate;
    9. For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning; and
    10. Beginning discussions about the potential for an Infant Plan of Safe Care.
  - viii. The PIHP must establish policies and procedures for coordinating with services provided by community and social support providers and submit them as part of its Care Management and

Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*). 42 C.F.R. § 438.208(b)(2)(iv).

- ix. The PIHP shall ensure that Tailored Care Management addresses Unmet Health-Related Resource Needs, including at a minimum:
  1. Provision of referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including:
    - i. Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers);
    - ii. Food and income supports;
    - iii. Housing;
    - iv. Transportation;
    - v. Employment services;
    - vi. Education;
    - vii. Child welfare services;
    - viii. Domestic violence services;
    - ix. Legal services;
    - x. Services for justice-involved populations; and
    - xi. Other services that help individuals achieve their highest level of function and independence.
  2. Use NCCARE360, to identify community-based resources, and connect Members to such resources and track closed-loop referrals. The PIHP shall ensure that organizations providing Tailored Care Management use NCCARE360, including for the following functionalities:
    - i. Act as their community-based organization and social service agency resource repository to identify local community-based resources;
    - ii. Refer Members to the community-based organizations and social service agencies available on NCCARE360; and
    - iii. Track closed-loop referrals.
  3. Provision of comprehensive assistance--available either in-person or electronically, at the Member's preference and depending on what is the most efficient, effective, and feasible approach--securing key health-related services, including assistance at initial application and renewal with filling out and submitting applications, and gathering and submitting required documentation, at a minimum to:
    - i. Food and Nutrition Services;
    - ii. Temporary Assistance for Needy Families;
    - iii. Child Care Subsidy;
    - iv. Low Income Energy Assistance Program;
    - v. ABLEnow Accounts (for individuals with disabilities);
    - vi. Women, Infants and Children (WIC) Program; and
    - vii. Other programs managed by the PIHP that address Unmet Health-Related Resource Needs.
  4. As part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall submit its policies for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.

- x. The PIHP shall ensure that a member has a post-partum visit with a physician within fifty-six (56) Calendar Days of delivery to assess for signs of postpartum depression. Postpartum care is further described in the Obstetrics Clinical Coverage Policy 1E-5.
- xi. For Members in foster care/adoption assistance and former foster youth, the PIHP shall ensure close coordination, as appropriate, with the assigned Department of Social Service County Child Welfare Worker to identify and manage emerging Member needs.
- xii. The Department has established a standardized methodology to assign each Member to a Tailored Care Management acuity tier (e.g., high, medium, low) and will release additional detail on the methodology prior to PIHP Contract Year 1.
  - 1. The PIHP shall use the acuity tiers to guide the intensity of Tailored Care Management for each member according to minimum contact requirements as described in *Section IV.G.2. Tailored Care Management*.
  - 2. The PIHP shall use the acuity tiers to determine payment for Tailored Care Management as described in *Section IV.H.4. Provider Payments*.
- xiii. The PIHP must ensure that care managers at the assigned organization providing Tailored Care Management meet the minimum contact requirements for Members according to their acuity tier as outlined below unless the Member expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP and reviewed with the supervising care manager or if the member is enrolled in the Innovations waiver (as described in *Section IV.M. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver*). In-person contact requirements must be met as described below. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing. If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the Member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The Department intends to release additional guidance on circumstances in which a Member's acuity tier may change.
  - 1. Care manager contacts for Members with BH needs
    - i. High Acuity: At least four (4) care manager-to-member contacts per month, including at least one (1) in-person contact with the member.
    - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    - iii. Low Acuity: At least two (2) care manager-to-member contacts per month and at least two (2) in-person contacts member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).
  - 2. Care manager contacts for Members with an I/DD or TBI
    - i. High Acuity: At least three (3) care manager-to-member contacts per month, including at least two (2) in-person contacts.
    - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    - iii. Low Acuity: At least one (1) telephonic or two-way real time video and audio conferencing, contact per month and at least two (2) in-person care manager-to-

member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).

3. If the Member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.
4. For Members who have a guardian, telephonic or two-way real time video and audio conferencing contact may be with a guardian in lieu of the Member, where appropriate or necessary. In-person contacts must involve the Member.
- xiv. The PIHP shall ensure that in-person contacts occur at a location, date, and time convenient to the Member and their chosen participants.
- xv. For specific requirements for ongoing care management related to Innovations waiver enrollees, see *Section IV.M. Innovations Waiver Services*.
- m. Transitional Care Management for Members Engaged in Tailored Care Management
  - i. Regardless of the organization providing Tailored Care Management, the PIHP shall oversee care transitions for all Members engaged in Tailored Care Management who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i) and in addition to the requirements in this Section.
  - ii. The PIHP shall ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.
  - iii. The PIHP shall ensure that organizations providing Tailored Care Management carry out the following transitional care management functions.
    1. Ensure that a care manager is assigned to manage the transition.
    2. Have a care manager assume coordination responsibility for transition planning.
    3. Have a care manager or care team member visit the Member during their stay in an institution (e.g., acute, subacute and long-term stay facilities) and be present on the day of discharge.
    4. Conduct outreach to the Member's providers.
    5. Obtain a copy of the discharge plan and review the discharge plan with the Member and facility staff.
    6. Facilitate clinical handoffs.
    7. Refer and assist Members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.
    8. Assist the Member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.
    9. Develop a ninety (90) Calendar Day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the Member, facility staff and the Member's care team, that outlines how the Member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
      - i. The ninety (90) Calendar Day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP.
      - ii. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) Calendar Day post-discharge transition plan.



- iii. The ninety (90) Calendar Day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
    - iv. Development of a ninety (90) Calendar Day post-discharge transition plan is not required for all ED visits but may be developed according to the care manager's discretion.
    - v. The assigned organization providing Tailored Care Management shall communicate with and provide education to the Member and the Member's caregivers and providers to promote understanding of the ninety (90) Calendar Day post-discharge transition plan.
  - 10. Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.
  - 11. Ensure that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.
  - 12. Arrange to visit the member in the new care setting after discharge/transition.
  - 13. Conduct a care management comprehensive assessment within thirty (30) Calendar Days of the discharge/transition or update the current assessment.
  - 14. Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) Calendar Days of the discharge/transition based on the results of the care management comprehensive assessment.
- iv. The PIHP must ensure that for individuals with I/DD or TBI, the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following "life transitions":
  - 1. Instances where a Member is transitioning out of school-related services;
  - 2. Instances where a Member experiences life changes such as employment, retirement, or other life events; and
  - 3. Instances where a Member has experienced the loss of a primary caregiver or a change of primary caregiver.
- v. The PIHP shall submit its policies and procedures for transitional care management, including the approach to working with members with LTSS needs, as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- n. Supporting Members Engaged in Tailored Care Management Aging out of Foster Care
  - i. Requirements for Individuals Transitioning Out of the Child Welfare System
    - 1. All requirements in this section shall apply regardless of the age at which a Member leaves the child welfare system, including individuals who age out of custody at age eighteen (18), otherwise emancipate, or leave the child welfare system (planned or unplanned) and are aged eighteen (18) to twenty-one (21).
    - 2. Transitional Living Plan
      - i. The PIHP shall ensure that the care manager, at the request of the County Child Welfare Worker and at the discretion of the Member, participates in the initial development of and periodic updates to each member's Transitional Living Plan.
      - ii. The PIHP shall ensure that the care manager assists the Member and County Child Welfare Worker, working in partnership with the member's providers, with identifying key healthcare-related goals to include in the Transitional Living Plan.
      - iii. The PIHP shall ensure that the care manager assists the Member and County Child Welfare Worker, working in partnership with the Member's providers, in identifying key health-related resources and supports necessary to achieve the Member's health

care goals and ensure those goals are included in the member's Transitional Living Plan.

3. DSS Ninety (90) Day Transition Plan
    - i. The PIHP shall ensure that the care manager participates in the development of each Member's DSS Ninety (90) Day Transition Plan with the assigned County Child Welfare Worker, family, Providers, and other support persons, at the discretion of the Member and the County Child Welfare Worker.
    - ii. The PIHP shall ensure that the member's DSS Ninety (90) Day Transition Plan includes accurate and up-to-date contact information on the Member's care manager, PCP, dental home, behavioral health and I/DD provider(s), and current medications, as applicable.
    - iii. The PIHP shall ensure that the care manager assists the Member and County Child Welfare Worker in identifying key health-related resources and supports necessary to achieve the Member's health care goals and ensure they are included in the member's DSS Ninety (90) Day Transition Plan.
  4. For Members who remain enrolled in the PIHP after leaving the child welfare system, the PIHP shall make its best effort to conduct a care management comprehensive assessment (or reassessment, as appropriate) within ninety (90) Calendar Days of the Member leaving the child welfare system.
- ii. Requirements for Former Foster Youth Aging out of Medicaid Coverage Eligibility
    1. The PIHP shall develop policies, processes, and procedures to support Members (i.e., former foster youth) aging out of Medicaid eligibility.
    2. At least six (6) months prior to the Member aging out of Medicaid coverage eligibility, the PIHP shall ensure that the care manager makes a Best Effort to meet with the Member (in-person or telephonic) to discuss options for health insurance coverage following the birthday on which the Member will age out of Medicaid coverage eligibility and plan for transitioning all current health care services and medications.
    3. The PIHP shall ensure that the care manager discusses potential health care resources that may be available to the member regardless of insurance status, including the Department's Medication Assistance Program, State-funded Services, and free and charitable clinics.
    4. The PIHP shall ensure that the care manager provides the Member with clear written guidance on strategies for achieving the Member's health-related goals. This must include, at minimum, the following:
      - i. Copies of the Member's full Care Plan/ISP and DSS Ninety (90) Day Transition Plan, if available;
      - ii. Summary of scheduled visits and recommended schedule of future visits;
      - iii. List of health care resources that may be available to the member regardless of insurance status, including the Department's Medication Assistance Program, State-funded mental health and substance abuse treatment programs, and free and charitable clinics;
      - iv. List of prescribed medications (including clear guidance on when medication should be taken); and
      - v. Copies of all known medical records, including copies of DSS Child Health Summary Component forms, as applicable.
  - o. Diversion from Institutional Settings for Members Eligible for Tailored Care Management
    - i. The PIHP shall identify Members who are at risk of requiring care in an institutional setting or ACH and provide the diversion interventions described below. The PIHP shall ensure that

diversion activities, including identification of eligible Members, are the responsibility of the assigned organization providing Tailored Care Management (outlined in *Section IV.G.2. Tailored Care Management*). If a Member who is not actively engaged in Tailored Care Management is eligible for diversion, the PIHP shall begin diversion activities and conduct outreach to engage the Member in Tailored Care Management. When the Member is engaged in Tailored Care Management, the PIHP shall transfer responsibility for diversion activities to the assigned organization providing Tailored Care Management.

- ii. The PIHP must ensure that the assigned organization providing Tailored Care Management consults with PIHP-based medical staff or medical staff based at the organization providing Tailored Care Management to assess the medical needs of the Member receiving diversion services.

- iii. Eligibility for Diversion

Members eligible for diversion activities include those meeting the following criteria:

1. Would have been eligible for to enroll in a BH I/DD Tailored Plan, as described in *Section IV.E.1. Eligibility and Enrollment for PIHPs*, if they were not part of a population delayed or excluded from Medicaid Managed Care; and
2. Meet one of the following criteria:
  - i. Have transitioned from an institutional or correctional setting, or an ACH for adult Members, within the previous six (6) months; or
  - ii. Are seeking entry into an institutional setting or ACH; or
  - iii. Meet one of the following additional criteria for members with I/DD or TBI:
    - i. Member has an aging caregiver who may be unable to provide the recipient their required interventions; or
    - ii. Member's caregiver is in fragile health, which may include but is not limited to Member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); or
    - iii. Member with two parents or guardians if one of those parents/guardians dies; or
    - iv. Any other indications that a Member's caregiver may be unable to provide the member their required interventions; or
    - v. Member is a child or youth with complex BH needs.

- iv. Diversion Activities

1. The PIHP shall ensure that the assigned organization providing Tailored Care Management (outlined in *Section IV.G.2. Tailored Care Management*) performs the following diversion activities in a timely manner. To the extent the Member has not yet actively engaged in Tailored Care Management, the PIHP shall initiate these functions, and transition them to the assigned organization providing Tailored Care Management.
  - i. Screen and assess the Member for eligibility for community-based services.
  - ii. Educate the Member on the choice to remain in the community and the services that would be available to support that decision.
  - iii. Facilitate referral and linkages to community-based and other support services for assistance.
  - iv. Determine if the Member is eligible for supportive housing, if needed.
  - v. For those who choose to remain in the community:
    - a. Develop a Community Integration Plan (CIP) that clearly documents that the Member's decision to remain in the community was based on informed choice, and the degree to which the Member's decision has been implemented.

- b. Integrate the Member's CIP as an addendum in the member's Care Plan or ISP.
    - c. For Members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.
  - 2. The PIHP shall ensure all diversion activities are documented and stored and made available to the Department for review upon request.
- p. Staffing and Training Requirements for Care Managers Delivering Tailored Care Management
  - i. The PIHP shall ensure that each care manager across AMH+ practices, CMAs and the PIHP is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers.
  - ii. Supervisors cannot have a caseload but will provide coverage for vacation and sick leave. They will be responsible for ensuring that all Care Plans/ISPs are complete, reviewing them for quality control, and providing guidance to care managers on how to meet Members' needs.
  - iii. The PIHP shall ensure that the assigned organization providing Tailored Care Management has access to clinical consultants to provide subject matter expert advice to the care team. The clinical consultants will not be part of the care team for any given Member.
    - 1. The AMH+ practice or CMA may employ or contract with consultants or do so through a CIN or Other Partner.
    - 2. The consultants should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.
    - 3. The following consultants must be available:
      - i. An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served);
      - ii. A neuropsychologist or psychologist; and
      - iii. A primary care physician appropriate for the population being served to the extent the Member's PCP is not available for consultation.
  - iv. Care Management Staff Qualifications
    - 1. The PIHP shall ensure that all care management staff providing Tailored Care Management to members have the following minimum qualifications:
      - a. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
      - b. If serving Members with BH needs, the care manager must have two (2) years of experience working directly with individuals with BH conditions.
      - c. If serving Members with an I/DD or TBI, the care manager must have two (2) years of experience working directly with individuals with I/DD or TBI.
      - d. If serving Members with LTSS needs, the care manager shall meet the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, as described above.
      - e. If serving Members in foster care/adoption assistance and former foster youth, the care manager must have experience working with children and/or adolescents with behavioral health concerns.
      - f. If the Member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine the appropriate care manager assignment.

2. The PIHP shall ensure that all supervising care managers overseeing care managers performing Tailored Care Management have the following minimum qualifications:
  - i. For Members with BH conditions:
    - i. Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN, and
    - ii. Three (3) years of experience providing care management, case management, or care coordination to the population being served.
  - ii. For Members with an I/DD or TBI, have one (1) of the following minimum qualifications:
    - i. A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI, or
    - ii. A Master's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.
  - iii. If the Member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall ensure that the supervising care manager is qualified to oversee the Member's care manager.
  - iv. The Department will grant a one-time staff exception ('grandfathering') for specified LME/MCO staff that:
    - i. Were employed in the role of Care Manager and Care Management Supervisor at the time of Tailored Plan contract award (July 26, 2021).
    - ii. This exception is based on the staff member possessing the required number of years of experience, but not the required degree, degree type or licensure type.
  - v. The PIHP shall designate a Foster Care point of contact for the purposes of facilitating connections between PIHP-based care managers, PCCM care managers, county child welfare workers, and AMH+/CMA care managers (as appropriate) for children/youth in foster care/adoption assistance and former foster youth. As long as all responsibilities defined in this Contract are fulfilled, this point of contact may be a PIHP staff who may also fulfill another role in the PIHP. PIHP Organizational Roles and Positions. This point of contact shall be in place until the Department launches the Child and Families Specialty Care Plan and:
    1. Be responsible for maintaining up-to-date records and contact information for the assigned care manager, the PCCM care manager, and the county child welfare worker.
    2. Be available to facilitate connections between any parties involved in the Member's care.
    3. Hold a Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area and have familiarity with the North Carolina child welfare system.
  - vi. The PIHP shall ensure all care managers and supervising care managers serving its members, whether based at the PIHP, AMH+ or CMA, are trained on all the topics described in this Section.
  - vii. The PIHP shall develop and implement a care management training curriculum that includes the following domains at a minimum, in addition to any training requirements specified in N.C. General Statute § 122c-115.4. The PIHP care management training curriculum may be shared across the PIHP and BH I/DD Tailored Plan, as described in *Section IV.G.2. Tailored Care Management of the BH I/DD Tailored Plan Contract*, so long as it incorporates the additional

training requirements for care managers and supervisors serving members in foster care/adoption assistance and former foster youth.

1. PIHP eligibility and services
  - i. PIHP eligibility criteria, services available through PIHPs, and differences between Standard Plan and PIHP benefit packages.
  - ii. Principles of integrated and coordinated physical and BH care and I/DD and TBI services.
  - iii. BH crisis response.
2. Knowledge of Innovations and TBI waiver eligibility criteria Whole-person health and unmet resource needs
  - i. Understanding and addressing ACEs, trauma, and trauma-informed care.
  - ii. Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the Member navigate available social supports and resources at the Member's local level.
  - iii. Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect PIHP Members.
3. Community integration
  - i. Independent living skills.
  - ii. Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities.
  - iii. Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community.
  - iv. Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.
4. Components of Health Home care management
  - i. Health Home overview, including but not limited to Health Homes' purpose, target population, and services, in addition to Members and their families' role in care planning.
  - ii. Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas, and facilitating meetings.
5. Health promotion
  - i. Common physical comorbidities of PIHP populations.
  - ii. Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease).
  - iii. Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children.
  - iv. Standard of care tobacco treatment, including both counseling and FDA approved tobacco treatment medications.
  - v. Self-management and self-help recovery resources (including substance use recovery).
  - vi. Brief tobacco use intervention and referral to treatment roles and responsibilities for medication management.
  - vii. Use of IT in care management comprehensive assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360.
6. Other care management skills

- i. Transitional care management best practices
  - ii. Supporting health behavior change, including motivational interviewing
  - iii. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs
  - iv. Preparing Members for and assisting them during emergencies and natural disasters
  - v. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for members receiving care in the home or community settings, or as Members transition across care settings.
  - vi. General understanding of virtual (e.g., Telehealth) applications to assist Members in using the tools
  - vii. Understanding needs of the justice-involved population
  - viii. Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible members, such as PACE
7. Additional trainings for care managers and supervisors serving Members with I/DD or TBI
    - i. Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers
    - ii. Understanding HCBS, related planning, and 1915(c) services and requirements
    - iii. Accessing and using assistive technologies to support individuals with I/DD and TBI
    - iv. Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services
    - v. Educating Members with I/DD and TBI about consenting to physical contact and sex
  8. Additional trainings for care managers and supervisors serving children
    - i. Child- and family-centered teams
    - ii. Understanding of the "System of Care" approach (see Section IV.G.10. System of Care), including knowledge of child welfare, school, and juvenile justice systems
    - iii. Methods for effectively coordinating with school-related programming and transition-planning activities
  9. Additional training for care managers and supervisors serving the children with complex needs: Specialized training in addressing co-occurring mental health disorders and I/DDs.
  10. Additional trainings for care managers and supervisors serving pregnant and postpartum women with SUD or with SUD history: best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal.
  11. Additional trainings for care managers and supervisors serving Members with LTSS Needs: Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission.
  12. Additional trainings for care managers and supervisors serving Members in foster care/adoption assistance and former foster youth:
    - i. Key components of the North Carolina child welfare system, including the role of local Departments of Social Services and County Child Welfare Workers;
    - ii. Coordination with County Child Welfare Workers;

- iii. Medication management for Members in foster care/adoption assistance and former foster youth;
  - iv. Incorporating foster parents, biological/adoptive parents, and kinship caregivers into the care planning process, as appropriate; and
  - v. Resources for youth aging out of foster care.
13. Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications) and
14. The State “System of Care” training curriculum (for care managers with assigned members age three (3) up to age eighteen (18) with BH needs).
- viii. As a best practice, the PIHP may collaborate with other PIHPs, BH I/DD Tailored Plans, and any Tailored Care Management organization it sees appropriate, on Tailored Care Management curriculum development.
  - ix. The PIHP shall allow care managers and supervisors, regardless of the organization in which they provide care management, to waive components of the required training if the care manager or supervisor can verify that they have previously completed and demonstrated competency in a specific training domain.
  - x. The PIHP must document and get approval for their approach to waiving components of the required training in their Care Management and Care Coordination Policy. (*Section IV.G.8. Care Management and Care Coordination Policy*).
  - xi. The PIHP must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.
  - xii. The PIHP shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.
  - xiii. The PIHP shall identify core modules that care managers must complete before being deployed to serve members; care managers must complete the remaining training modules within thirty (30) Calendar Days of being deployed to serve members.
  - xiv. Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.
  - xv. The PIHP shall provide training to its Network providers about Tailored Care Management.
  - xvi. The PIHP shall not require care managers and supervisors working in multiple PIHP catchment areas to complete and pass each required domain of the Tailored Care Management training curriculum more than once. Care managers and supervisors should complete and pass the training in the catchment area where they serve the most members.
  - xvii. The PIHP may require care managers and supervisors to complete additional training, beyond the required domains, specific to their catchment area or the populations they serve.
  - xviii. As part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall submit to the Department its Tailored Care Management training plan for approval:
    - 1. Policies and procedures for training and qualification of care managers and other multidisciplinary team members;
    - 2. Training modalities (e.g., in-person versus online);
    - 3. Approach to tracking and verifying that care managers have completed trainings;
    - 4. Process for addressing noncompliance with trainings;
    - 5. Timing/frequency of trainings;



6. Summary of curriculum;
  7. Approach for assessing competencies;
  8. Approach for annual refreshers and ongoing continuing education; and
  9. Approach for waiving specific training domains for care managers and supervisors.
- q. Tailored Care Management Data System Requirements, Data Sharing, and Risk Stratification
- i. Tailored Care Management Data System Requirements
    1. The PIHP shall have an IT infrastructure and data analytic capabilities to support the care management requirements of this Contract, including the capabilities to:
      - i. Consume and use BH, I/DD and TBI claims, pharmacy and encounter data, clinical data, ADT data, risk stratification information and/or Unmet Health-Related Resource Needs data; and
      - ii. Share and transmit data with AMH+ practices and CMAs.
    2. The PIHP shall ensure all organizations providing Tailored Care Management have care management data systems that have the ability to:
      - i. Maintain up-to-date documentation of Members enrolled in Tailored Care Management and assignments of individual members to care managers;
      - ii. Electronically document, store, and make available the care management comprehensive assessment and re-assessment;
      - iii. Electronically document, store, and make available Care Plans and ISPs;
      - iv. Consume and analyze claims and encounter data to generate Member clinical insights;
      - v. Provide access to – and electronically share, if requested – Member records with the Member’s care team to support coordinated care management, as well as the Member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
      - vi. Track referrals;
      - vii. Allow care managers to:
        - i. Identify risk factors for individual Members;
        - ii. Develop actionable Care Plans and ISPs;
        - iii. Monitor and quickly respond to changes in a Member’s health status;
        - iv. Track a member’s referrals and provide alerts where care gaps occur;
        - v. Monitor a member’s medication adherence;
        - vi. Transmit and share reports and summary of care records with care team members;
        - vii. Support data analytics and performance; and
        - viii. Transmit quality measures (where applicable); and
      - viii. Helping schedule and prepare Members (via, e.g., reminders and transportation) for appointment.
      - ix. The PIHP shall submit a description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
  - ii. Data Sharing in Support of Tailored Care Management
    1. The PIHP shall provide data to AMH+ practices and CMAs to support Tailored Care Management. The PIHP shall follow Departmental requirements for data sharing outlined in the AMH+ & CMA Program Technical & Data Requirements document. This document will be posted in the PCDU.
    2. The PIHP shall have the capability to consume data shared by AMH+ practices and CMAs.

3. In cases where the Department establishes additional standard file format for data-sharing reports, the PIHP shall utilize the file format, timing, and frequency specified by the Department.
4. To support care management activities, the PIHP shall provide the following information to all AMH+ practices, CMAs, and CINs or Other Partners in a format that may be specified by the Department for the Members assigned to them for Tailored Care Management:
  - i. Beneficiary assignment information as indicated above
  - ii. Acuity tiering and risk stratification information using the Department-specific format and frequency
  - iii. Quality measure performance information at the site-specific level
  - iv. The PIHP shall provide quality scoring results on both an annual and an interim basis as specified by the Department, and in a format to be defined by the Department, for measures which they collect all required data elements. These may include:
    - i. Practice-specific numerators and denominators for each measure.
    - ii. An exhibit comparing the practice's performance on each measure to its contracted benchmarks, and to the performance of other practices contracting with the PIHP.
    - iii. Practice-specific gap reports identifying Members who are in the measure denominator but do not meet numerator criteria.
    - iv. Sufficient information on lags in encounter data, Member (re) assignment, and other elements contributing to data quality that the practice can interpret the completeness and timeliness of the data included in the performance report.
    - v. Historical and current claims and encounter data as specified in the requirements referenced above.
5. The PIHP shall provide the following encounter and/or claims data directly to AMH+ practices and CMAs, or their designated CINs or Other Partners, as available and appropriate:
  - i. Encounter and/or claims data for physical health (to the extent such claims/encounters are available), BH, I/DD, TBI, NEMT or LTSS services, where the first delivery should include all available data dating back twenty-four (24) months, with new data delivered at least monthly thereafter.
  - ii. Pharmacy encounter and/or claims data, where the first delivery should include all available data dating back twenty-four (24) months, with new data delivered at least weekly thereafter.
  - iii. Data flows from the PIHP to AMH+ practices, CMAs, and CINs or Other Partners shall include only members assigned to the receiving practices or groups of practices.
6. The PIHP may also provide other available data or information that may be used to support Tailored Care Management (e.g., previously established care plans, historical member clinical information, ADT data) to all AMH+ practices and CMAs in a format agreed to by the PIHP and AMH+ or CMA.
7. The PIHP shall consume, integrate, and use available Medicare data to advance the whole-person care management activities and functions for Members who are dually eligible for Medicare and Medicaid as described in this Contract to the extent possible and applicable.
8. The PIHP shall adopt standardized data-sharing formats and protocols as advised by the Department.

9. The PIHP shall develop a strategy to share data with Members, in a format that is secure, takes into account varying levels of health literacy and promotes Member engagement in care.
  10. The PIHP shall setup an onboarding process for AMH+ and CMA practices and will work with them to ensure they clearly understand the technical requirements they need to follow to develop all the data interfaces specified in the AMH+ and CMA data sharing requirements. They will work with them to guide them through the development phase, share any test files and perform integration testing prior to start sharing and receiving production data with them.
  11. At launch PIHP shall enable all data interfaces required to support the Tailored Care Management with their contracted AMH+ practices and CMA per the data specifications shared by the Department in alignment with the Department's deployment schedule. PIHP should participate in End-to-End testing to ensure these interfaces are testing prior to enabling them. Post Launch, PIHP shall follow the below guidelines for enabling the data interfaces required to support the Tailored Care Management: (i) Beneficiary Assignment File: thirty (30) Calendar Days from the contract signing date between PIHP and AMH+ practices and CMA. (ii) Claims & and Pharmacy Lock-in files: sixty (60) Calendar Days from the contract signing date between PIHP & and AMH+ practices and CMA. (iii) Patient Risk File and any other files: ninety (90) Calendar Days from the contract signing date between PIHP and AMH+ practices and CMA.
- iii. Risk Stratification
1. As part of its approach to population health management, the PIHP may choose to establish a risk stratification methodology in addition to the Department's acuity tiering methodology. Any such methodology may be used to support Tailored Care Management assignment and segmentation of the population to target interventions to the right members at the right time (for example, to prioritize completion of care management comprehensive assessments across the population).
  2. If the PIHP adopts its own risk stratification methodology in addition to acuity tiering, the Department recommends the methodology consider the following information, to the extent available:
    - i. Acuity tier;
    - ii. Claims history;
    - iii. Claims analysis;
    - iv. Pharmacy data;
    - v. Risk factor assessment including assessment of tobacco use;
    - vi. Immunizations;
    - vii. Lab results;
    - viii. Admission, Discharge, Transfer (ADT) feed information;
    - ix. Provider referrals;
    - x. Member or caregiver self-referral;
    - xi. Referrals from social services;
    - xii. Member's zip code;
    - xiii. Member's race and ethnicity;
    - xiv. Administrative data to identify risk for:
      - xv. Overutilization of physical and BH services;
      - xvi. Adverse events;
      - xvii. High costs of care;

- xviii. Results/scores of level-of-care determination and screening tools e.g., LOCUS, CALOCUS, ASAM, CANS, and SIS® (to the extent available) and other tools, as recommended by the Department;
    - xix. Results of the care management comprehensive assessment (to the extent available); and
    - xx. Unmet Health-Related Resource Needs.
  - 3. If the PIHP adopts its own risk stratification methodology in addition to acuity tiering, as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall submit its risk stratification methodology.
- iv. ADT Feeds for Organizations Providing Tailored Care Management
  - 1. The PIHP shall ensure that organizations providing Tailored Care Management have access to an ADT data source that correctly identifies when Members are admitted, discharged, or transferred to/from an ED or hospital in real time or near-real time.
  - 2. As part of transitional care management, the PIHP shall ensure that there is a systematic, clinically appropriate process with designated staffing for care managers responding to certain high-risk ADT alerts, including:
    - i. Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
    - ii. Same-day or next-day outreach for designated high-risk subsets of the population; and
    - iii. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).
- r. Tailored Care Management Payments
 

The PIHP shall make payments for Tailored Care Management according to the requirements in *Section IV.H.4. Provider Payments*.
- s. Technical Assistance to AMH+ Practices and CMAs
  - i. The PIHP shall provide ongoing technical assistance to practices going through the certification process and already certified AMH+ practices and CMAs to enable them to become high-performing providers of Tailored Care Management.
  - ii. Areas of technical assistance shall include, but are not limited to, health IT and data analytics capabilities to support the Department’s vision for Tailored Care Management; population health; quality measurement and performance; and integration of physical health, behavioral health, and I/DD services for care management purposes.
  - iii. The PIHP shall submit a description of its approach for providing technical assistance as part of its Care Management and Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*).
- t. Certification of AMH+ Practices and CMAs
  - i. The Department has implemented a direct process to certify provider organizations to deliver Provider-based Tailored Care Management under this model as AMH+ practices or CMAs, further described in *Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities, Section IV.G.2. Tailored Care Management* and <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd-tailored-plan ncdhhs>.

- ii. The Department will be responsible for certification of AMH+ practices and CMA. Providers applying for certification as an AMH+ and CMA that are denied certification may appeal to the Department.
- iii. As stated above in *Section IV.G.2. Tailored Care Management*, the PIHP shall offer a contract for Tailored Care Management to all certified AMH+ practices and CMAs operating in its catchment area. The Department will be responsible for providing PIHPs with the list of certified providers in each catchment area. The only permitted exceptions to this contracting requirement are the following:
  - 1. The AMH+ practice or CMA notifies the Department that it elects to withdraw from certification. The Department will provide guidance to Providers for how to give such notification.
  - 2. During Readiness Review, if the PIHP determines that the AMH+ practice or CMA (or CIN or Other Partner on behalf of such organizations) is not ready to meet the requirements of the Tailored Care Management model. In this situation, the PIHP shall provide reasons to the Department why it proposes to decline to contract with that AMH+ practice, CMA or CIN or Other Partner, inclusive of technical assistance provided and why the AMH+ practice, CMA or CIN or Other Partner is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation if it deems the PIHP's reasons for not contracting to be unsatisfactory.
  - 3. After PIHP launch, if the PIHP finds the AMH+ practice or CMA to be out of compliance with the requirements of the Tailored Care Management model, then the PIHP follows its documented process, as described in *Section IV.G.2. Tailored Care Management* to terminate the contract with the AMH+ practice or CMA.
- u. Oversight of Tailored Care Management
  - i. The PIHP shall ensure that all requirements included in this Section are met, regardless of whether Tailored Care Management is provided by the PIHP, an AMH+ practice, or a CMA.
  - ii. The Department shall permit, but not require, AMH+ practices and CMAs to work with CINs or Other Partners to meet the requirements to provide Tailored Care Management.
    - 1. Subsidiaries of LME/MCOs, PIHPs, or other health plans generally may not be considered CINs or Other Partners for the purposes of Tailored Care Management, with one exception as follows:
      - a. The Department recognizes that AMH+ practices and CMAs may decide to enter into arrangements with PIHPs for use of their IT products or care management data systems, to meet the care management data system requirements.
      - b. In this scenario, the PIHP would be considered an "Other Partner" (not a CIN) for HIT support only.
    - 2. To the extent that a CIN or Other Partner contracts with the PIHP on behalf of an AMH+ practice or CMA, the PIHP must conduct oversight of the CIN or Other Partner.
    - 3. To the extent an AMH+ or CMA contracts with a CIN or Other Partner, the requirements and capabilities applicable to AMH+ and CMA apply to the CIN or Other Partner.
  - iii. The PIHP must create separate departments for UM and care management, overseen by separate leadership.
  - iv. The PIHP must ensure that no care managers (whether employed by the PIHP, an AMH+ practice, or a CMA) are related by blood or marriage or financially responsible for any of the Members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.

- v. As part of its UM process, the PIHP must review the utilization patterns of all Members receiving Tailored Care Management (whether from the PIHP, an AMH+ practice or a CMA).
  - 1. This UM review must assess whether any patterns exist that suggest that care managers have steered Members toward or away from particular Providers (e.g., toward the organization that employs the care manager or away from a competitor).
  - 2. As part of its standard UM responsibilities, the PIHP must assess whether members are receiving the appropriate level of care corresponding to their clinical information as described in *Section IV.F.1. Behavioral Health and I/DD Benefits Package*.
- vi. The PIHP shall submit its policies and procedures for ensuring conflict-free care management as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- vii. Duplication of Care Management
  - 1. The PIHP shall ensure that a Member does not receive duplicative care management services and Providers do not receive payment for duplicative services.
  - 2. The Department has determined that case management provided through ACT, ICF-IIDs, and nursing facilities (to Members who have resided or are likely to reside for a period of ninety (90) Calendar Days or longer, only) and care management provided through the High-Fidelity Wraparound program and Care Management for At-Risk Children are duplicative of Tailored Care Management.
  - 3. When a Member is receiving a service besides one listed in *Section IV.G. Care Management and Care Coordination* that has potential for duplication with Tailored Care Management, the PIHP and the Provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
  - 4. If a Member receives a service that duplicates Tailored Care Management, the PIHP must deny claims submitted by Providers for Tailored Care Management.
  - 5. The PIHP shall submit its policies and procedures for ensuring Members do not receive duplicative care management from multiple sources as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
- viii. The PIHP shall hold each AMH+ and CMA accountable to all elements of the Tailored Care Management model contained in this Contract and associated guidance, by ensuring that all details are reflected in its contract with each AMH+ and CMA. Contract templates governing contracts between PIHPs and AMH+ practices and CMAs (or CINs or Other Partners on their behalf), including all sections and attachments of such contracts, shall be approved by the Department.
  - i. The PIHP may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based on Department review and approval.
- ix. The PIHP shall monitor AMH+ practices and CMAs' performance against requirements contained in this contract as reflected in their contracts with AMH+ practices and CMAs. Any contract terms additional to the requirement in this contract that the PIHP to offer to AMH+ practices and CMAs must be approved by the Department as part of contract review.
- x. If the PIHP contracts directly with a CIN or Other Partner that is acting on behalf of an AMH+ practice or CMA, the PIHP shall monitor the CIN or Other Partner directly.
- xi. The PIHP shall not require an AMH+ practice, CMA, or CIN or Other Partner to undergo a pre-delegation audit for the purposes of NCQA accreditation in the first year of this contract. The PIHP must ensure that in conducting oversight of AMH+ practices and CMAs it is monitoring

not only in terms of NCQA requirements, but only Tailored Care Management-specific requirements contained in this Contract and the Tailored Care Management Provider Manual available at the following link, accurate as of the date of execution of this contract: <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd-tailored-plan.ncdhhs>.

- xii. To promote AMH+ practices and CMAs' ability to make informed decisions about CIN or Other Partner affiliations, the PIHP must:
  - 1. Send direct notification to each AMH+ practice or CMA practice describing the CIN or Other Partner oversight process, within ninety (90) Calendar Days of contracting with the AMH+ practice or CMA.
  - 2. Send direct notification to each AMH+ practice or CMA practice affiliated with a CIN or Other Partner the results of CIN or Other Partner level audits, including CAPs or similar processes as described below, within sixty (60) Calendar Days of the audit.
- xiii. The PIHP shall not terminate its contract with an AMH+, CMA or CIN or Other Partner under this provision until at least ninety (90) Calendar Days after PIHP launch. Notwithstanding the foregoing, the PIHP may immediately terminate the contract with an AMH+, CMA, or CIN or Other Partner if it determines, in its sole discretion, of fraud, waste, or abuse involving the subcontractor or such subcontractor's continued provision of services under this Agreement creates an imminent harm to members.
- xiv. In the event of underperformance by an AMH+ practice, CMA or CIN or Other Partner relative to the requirements for Tailored Care Management contained in this Section:
  - 1. The PIHP shall send a notice of underperformance to the AMH+ practice/CMA within fourteen (14) Calendar Days of identifying the underperformance, with a copy to the Department.
  - 2. The PIHP shall provide the AMH+ practice, CMA or CIN or Other Partner with the opportunity to remediate any identified issues through a Corrective Action Plan (CAP), and a copy of the CAP shall be sent to the Department.
  - 3. The PIHP shall ensure that a minimum of thirty (30) Calendar Days is provided for remediation of the identified underperformance addressed by the CAP, although the parties may establish longer remediation periods by mutual agreement.
- xv. In the event of continued underperformance by an AMH+ practice, a CMA or a CIN or Other Partner that is not corrected after the time limit set forth on the CAP, and the PIHP terminates its contract with the AMH+ practice, CMA, CIN, or other entity, then the PIHP shall notify the Department within seven (7) Calendar Days that it will no longer be contracting with the AMH+ practice, CMA or CIN or Other Partner for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.
- xvi. In the event of underperformance by an AMH+ practice, a CMA or a CIN or Other Partner for Tailored Care Management, the PIHP shall ensure that there are no gaps in care management functions for Members assigned to the AMH+ practice or CMA.
- xvii. As part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*), the PIHP shall have a documented process for how it will oversee AMH+ practices, CMAs and CINs or Other Partners that meet all the requirements above. This process must:
  - 1. Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner.
  - 2. Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance.

3. Describe how, if the PIHP terminates its contract for Tailored Care Management with AMH+ practice, CMA, or CIN or Other Partner, the PIHP would reassign members who were obtaining care management from that organization, taking member preferences into account and using the process described in *Section IV.G.2. Tailored Care Management*.
  4. Describe how, if the PIHP terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to:
    - i. Provide Tailored Care Management without contracting with a CIN or Other Partner, which would require the AMH+ practice or CMA to enter a direct contract with the PIHP for Tailored Care Management, or
    - ii. Contract with another CIN or Other Partner that in turn will contract with the PIHP.
3. Care Coordination and Care Transitions for All Members
- a. The PIHP shall be responsible for care coordination and care transitions for its Members in accordance with 42 C.F.R. § 438.208, N.C. General Statute § 122c- 115.4, and the scope of this contract, regardless of whether a Member opts out of Tailored Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management.
  - b. The PIHP shall use staff members trained in Tailored Care Management as described in *Section IV.B.3. Staff Training*, including care managers and supervising care managers, and care manager extenders, to perform all care coordination functions in this section, with the exception of *Section IV.G.3. Care Coordination and Care Transitions for All Members*.
  - c. Care Needs Screening
 

The PIHP shall conduct a care needs screening for All Members for all members that meets the requirements in 42 C.F.R. § 438.208(b)(3).

    - i. The PIHP shall undertake Best Efforts to conduct the care needs screening for All Members within ninety (90) Calendar Days of the effective date of a Member’s PIHP enrollment. 42 C.F.R. § 438.208(b)(3). For purposes of care needs screening, “Best Effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the member’s home or working with a known provider to meet the member at an appointment).
    - ii. The PIHP shall establish an evidence-based or evidence-supported tool to conduct the *Section IV.G.3. Care Coordination and Care Transitions for All Members*. At a minimum, the tool shall identify:
      - i. For all Members:
        - a. BH needs (inclusive of substance use disorders, mental health needs, and tobacco use disorders);
        - b. I/DD and/or TBI-related needs;
        - c. BH, I/DD, and TBI-related medications; and
        - d. Other factors or conditions (e.g., pregnancy) about which the PIHP would need to be aware to arrange available interventions for the member.
      - ii. For Members identified as eligible for Tailored Care Management:
        - a. Chronic health conditions, including chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
        - b. Acute health conditions;
        - c. Risk of requiring State Plan LTSS; and



- d. Detailed medication history—a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies.
- iii. For children/youth in foster care/adoption assistance, whether the DSS seven (7)- and thirty (30)-day assessments have been completed, whether a Member is in an institution, and whether a Member requires in-reach and transition-related supports.
- iii. The PIHP shall include standardized Unmet Health-Related Resource Needs questions to be provided by the Department for use in *Section IV.G.3. Care Coordination and Care Transitions for all Members*, covering four (4) priority domains:
  - 1. Housing;
  - 2. Food;
  - 3. Transportation; and
  - 4. Interpersonal Violence/Toxic Stress.
- iv. For Members assigned to Tailored Care Management:
  - 1. The PIHP shall share results of the *Section IV.G.3. Care Coordination and Care Transitions for all Members* monthly with organizations providing Tailored Care Management using the Department-approved template provided in the PCDU.
  - 2. The PIHP shall share the results of the *Section IV.G.3. Care Coordination and Care Transitions for All Members* with the assigned organization providing Tailored Care Management within seven (7) Calendar Days of screening, or within seven (7) Calendar Days of assignment to a new organization performing Tailored Care Management, whichever is earlier.
- v. The PIHP shall share with the Department and make available to any other Designated Care Management Entity (e.g., PCCM vendor, CAP/C or CAP/DA case management entity, CDSA, or other MCOs, PIHPs, and PAHPs) that may be serving the Member the results of the *Section IV.G.3. Care Coordination and Care Transitions for All Members* within seven (7) Calendar Days of screening to prevent duplication of identification and assessment activities.
- d. The PIHP shall identify all Members who are eligible for diversion from institutional settings and conduct outreach to engage the Member in Tailored Care Management and conduct diversion activities, as described in *Section IV.G.2. Tailored Care Management*.
- e. As part of the Member Welcome Packet sent to Members within eight (8) Calendar Days following receipt of the 834 enrollment packet (*Section IV.E.3. Member Engagement*), the PIHP must include the following information on care coordination as described in *Section IV.G.2.f*.
- f. The PIHP shall employ a sufficient number of dedicated housing specialist(s) with knowledge, expertise and experience to act as advisors on affordable and supportive housing programs for care managers and all Members, consistent with the Department’s expectation that PIHPs will play an integral role in the State’s supportive housing approach utilizing a Housing First model; community integration initiatives for individuals with mental illness, I/DD and/or substance use disorders; and requirements as outlined in *Section IV.D. Stakeholder Engagement and Community Partnerships*. The housing specialist(s) may be shared for both this Contract and the BH I/DD Tailored Plan Contract.
- g. The PIHP shall provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.
- h. The PIHP shall ensure that a Member does not receive duplicative care management, case management, or care coordination services.
- i. The PIHP shall offer the same level of care coordination, as appropriate, to Members who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the

coverage of Medicare premiums and cost sharing, and for whom the PIHP is paid a capitation payment, as is offered to Medicaid-only members.

4. Care Coordination for Members with a BH Transitional Care Need
  - a. Overview
    - i. There will be PIHP Members with a BH transitional care need who are not eligible for or are not part of a target population for engagement in Tailored Care Management, as described in *Section IV.G.2. Tailored Care Management*.
    - ii. The PIHP shall oversee care transitions for Members who have a BH transitional care need as defined in *Section IV.G.4. Care Coordination for Members with a BH Transitional Care Need* below to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes in line with requirements at 42 C.F.R. § 438.208(b)(2)(i).
  - b. Priority Populations for Care Coordination Among Members with a BH Transitional Care Need
    - i. The Department defines Members with a BH transitional care need as:
      1. Members for whom a crisis service, including an emergency department visit for a mental health or substance use condition, has been provided as the first mental health or substance use service;
      2. Members being discharged from an inpatient psychiatric unit or hospital or Facility-Based Crisis or general hospital unit following admission for a mental health or SUD condition;
      3. Members being discharged from a nursing facility who have an unmet BH need; or
      4. Other members as determined by the PIHP.
    - ii. The PIHP shall develop a process for identifying Members with a BH transitional care need who are at risk of poor outcomes and should be prioritized for care coordination when undergoing a transition. At a minimum:
      1. The PIHP shall access automated Admission, Discharge and Transfer (ADT) reports on at least a daily basis on Business Days, via the PCCM website, to the extent they are made available, to monitor hospital activity and inform prompt care coordination;
      2. For facilities not supplying ADT feeds, PIHP shall make best efforts to develop relationships with local emergency departments, hospitals, nursing facilities, and other facilities to receive timely notification of member admissions, discharges, and emergency utilization; and
      3. The PIHP shall accept provider referrals, and referrals from social services for members in need of care coordination for a BH transitional care need.
    - iii. The PIHP shall document its process for identifying Members with a BH transitional care need as part of its Care Management and Care Coordination Policy.
  - c. Transitional Care Assessment
    - i. For Members identified as having a BH transitional care need, the PIHP shall be responsible for conducting a transitional care assessment.
      1. For Members in an inpatient psychiatric unit or hospital for a mental health or SUD condition, Facility-Based Crisis, general hospital unit following admission for a mental health or SUD condition, or nursing facility, the PIHP shall make best efforts to conduct the transitional care assessment prior to discharge.
      2. For Members who have used a crisis service, including an emergency department visit for a mental health or substance use condition, the PIHP shall conduct the transitional care assessment as soon as possible, but no longer than seven (7) Calendar Days after utilization of the crisis service.
    - ii. The PIHP shall make the results of the transitional care assessment available to the Member's PCP, BH, I/DD, and LTSS providers within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, provided that the Member consents to making the

results available, if required by law. The PIHP shall not withhold medically necessary services for Members while awaiting completion of the care management comprehensive assessment.

- iii. The transitional care assessment shall address, at a minimum, the following:
    1. Immediate care needs;
    2. Current services and providers across all health needs;
    3. Functional needs, accessibility needs, strengths and goals;
    4. Other state or local services currently used;
    5. Physical health conditions, including dental conditions;
    6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
    7. Physical, intellectual or developmental disabilities;
    8. Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;
    9. Advanced directives, including advance instructions for mental health treatment;
    10. Available informal, caregiver or social supports;
    11. Any other ongoing conditions that require a course of treatment or regular care monitoring;
    12. Exposure to adverse childhood experiences (ACEs) or other trauma;
    13. Risks to the health, well-being, and safety of the member and others (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols);
    14. Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
    15. Employment/community involvement;
    16. Education (including individualized education plan and lifelong learning activities);
    17. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
    18. Risk factors that indicate an imminent need for LTSS;
    19. Caregiver’s strengths and needs;
    20. Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.);
    21. Self-management and planning skills; and
    22. Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare.
  - iv. If as part of conducting the transitional care assessment, the PIHP identifies that a Member is likely eligible for Tailored Care Management as described in *Section IV.G.2. Tailored Care Management* and is a member of one of the target populations for engagement as described in *Section IV.G.2. Tailored Care Management*, the PIHP shall assist them in requesting a review for eligibility for Tailored Care Management.
- d. Development of Ninety (90) Day Post-Discharge Transition Plan
    - i. The PIHP shall develop a ninety (90) day post-discharge transition plan that is informed by the transitional care assessment:
      1. To the maximum extent possible, prior to discharge from an inpatient psychiatric unit or hospital for a mental health or SUD condition, Facility-Based Crisis general hospital unit following admission for a mental health or SUD condition, or nursing facility; or
      2. As soon as possible, but no longer than seven (7) Calendar Days after a Member uses a crisis service, including an emergency department visit for a mental health or substance use condition.
    - ii. The ninety (90) day post-discharge transition plan must be developed in consultation with the Member, the Member’s legally responsible representative (if applicable), Member’s natural supports, facility or provider staff, and the Member’s PCCM care manager or CAP/C or CAP/DA

case manager (if applicable) as described in *Section IV.G.6. Care Coordination Responsibilities for Members Obtaining Care Management, Care Coordination, or Case Management Through Another Entity*.

- iii. The ninety (90) day post-discharge transition plan must outline how the Member will:
    - 1. Maintain or access needed services and supports;
    - 2. Safely transition to the new care setting or back to their home; and
    - 3. Integrate into their community.
  - iv. The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents, legally responsible representatives, and other caregivers to care for a Member post-discharge from an inpatient setting.
  - v. The PIHP shall communicate with and provide education to the Member and the Member's caregivers and Providers to promote understanding of the ninety (90) day post-discharge transition plan.
- e. Care Coordination Functions for Members with a BH Transitional Care Need
- i. The PIHP shall carry out the following care coordination functions for Members with a BH transitional care need:
    - 1. Ensure that a care manager is assigned to manage the transition.
    - 2. Have a care manager assume coordination responsibility for transition planning.
    - 3. Have a care manager visit the member during their stay in an inpatient psychiatric unit or hospital, Facility-Based Crisis, general hospital unit, or nursing facility and be present on the day of discharge.
    - 4. Conduct outreach to the Member's Providers.
    - 5. Obtain a copy of the discharge plan for members being discharged from an inpatient psychiatric unit or hospital, Facility-Based Crisis, or general hospital unit, or nursing facility and review the discharge plan with the member and facility staff.
    - 6. Facilitate clinical handoffs.
    - 7. Refer and assist members in accessing needed social services and supports identified as part of the care coordination process, including access to housing.
    - 8. Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge or use of a crisis service, unless required within a shorter timeframe.
    - 9. Ensure that the assigned care manager follows up with the Member within forty-eight (48) hours of discharge or use of a crisis service, to the maximum extent possible.
    - 10. Arrange to visit the Member in the new care setting after discharge/transition.
  - f. Staffing and Training Requirements for Care Managers Serving Members with a BH Transitional Care Need: The PIHP shall ensure that care managers, supervising care managers, and care manager extenders performing care coordination for Members with a BH transitional care need adhere to the staffing and training requirements in *Section IV.G.2. Tailored Care Management*.
5. Care Coordination Responsibilities for Members with an Unmet BH, I/DD, or TBI-Related Need Who Are Not Engaged in Tailored Care Management
- a. For Members who are not engaged in Tailored Care Management who the PIHP has identified as having an unmet BH, I/DD, and TBI-related need that is outside of those described in *Section IV.G.4. Care Coordination for Members with a BH Transitional Care Need*, the PIHP shall:
    - i. Ensure that each Member has an ongoing source of care appropriate to his or her needs and a person or entity (e.g., a care manager at the PIHP, a provider) formally designated as primarily responsible for coordinating the services accessed by the Member. The PIHP must provide the Member with information on how to contact the designated person or entity that is primarily

- responsible for coordinating their services, as well as an alternative contact if the primary contact cannot be reached. 42 C.F.R. § 438.208(b)(1).
- ii. Coordinate the services furnished to the Member as described in 42 C.F.R. § 438.208(b)(2):
    1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
    2. With the services the Member receives from any other MCO, PIHP, or PAHP;
    3. With any State-funded Services the member receives from the BH I/DD Tailored Plan;
    4. With the physical health and pharmacy services the Member receives from NC Medicaid Direct; and
    5. With the services the Member receives from community and social support providers.
  - iii. Provide Members with education about clinically relevant mental health, I/DD, TBI, and SUD services and supports, as well as education about other types of clinically-relevant Medicaid services, State-funded Services, and services addressing Members' Unmet Health-Related Resource Needs.
  - iv. Accept care coordination referrals from primary care providers and other providers serving a member, determine what level of care coordination services are needed, and provide referral status feedback to the referring provider within five (5) Business Days. If care coordination is not warranted, the PIHP shall notify the referral source and offer other options for assistance from the PIHP in connecting the member to treatment.
  - v. Refer eligible Members to Tailored Care Management and provide a Warm Handoff once an organization providing Tailored Care Management has been assigned.
  - vi. For members not identified as eligible for Tailored Care Management by the Department, but who are otherwise known to meet or are likely to meet Tailored Care Management eligibility criteria, assist them in requesting a review for eligibility for Tailored Care Management.
  - vii. Encourage, support, and facilitate communication between primary care providers and the PIHP network providers regarding medication management, shared roles in care transitions and ongoing care, the exchange of clinically-relevant information, annual exams, coordination of services, case consultation, and problem-solving as well as identification of a medical home for persons determined to have need.
  - viii. Provide linkages to medically necessary psychological, behavioral, educational, and physical evaluations.
  - ix. Follow up and attempt to resolve any issues related to the Member's health, safety, or service delivery, bringing any unresolved issues to the attention of the appropriate PIHP staff member and designated BH provider or medical provider for resolution.
  - x. Refer Members to providers offering specialized care models that address their BH, I/DD, or TBI-related needs.
  - xi. Answer any questions that the Member or legally responsible person (LRP) may have regarding available services.
  - xii. Make Member referrals to the BH I/DD Tailored Plan's appropriate 1915(c) waiver programs using all information available to it, including member self-referrals.
  - xiii. Connect Members to programs and resources that can assist in securing employment, supported employment (such as through the Individual Placement and Support-Supported Employment (IPS-SE) program), apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.
- b. The PIHP shall use claims data, predictive modeling, and/or the *Section IV.G.3. Care Coordination and Care Transitions for All Members* to identify members with a special health care need, defined

by the Department in *Section II.A. Definitions*, that is related to a BH condition, I/DD, or TBI. For members who are not engaged in Tailored Care Management, the PIHP shall:

- i. Implement mechanisms to identify members with a special health care need related to a BH condition, I/DD, or TBI and assess these members' needs related to any conditions that require a course of treatment or regular care monitoring.
  - ii. Develop engagement strategies for members with a special health care need related to a BH condition, I/DD, or TBI, including identification of barriers to treatment and referral.
  - iii. Connect members with a special health care needs related to a BH condition, I/DD, or TBI to any services identified by the assessment and develop a Care Plan/ISP for these members if the PIHP determines that it is appropriate. 42 C.F.R. § 438.208(c)(2).
  - iv. Permit members with a special health care need related to a BH condition, I/DD, or TBI to directly access specialists as appropriate for the member's condition and identified needs. 42 C.F.R. § 438.208(c)(4).
- c. The PIHP shall submit its policies and procedures for care coordination for members with an unmet BH, I/DD, or TBI-related need, including those with special health care needs, as part of its Care Management and Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*). The policies and procedures shall include the PIHP's approach for:
- i. Ensuring that each member with unmet BH, I/DD, or TBI-related needs has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating their services;
  - ii. Facilitating communication and coordinating with primary care providers, other network providers, and community and social support providers; and
  - iii. Coordinating care for members with special health care needs, including the process for engaging them, assessing their needs, and connecting them to services.
6. Care Coordination Responsibilities for Members Obtaining Care Management, Care Coordination, or Case Management Through Another Entity
- a. The PIHP shall have an expedited process to receive and respond to inquiries from medical providers, PCCM care managers, CAP/C and DA waiver case managers, State and local agencies, including but not limited to the Department of Social Services (DSS) and the Department of Juvenile Justice (DJJ), and any other care or case manager assigned to or responsible for a Member. This expedited process shall be designed and implemented by the PIHP to result in the successful reaching of specific, appropriate staff and in the quick provision of help to callers.
    - i. For urgent situations, the PIHP shall respond to inquiries within twenty-four (24) hours of receiving them.
    - ii. For non-urgent situations, the PIHP shall respond to inquiries within three (3) Business Days of receiving them.
    - iii. The PIHP shall submit its policies and procedures for its expedited process to receive and respond to inquiries as part of its Care Management and Care Coordination Policy (*Section IV.G.8. Care Management and Care Coordination Policy*).
  - b. The PIHP shall participate in any Member care team meetings to which the PIHP has been invited by another care management, care coordination, or case management entity, including, but not limited, to care team meetings convened by the PCCM vendor or CAP/C or CAP/DA case management entity.
  - c. The PIHP shall ensure that care managers and supervising care managers receive training on coordinating care with the PCCM vendor and CAP/C and CAP/DA waiver case management entities.
  - d. Coordination with PCCM Vendor

- i. Members who are not obtaining Tailored Care Management may obtain both care management through the PCCM vendor and care coordination through the PIHP.
  - 1. The PIHP shall be the lead care coordination entity for Members with a BH transitional care need.
  - 2. For all other Members obtaining both care management through the PCCM vendor and care coordination through the PIHP, the PCCM vendor shall take the lead in coordinating the Member's care.
- ii. The PIHP shall collaborate with the Department's PCCM vendor in the areas outlined below. The PIHP's obligations are subject to reciprocal collaboration from the PCCM vendor as required by the Department's contract with the PCCM:
  - 1. Whenever a Member is receiving care coordination, the PIHP shall check the PCCM Care Management Information System to determine whether the Member is also being managed by a PCCM care manager.
  - 2. For members obtaining PIHP care coordination, the PIHP shall coordinate with each Member's PCCM care manager to the extent the Member is engaged in care management through the PCCM vendor.
  - 3. The PIHP must share the results of the *Section IV.G.3. Care Coordination and Care Transitions for all Members*, any assessments conducted, the Member's person-centered plan, and the Member's Care Plan (to the extent one exists) with the PCCM vendor.
  - 4. The PIHP, with the assistance of the PCCM vendor, shall encourage, support, and facilitate communication between primary care providers and the PIHP network Providers regarding medication management, shared roles in care transitions and ongoing care, the exchange of clinically-relevant information, annual exams, coordination of services, case consultation, and problem-solving as well as identification of a medical home for persons determined to have need.
  - 5. The PIHP shall accept care coordination referrals from primary care providers and PCCM care managers, determine what level of care coordination services are needed, and provide referral status feedback to the referring Provider or PCCM care manager within five (5) Business Days. If care coordination is not warranted, the PIHP shall notify the referral source and offer other options for assistance from the PIHP in connecting the member to treatment.
  - 6. The PIHP shall initiate care management and physical health referrals to the PCCM vendor as such needs are identified and receive and document feedback from the PCCM vendor regarding the referral status.
  - 7. The PIHP shall have a weekly conference with the PCCM vendor to share information on high-risk members, including members with a BH transitional care need and members with special health care needs, who are receiving care coordination and care management from both entities or require referrals.
- iii. Coordination with PCCM Vendor for Members with a BH Transitional Care Need  
For members with a BH transitional care need who have been assigned a PCCM care manager, the PIHP shall perform the following additional responsibilities:
  - 1. Notify the member's PCCM care manager that the Member is undergoing a transition and engage the Member's assigned PCCM care manager to assist with transitioning the Member into the community, including in the development of the ninety (90) day post-discharge transition plan to the extent there are items within the PCCM care manager's scope.
  - 2. Share the transitional care assessment and ninety (90) day post-discharge transition plan with the PCCM care manager.

3. Identify in the ninety (90) day post-discharge transition plan the role that the PCCM care manager will play in ensuring a successful transition.
  4. During the week of the transition, ensure that the Member is discussed in the weekly conference between the PIHP and PCCM vendor.
- iv. Coordination with PCCM Vendor for Members in Foster care/Adoption Assistance and Former Foster Youth
1. The PIHP shall defer to the PCCM care manager as the lead care manager for Members in foster care/adoption assistance and former foster youth who do not otherwise meet Tailored Plan eligibility criteria. As described in *Section IV.D.3. Integration with Other Department Partners*, the PIHP shall serve as the lead care manager for members in foster care/adoption assistance and former foster youth who otherwise meet Tailored Plan eligibility criteria.
  2. For members who do not otherwise meet Tailored Plan eligibility criteria, the PIHP shall honor any requests by the county DSS/county child welfare worker to assign an ongoing PIHP care Section manager (e.g., if the county child welfare worker needs additional support in connecting the member to needed BH services).
- e. Coordination with CAP/C and CAP/DA Waiver Case Management Entities
- i. Members may obtain both CAP/C or CAP/DA waiver case management and care coordination through the PIHP.
  - ii. For these members, the CAP/C or CAP/DA waiver case management entity shall be the lead case management/care coordination entity, except in the case of when a member has a BH transitional care need, as described in more detail below.
  - iii. For members enrolled in CAP/C or CAP/DA who have a BH need, I/DD, or TBI, the PIHP shall coordinate with the member's waiver case management entity as follows:
    1. The PIHP shall coordinate with the Member's waiver case manager to ensure that there is not duplication of services between the applicable waiver and services authorized by the PIHP.
    2. The PIHP shall share the Member's person-centered plan, to the extent one exists, with the member's waiver case manager.
    3. If the member has a BH transitional care need, as described in *Section IV.G.4. Care Coordination for Members with a BH Transitional Care Need*, the PIHP shall take the lead in coordinating the transition. The PIHP shall engage the member's waiver case manager in the development of the ninety (90) day post-discharge transition plan.
    4. The PIHP shall accept care coordination referrals from a member's waiver case manager, determine what level of care coordination services are needed, and provide referral status feedback to the referring provider or waiver case manager within five (5) Business Days. If care coordination is not warranted, the PIHP shall notify the referral source and offer other options for assistance from the PIHP in connecting the member to treatment.
    5. The PIHP shall provide trainings twice annually to CAP/C and DA waiver case management entities in its service area to educate waiver case managers on the services available through the PIHP and the PIHP's policies and procedures for coordinating with CAP/C and DA waiver case managers.
7. Other Care Management Programs
- a. High-Fidelity Wraparound
    - i. Overview of High-Fidelity Wraparound
      1. The Department recognizes that High-Fidelity Wraparound, an evidence-based intervention targeted toward youth ages three (3) to twenty (20) years old with serious



- emotional disturbance, has produced cost savings as compared with psychiatric residential treatment facility services and Level III/IV group home services.
2. The Department is committed to expanding access to High-Fidelity Wraparound with the launch of PIHPs, and strongly encourages PIHPs to offer this intervention as an In Lieu of Service.
  3. If the PIHP offers High-Fidelity Wraparound as an In Lieu of Service, the PIHP shall ensure the following: Provider organizations may choose to seek certification to offer High-Fidelity Wraparound to children with serious emotional disturbance who meet eligibility criteria that will be documented in the Department's forthcoming High-Fidelity Wraparound Policy. Only providers that meet requirements as described in this *Section IV.G.8. Other Care Management Programs* may offer High-Fidelity Wraparound.
  4. The PIHP shall ensure that High-Fidelity Wraparound providers meet all data sharing requirements described in *Section IV.G.2. Tailored Care Management*.
  5. The PIHP shall ensure that the High-Fidelity Wraparound program is subject to requirements for facilitating timely communication across the care team as described in *Section IV.G.2. Tailored Care Management*.
  6. The PIHP shall ensure that it has sufficient providers in its Network to meet the needs of members who are eligible for the services, as defined below in *Section IV.G.8 Other Care Management Programs*.
- ii. Eligibility and Assignment to High-Fidelity Wraparound
    1. Youth ages three (3) through twenty (20) are eligible for High-Fidelity Wraparound if they meet the criteria documented in the Department's High-Fidelity Wraparound Policy.
    2. On an ongoing basis, if the PIHP offers High-Fidelity Wraparound as an In Lieu of Service:
      - i. The PIHP shall identify members who may meet the High-Fidelity Wraparound eligibility criteria and would benefit from the program. The PIHP shall also accept referrals from Network providers for members who may be eligible for and benefit from High-Fidelity Wraparound.
      - ii. If the PIHP identifies that a member may meet the High-Fidelity Wraparound eligibility criteria, the PIHP shall contact the member and their caregiver/legal guardian (if applicable) to determine interest in High-Fidelity Wraparound.
      - iii. If the member and their caregiver/legal guardian indicate interest in High-Fidelity Wraparound, the PIHP shall determine whether the member meets the High-Fidelity Wraparound eligibility criteria, as specified in the Department's forthcoming High-Fidelity Wraparound Policy.
      - iv. If the PIHP determines that the member meets the High-Fidelity Wraparound eligibility criteria, the PIHP shall refer the member to a provider that offers High-Fidelity Wraparound for care management.
      - v. If the member is engaged in Tailored Care Management, meets the High-Fidelity Wraparound eligibility criteria, and elects to participate in High-Fidelity Wraparound, the member will be transitioned from Tailored Care Management to High-Fidelity Wraparound. The assigned organization providing Tailored Care Management shall facilitate a Warm Handoff to the High-Fidelity Wraparound Team.
      - vi. The PIHP shall disenroll the member from Tailored Care Management at the time of the Warm Handoff.
  - iii. High-Fidelity Wraparound Services and Fidelity Monitoring

If the PIHP offers High-Fidelity Wraparound as an In Lieu of Service:

    1. The PIHP shall ensure that all providers offering High-Fidelity Wraparound meet fidelity requirements, as assessed by the vendor performing fidelity monitoring.

2. The PIHP must ensure that providers offering High-Fidelity Wraparound meet all requirements documented in the Department's High-Fidelity Wraparound Policy, including requirements for staffing, qualifications, and training.
  3. When a member has completed the High-Fidelity Wraparound intervention, the PIHP must assign the member to an AMH+, a CMA or the PIHP for Tailored Care Management as described in Section IV.G.2. Tailored Care Management, unless the member opts out of Tailored Care Management. The PIHP must give preference to the provider that delivered High-Fidelity Wraparound if that provider is certified as a CMA and has the capacity to serve that member.
  4. The PIHP shall require a Warm Handoff between the High-Fidelity Wraparound team and the assigned organization providing Tailored Care Management.
- b. Members Receiving ACT, Residing in an ICF-IID, or Residing in a Nursing Facility for a Period of 90 Days or Longer
- i. The PIHP must implement the following protocols for members receiving ACT, residing in an ICF-IID, or residing in a nursing facility for a period of ninety (90) Calendar Days or longer:
    1. For members receiving ACT:
      - i. For members who were engaged in Tailored Care Management prior to receiving ACT, ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management, in the first month of obtaining ACT.
      - ii. Assign the member to an organization for Tailored Care Management in the last month of receiving ACT, as described in Section IV.G.2. Tailored Care Management, and ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management.
    2. For members receiving services in an ICF-IID:
      - i. For members who were engaged in Tailored Care Management prior to obtaining services, ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management in the first month of obtaining services in an ICF-IID.
      - ii. Assign the member to an organization for Tailored Care Management in the last month of obtaining services through an ICF-IID, as described in Section IV.G.2. Tailored Care Management, and ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management.
    3. For members receiving services in a nursing facility for a period of ninety (90) Calendar Days or longer:
      - i. For members who were engaged in Tailored Care Management prior to obtaining services, ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management in the first month of obtaining services in a nursing facility.
      - ii. For members who are eligible for and part of a priority population for Tailored Care Management, assign the member to an organization for Tailored Care Management in the last month of obtaining services through a nursing facility, as described in Section IV.G.2. Tailored Care Management, and ensure that the member receives transitional care management, as described in Section IV.G.2. Tailored Care Management.
      - iii. For members who have BH needs but are not eligible for or not part of a priority population for Tailored Care Management, ensure that the member receives care coordination for a BH transitional care need, as described in Section IV.G.4. Care

- Coordination for Members with a BH Transitional Care Need, in the last month of obtaining services through a nursing facility.
4. Deny claims submitted by providers for Tailored Care Management except in the first or last month of the member obtaining ACT, residing in an ICF-IID, or residing in a nursing facility.
  5. Ensure that when a member begins receiving ACT or residing in an ICF-IID or nursing facility, the member's care manager for Tailored Care Management shares the member's Care Plan/ISP with the ACT, ICF-IID, or nursing facility case manager, as lawful.
- c. Coordination with Children's Developmental Service Agencies
- i. The PIHP shall coordinate with every Early Intervention (EI) Program Children's Developmental Service Agency (CDSA) in the catchment area in which it operates.
  - ii. The PIHP shall establish reciprocal information-sharing agreements with CDSAs that reflect parental consent requirements and are compliant with HIPAA and the Family Educational Rights and Privacy Act (FERPA).
  - iii. For children who are actively engaged in Tailored Care Management:
    1. The care manager providing Tailored Care Management shall coordinate with the CDSA service coordinator, to the maximum extent possible, to facilitate information sharing and coordination between the PIHP and the CDSAs.
    2. For any child ages zero (0) to three (3) identified as receiving EI services through the needs assessment, the organization providing Tailored Care Management shall:
      - i. Incorporate the child's Individualized Family Service Plan (IFSP) into the Care Plan or ISP.
      - ii. Update the child's PIHP Care Plan or ISP to reflect any changes to the IFSP on an ongoing basis.
      - iii. Request that the CDSA service coordinator take part in the child's Tailored Care Management case conferences, upon consent of the parent/legally responsible person.
      - iv. Partner with the CDSA service coordinator to identify Unmet Health-Related Resource Needs and connect the family to appropriate social and community-based services, as needed.
    3. For any child age zero (0) up to age three (3) who is not receiving EI services, but whose developmental assessment demonstrates evidence of developmental delay, the organization providing Tailored Care Management shall provide referral information to the parents for an EI evaluation, facilitate a Warm Handoff to the appropriate CDSA, and follow up on the results of the referral and whether an EI evaluation was conducted.
  - iv. For children who have a BH or I/DD-related need, but are not actively engaged in Tailored Care Management:
    1. The PIHP shall coordinate with the CDSA service coordinator, to the maximum extent possible, to facilitate information sharing and coordination between the PIHP and the CDSAs.
    2. The PIHP shall partner with the CDSA service coordinator to identify Unmet Health-Related Resource Needs and connect the family to appropriate social and community-based services, as needed.
  - v. The PIHP shall ensure that appropriate staff, such as member services staff and care managers, are generally knowledgeable about EI services and provide referrals to the appropriate local CDSA to assist and consult with Members concerning EI services.
  - vi. In its Care Management and Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*), the PIHP shall detail the plan to ensure referral and coordination for

all children who receive service coordination through a CDSA during Contract Year 1, or a time otherwise defined by the Department, and annually thereafter.

- d. Care Management through the Indian Health Service or EBCI  
At the request of the Department, the PIHP shall enter into a contract with EBCI to perform care management or other functions for tribal members and IHS-eligibles as prescribed by the Department, in consultation with EBCI.
- 8. Care Management and Care Coordination Policy
  - a. The PIHP shall submit its Care Management and Care Coordination Policy for review and approval by the Department within ninety (90) Calendar Days after Contract Effective Date. The PIHP must submit an updated version of the Care Management and Care Coordination Policy sixty (60) Calendar Days prior to PIHP launch and at the beginning of each Contract Year.
  - b. The PIHP may use the same policies and procedures for Tailored Care Management as those used by the BH I/DD Tailored Plan but must incorporate any additions specific to the PIHP population.
  - c. The Care Management and Care Coordination Policy shall include the PIHP's policies for Tailored Care Management, including the PIHP's:
    - i. Plan for supporting development of Provider-based Tailored Care Management and oversight of Provider-based Tailored Care Management (including, but not limited to CAP procedures).
    - ii. Sample Tailored Care Management information for the Member Welcome Packet and opt-out form.
    - iii. Policies and procedures for identifying target populations for engagement in Tailored Care Management, as defined in *Section IV.G.2. Tailored Care Management*.
    - iv. Policies and procedures for Tailored Care Management assignment, including methodology for assigning eligible members, as defined in *Section IV.G.2. Tailored Care Management*, to Tailored Care Management based at an AMH+ practice, a CMA or the PIHP.
    - v. Policies and procedures for outreach and engagement for members assigned to Tailored Care Management.
    - vi. Process for how members are notified of the name of their assigned care manager and how to contact them:
      - 1. Process for how the care manager is made aware of Grievances and Appeals filed by members or by providers (when providers file an Appeal based on a denial of service);
      - 2. Strategies to outreach to and engage members who are hard to contact/locate (because of, for example, incorrect address information, a missing or incorrect phone number, or homelessness); and
      - 3. Strategies that shall be used to document attempted contacts; "robocalls" and automated telephone calls that deliver recorded messages can be part of the outreach strategy but will not solely be an acceptable form of contacting members.
    - vii. Policies and procedures for coordinating care with County Child Welfare Workers for members involved in the Child Welfare System who are enrolled in Tailored Care Management,
    - viii. Policies and procedures for care management comprehensive assessments, including but not limited to:
      - 1. Assessment tools/questions used;
      - 2. Variation in care management comprehensive assessment based on population (including LTSS);
      - 3. Expected volume of care management comprehensive assessments monthly and annually;
      - 4. Method of conducting the care management comprehensive assessment based on member needs or other factors; and

5. Audits of care management comprehensive assessments to ensure they meet quality expectations.
- ix. Policies and procedures for Care Plan/ISP development with members who are engaged in Tailored Care Management, including:
  1. Approach for involving multidisciplinary care team;
  2. Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved;
  3. Process for and frequency of Care Plan/ISP updates;
  4. Approach for ISP development for members enrolled in the Innovations waiver; and
  5. Audits of Care Plan/ISP to ensure they meet quality expectations.
- x. Policies and procedures for transitional care management, including the approach to working with members with LTSS needs.
- xi. Policies and procedures for supporting members who are aging out of foster care.
- xii. Policies and procedures for linkages with community resources for all members as needed, including for those identified as having Unmet Health-Related Resource Needs.
- xiii. Policies and procedures for providing members engaged in Tailored Care Management with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.
- xiv. Approach to providing technical assistance to AMH+ practices and CMAs.
- xv. Training plan, including:
  1. Policies and procedures for training and qualification of care managers and other multidisciplinary team members (e.g., care manager extenders);
  2. Training modalities (e.g., in person versus online);
  3. Approach to tracking and verifying that care managers have completed trainings;
  4. Process for addressing noncompliance with trainings;
  5. Timing/frequency of trainings;
  6. Summary of curriculum and training modalities (e.g., in person versus online);
  7. Approach for assessing competencies;
  8. Approach for annual refreshers and ongoing continuing education; and
  9. Approach for permitting care managers and supervisors to waive specific training domains if they have previously obtained comparable training.
- xvi. Policies and procedures for population health management, including any risk scoring and stratification approach in addition to acuity tiering.
- xvii. Proposed methodology and schedule for sharing data with AMH+ practices and CMAs.
- xviii. Proposed methodology for calculating costs and outcomes of the Tailored Care Management program.
- xix. Policies and procedures for conflict-free Tailored Care Management.
- xx. Process for overseeing AMH+ practices, CMAs, and CINs or Other Partners, as described in *Section IV.G.2. Tailored Care Management*. This process must:
  1. Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner;
  2. Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance;
  3. Describe how, if the PIHP terminates its contract for Tailored Care Management with AMH+ practice, CMA or CIN or Other Partner, the PIHP would reassign members who were obtaining care management through that organization, taking member preferences

- into account and using the process described in *Section IV.G.2. Tailored Care Management*; and
4. Describe how, if the PIHP terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to contract directly with the PIHP or the option to contract with another CIN or Other Partner that in turn will contract with the PIHP.
- xxi. Protocols for ensuring that individuals moving between the following services and the Tailored Care Management model experience smooth transitions:
1. ACT;
  2. ICF-IIDs;
  3. Nursing facilities for members who residing for a period of ninety (90) Calendar Days or longer;
  4. Care Management for At-Risk Children; and
  5. High-Fidelity Wraparound program.
- d. The Care Management and Care Coordination Policy shall also include the PIHP's policies for Care Coordination and Care Transitions for all Members and Care Coordination for Members with a BH Transitional Care Need, including the PIHP's:
- i. Policies and procedures for completing the required *Section IV.G.3. Care Coordination and Care Transitions for All Members* according to requirements in this Section and a copy of the *Section IV.G.3. Care Coordination and Care Transitions for All Members* to be used.
  - ii. Policies and procedures for coordinating care for members with a BH transitional care need, including:
    1. The process that the PIHP will use to identify members with a BH transitional care need for engagement in care coordination.
    2. Policies and procedures for transitional care assessments, including but not limited to:
      - i. Assessment tools/questions used;
      - ii. Variation in transitional care assessment by population;
      - iii. Expected volume of transitional care assessments monthly and annually;
      - iv. Method of conducting the transitional care assessment based on member needs or other factors; and
      - v. Audits of transitional care assessments to ensure they meet quality expectations.
    3. Approach for developing the ninety (90) day post-discharge transition plan, including but not limited to:
      - i. Involvement of member's PCCM care manager or CAP/C or CAP/DA case manager; and
      - ii. Ensuring that the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved.
  - iii. Policies and procedures for care coordination for members with an unmet BH, I/DD, or TBI-related need who are not engaged in Tailored Care Management, including:
    1. Description of how the PIHP will prioritize members in this group for care coordination;
    2. Approach to determining the level of care coordination that a member needs;
    3. Strategies for identifying and engaging members with special health care needs;
    4. Assessment tools to be used for members with special health care needs;
    5. Process for connecting members with special health care needs to services;

6. Approach for ensuring that these members have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating their services; and
  7. Strategies for facilitating communication and coordinating with primary care providers, other network providers, and community and social support providers.
- iv. Policies and procedures for care coordination responsibilities for members obtaining care management, care coordination, or case management through another entity, including:
    1. Description of the expedited process to receive and respond to inquiries from other entities conducting care management, care coordination, or case management for a member;
    2. Description of process for coordinating with the PCCM vendor for all members, including but not limited to:
      - i. Process for transmitting relevant information, including results of the Section IV.G.3. Care Coordination and Care Transitions for All Members and any assessments conducted, to the PCCM vendor;
      - ii. Approach to promoting integrated care for members engaged in both PIHP care coordination and care management through the PCCM vendor;
      - iii. Process for engaging the PCCM vendor in ensuring a successful transition for members with a BH transitional care need; and
      - iv. Process for regular communication between the PIHP and PCCM vendor, including proposed approach for weekly conferences with the PCCM vendor.
    3. Policies and procedures for coordinating with CAP/C and CAP/DA waiver case management entities, including but not limited to:
      - i. Process for transmitting relevant information, including results of the Section IV.G.3. Care Coordination and Care Transitions for All Members and any assessments conducted, to CAP/C and CAP/DA waiver case management entities;
      - ii. Process for engaging the CAP/C and DA waiver case management entity in ensuring a successful transition for members with a BH transitional care need; and
      - iii. Plan for twice-annual training sessions with CAP/C and CAP/DA waiver case management entities.
  - v. Policies and procedures for linkages with community resources for all members as needed, including for those identified as having Unmet Health-Related Resource Needs.
  - vi. Policies and procedures for ensuring members do not receive duplicative care management or care coordination from multiple sources.
  - vii. Description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies.
  - viii. Policies and procedures for obtaining and using member data from NC Medicaid and CMS/Medicare and Medicare plans for Members receiving care through multiple plans and delivery systems, as applicable and in accordance with federal interoperability rules (e.g., 85 FR 25510).
  - ix. Specialized care management strategies that address the medical and psychosocial needs of infants who are substance affected; address the needs of the infant's mother/caregiver, including parental/caregiver education on the potential psychosocial development of an infant who is substance affected; and establish coordination with the mother's care manager to ensure that care management services for the infant and the mother are aligned.
  - x. Care management strategies to manage the needs of pregnant and postpartum women with SUD diagnoses/history or mental health diagnoses/history, including strategies to facilitate a

recovery environment addressing improvements in maternal and child health, positive birth outcomes, and addiction and recovery treatment approaches.

- xi. Policies and procedures for referral and coordination for all children who receive service coordination through a CDSA.
- xii. Protocols for ensuring compliance with foster care-specific provisions, including (but not limited to) coordination with the County Departments of Social Service, coordination with the PCCM vendor, and ensuring prompt outreach to individuals in foster care/adoption assistance and former foster youth upon launch of the PIHP.
- e. The PIHP shall modify the Care Management and Care Coordination Policy based on EQRO review, Department review, or care management improvement activities as part of the QAPI.

## 9. System of Care

### a. System of Care Background

- i. The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina's System of Care is to provide evidence-based, trauma-informed/resiliency developed BH services to all children, youth, and their families.
- ii. The PIHP shall use a System of Care approach, including use of specific strategies and protocols described in the PIHP System of Care Policy (*Section IV.G.9. System of Care*) for all Members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving mental health or substance use services, including special populations such as youth with a dual I/DD and mental health disorder at risk of out-of-home placement or unable to return from out-of-home placement; youth with dual physical and mental health or SUD diagnoses with or without the risk of out-of-home placement; youth and young adults transitioning from child service systems into adult service systems; and youth involved in the child welfare and/or the juvenile justice system.
- iii. The System of Care's core elements are:
  - 1. Family-driven, youth-guided services;
  - 2. Interagency collaboration;
  - 3. Service coordination through a single facilitator;
  - 4. Individualized, strength-based, trauma-informed/resilience development approach;
  - 5. Culturally and Linguistically Competent care;
  - 6. Evidence-based or informed services provided in a home or community setting; and
  - 7. Family and youth involvement in regional and state policy development, implementation, and evaluation.

### b. System of Care Staffing Requirements

- i. The PIHP shall employ or contract with the following dedicated System of Care staff, which may be shared between the PIHP and BH I/DD Tailored Plan:
  - 1. At least one (1) System of Care Coordinator per three (3) counties for the catchment area in which it operates; and
  - 2. At least one (1) Family Partner per three (3) counties for the catchment area in which it operates.
- ii. PIHP System of Care Coordinators and Family Partners shall be responsible for comprehensive System of Care planning, implementation, coordination, and training related to required core functions within the catchment area in which it operates. System of Care Coordinators and Family Partners shall develop, facilitate, and evaluate the following required System of Care functions and responsibilities throughout the catchment area in which the PIHP operates:
  - 1. Serve as staff to each city or county local community collaborative in the catchment area in which the PIHP operates and shall recruit and maintain membership that includes



- family members and youth who are receiving or have received public BH services, child-serving agencies, and a variety of community partners.
2. Work with Community Collaboratives to:
    - i. Influence the development of a broad and appropriate service array to meet the range of BH needs of children being serviced under the System of Care framework.
    - ii. Develop the capacity of the community collaborative to gather and use data for System of Care decision making.
    - iii. Support BH workforce development through systems partners jointly developing training plans and sharing resources to implement those plans.
    - iv. Develop and implement a strategic communication plan that promotes access to and utilization of BH services, deepens local leadership's understanding of the System of Care framework, and builds public support for local Systems of Care.
  3. Foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, work with care managers to ensure that youth and families are leading their person-centered planning processes, and provide and support leadership opportunities for youth and families.
  4. Work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of System of Care principles and processes, and provide or facilitate regular consultation, technical assistance, and training to provider agencies in System of Care implementation fidelity.
  5. Work with community agencies in identifying and responding to community needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and substance abuse disorder treatment and recovery services.
  6. Regularly identify and respond to consultation, technical assistance and training needs of the Community Collaboratives, provider agencies, families and PIHP staff, and either directly provide such System of Care consultation, technical assistance, and training or facilitate the provision of such activities.
  7. Take an active role in promoting PIHP and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.
  8. Complete and submit PIHP System of Care reports to the Department. These reports shall be submitted to the Department in accordance with the Department's requirements.
  9. Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits to support a high level of statewide coordination, networking, monitoring, and evaluation for and with System of Care Coordinators and staff.
- iii. The PIHP shall ensure System of Care Coordinators and Family Partners are trained on all the topics described in this Section.
  - iv. The PIHP shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:
    1. Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system;
    2. Partnering with families and youth in Care Plan development, implementation, and evaluation process;

3. Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive, and implementation is shared across sectors;
  4. Developing, supporting, and expanding relationships among systems;
  5. Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and
  6. Child and family team care management and High-Fidelity Wraparound.
- c. System of Care Policy
- i. The PIHP shall submit a System of Care Policy for review and approval by the Department due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution.
  - ii. As long as the System of Care Policy clearly states it applies to Medicaid Direct, the System of Care Policy may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
  - iii. The scope of this policy includes PIHP Members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving mental health or substance abuse services.
  - iv. The System of Care Policy shall include a brief description of the PIHP's history and experience coordinating with members' care under the System of Care framework, including examples of specific successes and challenges to date in meeting the needs of children with BH needs.
  - v. The System of Care Policy shall include the PIHP's policies and processes for implementing the System of Care as required in the *Section IV.G.9. System of Care* and:
    1. Integrating into the System of Care framework and applying the System of Care core elements into its approach for covering services for child and youth members with BH needs and their families.
    2. Ensuring that the PIHP is an active partner within a Member's System of Care.
    3. Supporting coordinated multi-system care delivery through:
      - i. Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
      - ii. Conducting outreach to families to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;
      - iii. Instituting effective and timely cross-system communication, including for children in crisis; and
      - iv. Collaborating with system partners to ensure that children receive needed services in the least restrictive setting.
    4. Describing how the PIHP will work with local and State public agency partners to:
      - i. Reduce the number and length of out-of-home placements for children receiving public BH services;
      - ii. Ensure timely access to an appropriate service array of evidenced based home- and community-based care for children receiving Medicaid public BH services; and
      - iii. Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography.
    5. Describing how the PIHP will develop capacity to strengthen existing and build new relationships with local and State public agency partners youth and/or family members with lived experience with a child in the BH system and local child and family support education and/or advocacy groups, including but not limited to:
      - i. Local school systems;

- ii. County government;
- iii. Juvenile justice system;
- iv. Child welfare system;
- v. Public health system;
- vi. Private and local community-based providers;
- vii. Child and Family Advisory Committees;
- viii. Community Collaboratives; and
- ix. The DMH/DD/SAS System of Care Coordinator.

10. In-Reach and Transition from Institutional Settings

a. In-Reach and Transition Overview

- i. The PIHP shall assume primary responsibility for the in-reach and transition activities described in this Section.
  - 1. In-reach activities shall be conducted with the goal of identifying and engaging members receiving care in a setting described in *Section IV.G.11. In-Reach and Transition from Institutional Settings Not Operated by the State* who may be able to have their needs safely met in a community setting.
  - 2. Transition activities shall be conducted with the goal of facilitating the relocation of a member receiving services in a setting described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* to a community setting, while ensuring the appropriate level of services and supports that member requires.
- ii. The PIHP shall ensure all in-reach and transition activities are documented and stored and made available to the Department for review upon request.
- iii. The PIHP shall provide the in-reach and transition reports in the form and frequency as described in *Section VI. Attachment I. Reporting Requirements*.

b. Eligibility for In-Reach and Transition Services

- i. The PIHP shall consider all Members residing in the following settings as eligible for in-reach and transition services:
  - 1. State psychiatric hospitals;
  - 2. ACHs (members with SMI only);
  - 3. State developmental centers;
  - 4. PRTFs; and
  - 5. Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2.
- ii. The PIHP shall also provide in-reach and transition services to Members residing in ICF-IIDs not operated by the state as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings Not Operated by the State*.

c. The PIHP shall ensure the individuals as designated in *Section IV.G.10. In-Reach and Transition from Institutional Settings* perform the following in-reach activities for Members receiving services in a setting described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*, beginning within seven (7) Calendar Days of admission and occurring on a regular basis until the member is referred for transition services described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*:

- i. Identify candidates for in-reach services. The PIHP, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
  - 1. Claims and enrollment data;
  - 2. Facility referrals;
  - 3. Stakeholder and family/guardian referrals; and
  - 4. Automatic in-reach trigger points the PIHP shall establish.

- ii. Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the Member and the Member's family Members and/or guardians are accurately and fully informed about community-based options available.
- iii. Facilitate and accompany the Member and their family members and/or guardians on visits to community-based services.
- iv. Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing.
- v. To the maximum extent possible, explore and address the concerns of the Member and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns. For Members who decline the opportunity to transition, the PIHP shall:
  - 1. Continue to engage the Member and/or their family members or guardians about the opportunity to transition to a more integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
  - 2. Clearly document that the Member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the Member of available community services, including supportive housing.
- vi. Provide the Member and/or the Member's family members or guardians opportunities to meet with other individuals with SMI, SED, I/DD or TBI (as relevant to the Member) who are living, working, and receiving services in integrated settings.
- vii. Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI, SED, I/DD or TBI to live in their home/community.
- viii. For all eligible Members who have previously opted out of Tailored Care Management, the PIHP shall be responsible for providing information on the opportunity and process for opting back in.
- ix. For Members residing in an ACH or state developmental center, and Members age 18 and over residing in a state psychiatric hospital and who have been identified for transition, refer the member to a PIHP transition coordinator, the member's care manager in the Tailored Care Management model, or DSOHF Admission Through Discharge Manager for transition services (see *Section IV.G.10. In-Reach and Transition from Institutional Settings*) and ensure a timely, Warm Handoff to the transition staff or care manager in the Tailored Care Management model that the PIHP assigns to the Member.
- x. For Members age 18 and above admitted to a state psychiatric hospital, PIHP-based peer support specialists shall coordinate with the member's care manager in the Tailored Care Management model on in-reach activities, if applicable.
- xi. Additional required activities for Members who may be eligible for supportive housing:
  - i. Ensure the Member and their family members and/or guardians are accurately and fully informed about all available supportive housing options.
  - ii. Facilitate and accompany the member and their family members and/or guardians on visits to supportive housing settings.
- d. The PIHP shall ensure the individual as designated in *Section IV.G.10. In-Reach and Transition from Institutional Settings* performs the following transition activities for members receiving services in a setting described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*:

- i. Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care upon referral from the PIHP in-reach staff as designated in *Section IV.G.10. In-Reach and Transition from Institutional Settings*.
- ii. Collaborate with the following individuals, specialists, and provider types as applicable depending on the Member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
  1. The Member and/or the Member's family or guardian;
  2. Facility providers;
  3. Facility discharge planners;
  4. The Member's care manager;
  5. The Member's community-based PCP;
  6. Peer support specialist or other individuals determined to have appropriate shared lived experience;
  7. Educational specialists; and
  8. Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.
- iii. Engage the Member's community PCP and other providers as appropriate so that they are actively engaged in the transition planning process prior to member's discharge.
- iv. Assist the Member, prior to discharge, either by phone or in person, to select a qualified community PCP and clinical specialists as needed, including by assisting the Member and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
- v. Collaborate with the Member and/or the Member's family members or guardians, Peer Support Specialists when available, facility providers, and other relevant community service providers to make arrangements for individualized supports and services needed to be in place upon discharge.
- vi. Collaborate with the Member and/or the Member's family members or guardians, the facility provider, and selected community provider(s) prior to the Member's discharge to identify and prioritize the most critical services necessary to address the member's specific needs, including complex BH, primary care and medical needs.
- vii. Schedule post-discharge appointments for critical services to occur in a timely manner based upon the Member's identified needs and no later than seven (7) Calendar Days following discharge.
- viii. When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
- ix. Assist the Member and/or the Member's family members or guardians in initiating selected community service options including but not limited to BH services.
- x. Work with receiving Providers and/or agencies if applicable, to identify if any specific training is needed by the receiving Providers and/or agencies to ensure a seamless transition.
- xi. Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), resource identification and referrals to qualified providers and care manager, and training of family or guardians and natural supports prior to the Member's discharge.
- xii. Assess settings that the Member is transitioning to, using the checklist developed by the PIHP and approved by the Department as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*.

- xiii. Explore and secure appropriate and available funding options and work through any potential funding needs with community providers such as managing spend downs, if needed, prior to discharge.
- xiv. When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the Member's individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make Best Efforts to secure authorization and/or denial of services requested to begin upon discharge.
  - 1. If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the member's discharge.
  - 2. Make Best Efforts to ensure that the information contained in the discharge service order, the ninety (90)-day post-discharge transition plan and the discharge summary are made available to the community providers who will be serving the member after discharge.
  - 3. Ensure the discharge service order, the transition plan and the discharge summary are made available to the organization providing Tailored Care Management if the Member is eligible for Tailored Care Management.
- xv. For Members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with the Department to ensure Medicaid eligibility is active upon or soon after discharge.
- xvi. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
- xvii. For Members residing in state developmental centers: If needed, request an extension of Memorandum of Agreement in writing to the DSOHF Developmental Center Director prior to the discharge date outlining the reasons for the extension and anticipated length of extension needed.
- xviii. DSOHF Admission Through Discharge Managers shall coordinate with PIHP In-Reach Specialists, Transition Coordinators, System of Care Coordinator, and other relevant community service providers as determined needed by the DSOHF Admission Through Discharge Managers in cases involving members with complex needs or severe symptoms.
- xix. On the day of discharge:
  - 1. Obtain a copy of the discharge plan and review the discharge plan with the Member and/or the Member's family members or guardians and facility staff.
  - 2. Assist the Member in obtaining needed medications and ensure an appropriate care team member or facility staff conducts medication reconciliation/management and supports medication adherence.
- xx. Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct member population served, and the discharge and transition responsibilities included in the Department contract including those set forth in this Section.
- xxi. Following discharge, ensure the transition coordinator performs the following activities:
  - 1. Ensure Member is receiving needed transition-related services.
  - 2. Coordinate and facilitate thirty (30)-day post-discharge meetings with the Member and the Member's family members or guardians, the member's care manager and/or Child

- and Family Team (if applicable), and community provider(s) including NC START (if applicable) to promptly address any areas of concern identified following transition of the member from the facility to the community.
3. Convene follow-up post-discharge meetings no less than every thirty (30) Calendar Days until any issues or areas of concern are addressed.
- xxii. Additional required activities for Members who may be eligible for supportive housing:
1. Collaborate with the PIHP's housing specialist to make arrangements for individualized supports and services needed to be in place upon discharge.
  2. Assist the Member and/or the Member's family members or guardians in initiating housing-related services and supports including but not limited to: locating and securing housing; ensuring the home environment is safe and move-in ready; and other ongoing tenancy supports that enable the Member to maintain housing.
  3. Ensure the transition is completed within ninety (90) Calendar Days of receiving a housing slot.
- xxiii. Additional required activities for Members residing in a PRTF or Residential Treatment Levels II/Program Type, III, and IV, and members under age 18 residing in a state psychiatric hospital:
1. Convene the member's Child and Family Team and work with team, including the member's care manager, if applicable, to add new team members as needed to ensure an effective and timely transition.
  2. Engage the member's Child and Family Team through the entire transition planning process.
  3. Ensure PRTF Family Peer Partner is included in transition planning for Members in a PRTF, when applicable.
  4. As required as part of Tailored Care Management (see *Section IV.G.2. Tailored Care Management*):
    - i. Provide the Member and their family or guardian linkages to relevant state agencies and systems that support the development and well-being of children, including local school systems and child welfare systems.
    - ii. Provide the Member and the Member's family or guardian with linkages to community-based services and supports that address Unmet Health Related Resource Needs, including:
      - i. Disability benefits;
      - ii. Food and income supports;
      - iii. Transportation;
      - iv. Education; and
      - v. Services for justice-involved populations.
  5. Collaborate with the Member and their family or guardian and all relevant service providers to ensure needed individualized supports and services—including any school-related services, recreational and pro-social activities, supervision plans, and family supports—are in place upon discharge.
  6. Work with the Member and their family or guardian to assess and prepare the Member's home so that it provides the Member with a safe and appropriate community setting.
  7. Assess settings that the Member is transitioning to, using the checklist developed by the PIHP and approved by the Department as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*.
  8. Identify and address any barriers to active engagement of a Member's family or guardian in transition planning.

9. Educate and train the Member and the member's family or guardians on resource availability, and how to independently access resources to maintain self-sufficiency in caring for the Member in the community.
  10. If the Member has no permanent family or guardian, work with supervising care manager to request that a Department of Social Services (DSS) guardian locate a permanent placement for the Member and escalate to DSS supervising staff if permanent placement is not being pursued.
- xxiv. For Members not already engaged in Tailored Care Management, the PIHP shall assign Members transitioning out of a facility to Tailored Care Management as described in Section IV.G.2. Tailored Care Management upon referral from the transition coordinator and/or DSOHF Admission Through Discharge Manager prior to discharge unless the member is transitioning to another ICF-IID, is transitioning to a nursing facility, is authorized for ACT or High-Fidelity Wraparound, or is enrolled in CAP/C or CAP/DA.
1. The PIHP shall ensure a Warm Handoff from a Member's transition coordinator or DSOHF Admission Through Discharge Manager to the Member's assigned care manager, ACT team, High-Fidelity Wraparound provider, CAP/C or CAP/DA Waiver Case Management Entity, or other entity providing care management.
  2. The Warm Handoff to the care manager providing Tailored Care Management shall take place upon discharge.
  3. The transition coordinator and DSOHF Admission Through Discharge Manager shall ensure the care manager providing Tailored Care Management meets with the Member and/or the Member's family members or guardians prior to discharge.
  4. The transition coordinator shall remain a part of the Member's care team following the Warm Handoff until ninety (90) Calendar Days post-discharge. During this time, the transition coordinator shall remain available to the care manager providing Tailored Care Management for consultation.
  5. For specific requirements related to members transitioning into Innovations/TBI waivers, see *Section IV.M. Innovations Waiver Services*.
- xxv. The PIHP shall assign a Member of the PIHP clinical leadership (i.e., clinical Director-level or above) to attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as Members with co-occurring disorders or a history of aggression and/or serious self-harm.
- e. Staffing Requirements
- i. All PIHP-based in-reach and transition staff may be shared across this product and the BH I/DD Tailored Plan.
  - ii. In-Reach Staffing Requirements  
As described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*, the PIHP shall ensure that the following parties are responsible for in-reach activities:
    1. For Members admitted to a PRTF or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, in-reach activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* shall be coordinated and/or performed by the Member's care manager as part of the Tailored Care Management model.
    2. For Members under age 18 admitted to a state psychiatric hospital, in-reach activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* shall be coordinated and/or performed by the Member's care manager as part of the Tailored Care Management model.



3. For Members admitted to an ACH and Members age 18 and above admitted to a state psychiatric hospital, in-reach activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* shall be coordinated and/or performed by a PIHP-based peer support specialist.
  4. For Members admitted to a state developmental center, in-reach activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* shall be coordinated and/or performed by a PIHP-based in-reach specialist.
- iii. Transition Staffing Requirements
1. As described in *Section IV.G.10. Table 1. In-Reach and Transition Staffing Requirements*, the PIHP shall ensure that the transition coordinator is responsible for coordinating and/or performing transition activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* for the following populations:
    - i. Members transitioning from a state psychiatric hospital to supportive housing, including members under age twenty-one (21),
    - ii. Members transitioning from an ACH into supportive housing, and
    - iii. Members transitioning from a state developmental center.
  2. As described in *Section IV.G.10. Table 1. In-Reach and Transition Staffing Requirements*, the PIHP shall ensure that the DSOHF Admission Through Discharge Manager is responsible for coordinating and/or performing transition activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* for members age twenty-one (21) and above transitioning from a state psychiatric hospital who are not transitioning to supportive housing.
  3. As described in *Section IV.G.10. Table 1. In-Reach and Transition Staffing Requirements*, the PIHP shall ensure that a Member’s care manager is responsible for coordinating and/or performing transition activities described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* for the following populations:
    - i. Members transitioning from an ACH who are not transitioning into supportive housing;
    - ii. Members transitioning from a PRTF;
    - iii. Members transitioning from Residential Treatment Levels II/Program Type, III, and IV as defined in the Department’s Clinical Coverage Policy 8-D-2; and
    - iv. Members under age twenty-one (21) transitioning from a state psychiatric hospital who are not transitioning to supportive housing.

<b>Section IV.G.10. Table 1. In-Reach and Transition Staffing Requirements</b>			
	<b>Setting</b>	<b>Individual Responsible for Conducting In-Reach Activities</b>	<b>Individual Responsible for Conducting Transition Activities</b>
1.	DSOHF Psychiatric Hospital	<p><i>Members Under Age 18:</i> Member’s Care Manager in Tailored Care Management model</p> <p><i>Members Age 18 and Above:</i> PIHP-Based Peer Support Specialist</p>	<p><u>All</u> <i>Members Transitioning to Supportive Housing:</i> PIHP-based Transition Coordinator</p> <p><i>Members Under Age 21 Not Transitioning to Supportive Housing:</i> Member’s Care Manager</p>

Section IV.G.10. Table 1. In-Reach and Transition Staffing Requirements			
	Setting	Individual Responsible for Conducting In-Reach Activities	Individual Responsible for Conducting Transition Activities
			in Tailored Care Management model  <i>Members Age 21 and Above Not Transitioning to Supportive Housing: PIHP-based DSOHF Admission Through Discharge Manager</i>
2.	ACH	PIHP-Based Peer Support Specialist	<i>Members Transitioning to Supportive Housing: PIHP-based Transition Coordinator</i>  <i>Members <u>Not</u> Transitioning to Supportive Housing: Member's Care Manager in Tailored Care Management model</i>
3.	DSOHF Developmental Center	PIHP-Based In-Reach Specialist	PIHP-based Transition Coordinator
5.	PRTF	Member's Care Manager in Tailored Care Management model	Member's Care Manager in Tailored Care Management model
6.	Residential Treatment Levels II/Program Type, III, and IV	Member's Care Manager in Tailored Care Management model	Member's Care Manager in Tailored Care Management model

iv. Transition Supervisor Requirements

1. The PIHP shall ensure that all PIHP-based in-reach and transition staff working with Members who are in or transitioning out of an institutional setting or ACH are supervised by a transition supervisor.
2. The PIHP shall ensure transition supervisors have no caseload but will provide coverage for other in-reach and transition staff's vacation and sick leave.
3. The PIHP shall ensure transition supervisors are responsible for providing guidance to Peer Support Specialists, In-Reach Specialists, Transition Coordinators, DSOHF Admission Through Discharge Managers, and care managers under the Tailored Care Management model working with individuals transitioning out of an institutional setting or an ACH.
4. The PIHP shall ensure transition supervisors attend and participate in case discussions and transition planning for Members with complex needs identified by facility clinical

leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm.

- v. Additional Staffing Requirements for DSOHF Facilities
    - 1. The PIHP shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager to each DSOHF psychiatric hospital associated with the PIHP's catchment area.
    - 2. The PIHP shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager who will be responsible for serving its members across all DSOHF developmental centers.
    - 3. The PIHP shall ensure that the total number of DSOHF Admission Through Discharge Managers is sufficient for fulfilling transition responsibilities for its members at DSOHF facilities.
  - vi. For Members for whom in-reach and transition activities are coordinated and/or performed by the member's care manager as part of the Tailored Care Management model as described in *Section IV.G.11. Table 1. In-Reach and Transition Staffing Requirements*, but who have previously opted out of Tailored Care Management, the PIHP shall be responsible for coordinating and/or performing in-reach and transition activities.
  - vii. The PIHP shall ensure all individuals responsible for conducting in-reach and transition activities report potential rights violations of Members residing in ACHs in accordance with General Statute 131D.
- f. In-Reach and Transition Staff Qualifications
- i. The PIHP shall ensure that Peer Support Specialists serving members residing in an ACH or state psychiatric hospital have the following minimum qualifications:
    - 1. NC Certified Peer Support Specialist Program Certification;
    - 2. Specific background and expertise working with people with SMI and their families or guardians; and
    - 3. Must be knowledgeable about community services and supports, including supportive housing.
  - ii. The PIHP shall ensure that In-Reach Specialists serving Members residing in a state developmental center have the following minimum qualifications:
    - 1. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area;
    - 2. Must be knowledgeable about community services and supports, including supportive housing; and
    - 3. Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.
  - iii. The PIHP shall ensure that DSOHF Admission Through Discharge Manager serving residents of DSOHF psychiatric hospitals have the following minimum qualifications: Master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), or bachelor's-level registered nurse (RN) plus one (1) year of experience working directly with individuals with SMI.
  - iv. The PIHP shall ensure that DSOHF Admission Through Discharge Manager serving residents of DSOHF developmental centers have the following minimum qualifications:
    - 1. Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or
    - 2. Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or
    - 3. Bachelor's-level registered nurse (RN) plus three (3) year of relevant experience working directly with individuals with I/DD.

- v. The PIHP shall ensure that Transition Coordinators have the following minimum qualifications:
  - 1. If serving members with SMI needs:
    - i. Master's degree in a human services field or licensure as a registered nurse (RN), plus one (1) year of relevant experience working directly with individuals with SMI or SED; or
    - ii. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with SMI or SED.
  - 2. If serving members with I/DD or TBI:
    - i. Master's degree in a human services field or licensure as a registered nurse (RN), plus one (1) year of relevant experience working directly with individuals with I/DD or TBI; or
    - ii. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD or TBI.
- vi. The PIHP shall ensure that Transition Supervisors overseeing PIHP in-reach and transition staff meet the minimum qualifications of a supervising care manager as described in *Section IV.G.10. System of Care*. Transition Supervisors shall also meet the following minimum qualifications: Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
- vii. The PIHP may submit to the Department for approval alternate minimum qualifications for in-reach and transition staffing as part of the PIHP In-Reach and Transition Policy as described in *Section IV.G.11. In-Reach and Transition from Institutional Settings*.
- viii. The PIHP shall provide in the application justification for the alternate minimum qualifications and shall describe how the PIHP will ensure individuals conducting in-reach and transition activities provide required in-reach and transition services in a clinically appropriate manner as described in this Section (*Section IV.G.11. In-reach and Transition from Institutional Settings*).
- g. In-Reach and Transition Staff Training
  - i. The PIHP shall conduct training for individuals conducting in-reach and transition activities as described in *Section IV.B.3. Staff Training*.
  - ii. In addition to the training domains described in *Section IV.B.3. Staff Training*, the PIHP shall develop a separate training module for in-reach and transition staff that addresses the following domains:
    - 1. Full knowledge of the array of available community services and supports that ensure the health and well-being and safe community living for members receiving in-reach and transition services.
    - 2. Engagement methods including assertive engagement, and active listening skills.
    - 3. Motivating and working with a member's family or guardian and facility staff, including cultural and linguistic needs of a member and their family or guardian.
    - 4. Developing an interdisciplinary transition plan.
    - 5. Components of the Permanent Supportive Housing model during pre-tenancy, tenancy, and post-tenancy phases, including the process for assessing living arrangements for health and safety issues.
- h. In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State
  - i. The Department seeks to expand community inclusion opportunities for members residing in ICF-IIDs not operated by the state, and has established the requirements described in this Section in order to create opportunities for members in ICF-IIDs not operated by the state to receive services in more integrated settings.

- ii. The PIHP shall ensure that members residing in ICF-IIDs not operated by the state receive in-reach and transition services as described in this Section.
- iii. The PIHP is not subject to in-reach and transition requirements described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* for members residing in ICF-IIDs not operated by the state.
- iv. The PIHP shall be responsible for providing members residing in ICF-IIDs not operated by the state in-reach services on a regular basis until the member is referred for transition services. In-reach activities for members residing in ICF-IIDs not operated by the state must include, at a minimum:
  - 1. Provide age- and developmentally-appropriate education for the member and the member's family members and/or guardians about the opportunity to receive care in a more integrated setting and available services in such settings.
  - 2. Provide the member and/or the member's family members or guardians opportunities to meet with other individuals with I/DD who are living, working and receiving services in a more integrated setting.
  - 3. Identify, document and attempt to address barriers to relocation to a more integrated setting.
  - 4. For members who decline the opportunity to transition, the PIHP shall clearly document that the member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the member of available community services.
  - 5. Engage and collaborate with stakeholder groups that represent members residing in non-state operated ICF-IIDs and/or their family members or guardians, provider groups, and state and local government agencies on the in-reach process, including identifying more integrated settings for members to transition to and supports and services available in those settings.
- v. The minimum frequency for ongoing in-reach engagement for members residing in ICF-IIDs not operated by the state will be determined by the Department.
- vi. The PIHP shall be responsible for providing transition services for members residing in ICF-IIDs not operated by the state. Transition activities for members residing in ICF-IIDs not operated by the state must include, at a minimum:
  - 1. Collaborate with the member and/or the member's family members or guardians, facility and community-based providers and specialists, and the member's support network as applicable and depending on the member's needs to ensure effective and timely discharge and transition to a more integrated setting.
  - 2. Provide referrals and linkages to individualized community-based supports and services, including but not limited to:
    - i. Medical care, including primary care, clinical specialists, and specialized therapies;
    - ii. Tailored Care Management;
    - iii. Behavioral health services;
    - iv. Crisis prevention services;
    - v. I/DD services;
    - vi. Employment services;
    - vii. Innovations Waiver waitlist; and
    - viii. For children/young adults: relevant state and local agencies and systems that support the development and well-being of children.
  - 3. Continuity planning for young adult members transitioning into adult services.

4. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
  5. Identify, document and attempt to address barriers to relocation in a more integrated setting.
  6. Following discharge, ensure the member is receiving needed transition-related services and promptly address any areas of concern identified following transition of the member to a more integrated setting.
- vii. The PIHP shall develop policies and procedures for providing in-reach and transition services to members residing in ICF-IIDs not operated by the state, including the proposed staffing model for these activities, and submit them to the Department as part of the PIHP In-Reach and Transition Policy as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings*.
  - i. The PIHP shall permit their in-reach and transition staff to transport Members and their family or guardians when needed to fulfill the required in-reach and transition activities described in this Section.
  - j. The Department reserves the right to establish caseload requirements for PIHP-based in-reach and transition staff serving members in and transitioning out of an ACH or institutional setting, including ICF-IIDs not operated by the state, and will release any additional requirements in forthcoming guidance.
  - k. The PIHP shall be subject to any additional in-reach and transition requirements issued by the Department, including those developed as part of North Carolina's Olmstead Plan.
  - l. The PIHP shall ensure that a Member does not receive in-reach and transition services that are duplicative of other care management services the member is receiving.
    - i. When a Member is receiving both in-reach and transition services and Tailored Care Management, the PIHP must ensure that the in-reach and transition staff and organization providing Tailored Care Management explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
    - ii. When a Member is receiving both in-reach and transition services and another care management service besides Tailored Care Management, the PIHP must ensure that the in-reach and transition staff and Provider of the duplicative service explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
  - m. In-Reach and Transition Policy
    - i. The PIHP shall submit an In-Reach and Transition Policy for review and approval by the Department within ninety (90) Calendar Days after Contract Effective Date and annually thereafter.
    - ii. As long as the In-Reach and Transition Policy clearly states it applies to Medicaid Direct, the In-Reach and Transition Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
    - iii. The scope of this policy includes all PIHP members eligible for in-reach and transition services as described in *Section IV.G.10. In-Reach and Transition from Institutional Settings* and members residing in ICF-IIDs not operated by the state.
    - iv. The In-Reach and Transition Policy shall include the PIHP's policies and processes for implementing in-reach and transition requirements described in *Section IV.G.10. In-reach and Transition from Institutional Settings*, including:
      1. Policies and procedures for outreach and engagement of members eligible to receive in-reach and/or transition services.

2. Training plan for individuals responsible for conducting in-reach and transition activities.
3. Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support Member transitions to more integrated settings.
4. Additional required policies and processes for Members residing in ICF-IIDs not operated by the State:
  - i. Staffing model for conducting in-reach and transition activities for members residing in ICF-IIDs not operated by the state. The model shall address supervision and oversight, minimum qualifications, training requirements, and caseload requirements for all in-reach and transition staff.
  - ii. Approach for identifying, engaging, and collaborating with stakeholders on providing in-reach and transition services to Members residing in ICF-IIDs not operated by the state.
  - iii. Approach to expanding opportunities for community inclusion for Members residing in ICF-IIDs not operated by the state.
- v. The In-Reach and Transition Policy shall include a checklist that individuals responsible for conducting transition activities will use to assess the safety and appropriateness of settings that PIHP members will transition to when leaving an institutional setting or ACH. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards and are consistent across PIHPs.

## H. Providers

### 1. Provider Network

- a. The Department seeks a PIHP with a robust Network to meet BH, I/DD, and TBI needs of all PIHP members, including those with limited English proficiency, physical disability, or BH or I/DD needs. The PIHP shall demonstrate that its Network meets Department's availability, access, quality goals, and requirements and is willing to act to continuously improve its delivery of health care services to members.
- b. Availability of Services (42 C.F.R. § 438.206)
  - i. The PIHP shall establish and maintain a Network that is sufficient to ensure that all services covered under the Contract are available and accessible to all members in a timely manner, including those members with limited English proficiency or physical or mental disabilities. The PIHP shall enter into a written contract with each Network provider, the terms of which are further specified herein.
  - ii. The PIHP shall meet all federal and state provisions for availability, including:
    1. Providing for a second opinion from a Network provider or arrange for the member to obtain an opinion from an out-of-network provider at no cost to the member if requested by the member, provided that the out-of-network provider is not excluded from participation in federal or the State's health care programs and subject to the UM program requirements if applicable. The PIHP shall clearly state its procedure for obtaining a second opinion in its Member Handbook.
    2. Adequately and timely covering services out-of-network for a Member if the PIHP's network is unable to provide the covered service within its current Network, taking into account the urgency of the need for services. PIHP shall cover the member's out-of-network services for the duration of the Network's inability to provide them in network.
    3. Ensuring that no incentive is given to providers, monetary or otherwise, for withholding medically necessary services.

4. Coordinating payment for services to out-of-network providers and ensuring the cost to the member is not greater than it would be if the services were furnished by a Network provider.
- iii. Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)
    1. The PIHP shall make good faith efforts to contract with Indian Health Care Providers (IHCPs) and demonstrate that a sufficient number of IHCPs are participating in its network to ensure timely access to contracted services for the members of federally recognized tribes and other individuals eligible to receive services at IHS facilities.
    2. The PIHP shall provide members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
    3. The PIHP shall permit members to obtain services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.
    4. If the PIHP cannot provide timely access to necessary services in state and/or in-network for Tribal members, the PIHP must provide access to out-of-state and/or out-of-network IHCPs.
    5. The PIHP must refer Tribal members to IHCPs and other sources of Culturally and Linguistically Competent care as determined by the Department. The PIHP enrolling Tribal populations shall provide training for Culturally and Linguistically Competent care to all of its Network providers.
    6. The PIHP shall permit out-of-network IHCPs to make referrals to Network providers for any of its members without prior authorization or a referral from a Network provider.
    7. The PIHP shall permit IHCPs to refer its member to any provider within the IHCP Purchased and Referred Care network, even if the provider is not a Network provider, without having to obtain prior authorization or a referral from a Network provider.
    8. The PIHP shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contracted health services.
  - iv. Outpatient Commitment
    1. The PIHP shall ensure the availability of qualified providers of services provided under Outpatient Commitment to members who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment.
    2. Consistent with the requirements in N.C. Gen. Stat. § 122C-263, the PIHP shall be able to accept a copy of the Outpatient Commitment order for Members who are served by Network outpatient treatment physicians and centers.
    3. The PIHP shall require network providers of services provided under Outpatient Commitment to a member to notify the PIHP of the Outpatient Commitment order upon receipt.
    4. Once the PIHP is notified of a member's Outpatient Commitment order, the PIHP shall provide Tailored Care Management or care coordination as defined in *Section IV.G.P Care Management and Care Coordination Policy*.
  - v. Telehealth and Virtual Patient Communications.
    1. The PIHP may use Telehealth and Virtual Patient Communications as tools for facilitating access to needed services in a clinically appropriate manner that are not available from providers in the Network and in accordance with the NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring.
    2. The PIHP shall be permitted to include Telehealth in its Request for Exception to the Department's PIHP Network adequacy standards, as clinically appropriate.



3. The PIHP shall not require a Member to receive services from Telehealth, Virtual Patient Communications and must allow the member to access an in-person service from an out-of-network provider if the member requests.
  4. Access to Telehealth providers does not count toward meeting Network adequacy standards, unless approved as part of an exception to Network requirements.
- vi. SUD Residential Treatment Services
    1. PIHPs shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VI. Attachment E. PIHP Network Adequacy Standards*.
    2. The Department will establish network adequacy standards for SUD residential treatment services prior to PIHP launch.
- c. Furnishing of Services (42 C.F.R. § 438.206(c))
    - i. The PIHP shall meet the network time or travel distance, and appointment wait time standards established by the Department as described in *Section VI. Attachment E. PIHP Network Adequacy Standards*, unless otherwise approved by the Department in accordance with the requirements herein.
      1. The PIHP shall monitor Network providers regularly to determine compliance with the timely access requirements.
      2. The PIHP shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
      3. The Department is studying the application of provider-patient ratios and may implement ratios by catchment area. The Department shall provide the PIHP one hundred twenty (120) Calendar Days prior notice of the ratio requirements.
      4. The Department may amend the network time or travel distance, appointment wait time, or other adequacy standards from time to time. The PIHP shall comply with the new standards as adopted through an amendment to the Contract or as otherwise directed through formal notice to PIHP from the Department. The PIHP shall comply with the new standards as directed by the Department, but the PIHP shall have no less than ninety (90) Calendar Days to comply with any new or amended network adequacy standards adopted by the Department.
    - ii. The PIHP shall meet and require its Network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services.
    - iii. The PIHP shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial members. The Department may require after hours and weekend hours to address the needs of the member.
    - iv. The PIHP shall ensure that covered services are available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
    - v. The PIHP shall ensure that Network providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all members with physical disabilities or BH and I/DD needs.
    - vi. The PIHP shall promote the delivery of services by Network providers in a Culturally and Linguistically Competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation, or gender identity.
      1. The PIHP shall assist providers with meeting these requirements, including educating providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.

2. The PIHP shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.
- vii. The PIHP is encouraged to contract with providers outside of the PIHP's catchment area to ensure services to meet member's accessibility needs. An individual Member's accessibility and PIHP's network adequacy may be satisfied, in part, by contracting with providers outside PIHP's catchment area where appropriate.
- viii. Notwithstanding anything to the contrary in this section, the PIHP is not required to contract with more providers than necessary to satisfy the Network Adequacy Standards found in *Section VI. Attachment E PIHP Network Adequacy Standards*.
- d. Exceptions to Network Requirements
- i. Network adequacy measures ensure the PIHP's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network providers, and all health care services included under the terms of the Contract. Recognizing that there are circumstances which cannot be remedied by the PIHP alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to network requirements, including exception requests related to newly adopted or amended network requirements, in a time-limited manner.
- ii. In accordance with 42 C.F.R. § 438.68(d)(1), the PIHP may request Department approval for an exception to meeting the Department's PIHP network adequacy standards in a specific county for a specific provider type and member age (adult or pediatric, as applicable). Requests must:
1. Be made in writing;
  2. Describe efforts to negotiate in good faith;
  3. Include justification for the exception and a description of how member needs for the specific county and provider type will be met; and
  4. Include the PIHP's plan to address member needs and remedy the network deficiency, including an estimated timeline to close the network gap.
- iii. The Department's approval of an exception request to the PIHP network adequacy standards will be due upon request and limited to a specific time frame. Forty-five (45) Calendar Days before an exception is set to expire, the PIHP shall submit a new request for the exception or inform the Department the exception is no longer needed.
- iv. The Department is not required to approve a request for an exception to meeting the Department's PIHP network adequacy standards and may deem a PIHP to be out of compliance.
- e. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)
- i. The PIHP shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire catchment area in accordance with the Department's PIHP Network adequacy standards (as found *Section VI. Attachment E. PIHP Network Adequacy Standards*), state and federal law, and the terms of this Contract. As long as the Network Access Plan clearly states that it applies to the PIHP, the Network Access Plan may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.
1. The PIHP's Network Access Plan must:
    - i. Demonstrate compliance, or submit plans for compliance, with all the following components:
      - i. Offers an appropriate range of BH I/DD and TBI services that is adequate for the anticipated number of members for the catchment area.

- ii. Maintains a Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the Region, including Tribal members.
- ii. Include procedures to address the following:
  - i. Referrals;
  - ii. Disclosures and notices to members of PIHP services and features;
  - iii. Coordination and continuity of care; and
  - iv. Transitions of Care that comply with Department requirements set forth in *Section IV.E.2. Transition of Care*.
- iii. Demonstrate the PIHP's efforts to:
  - i. Address the needs of all Members, including those with limited English proficiency or illiteracy;
  - ii. Address the needs of Historically Marginalized Populations;
  - iii. Ensure that Network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities;
  - iv. Assist the Department, as directed, to assess the capacity of select providers to ensure that members residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:
    - 1. Community ICF-IIDs licensed under 10A NCAC 27G.2100;
    - 2. Behavioral health residential treatment facilities licensed under 10A NCAC 27G.1300,.1700,.3100, 3200,.3400,.4100,.4300,.5600; and
    - 3. Adult care homes licensed under 10A NCAC 13F and 13.
  - v. Support and sustain providers, including hospitals, in rural and other traditionally underserved areas, as well as provider representatives of Historically Marginalized Populations; and
  - vi. Reach agreements with local education agencies that are responsible for providing the education within child and adolescent day treatment programs. This may include, but is not limited to, the list of school districts with which the PIHP has an agreement for day treatment and how these agreements provide adequate coverage.
- vii. Include the PIHP's:
  - i. Efforts to establish a Network that meets the Department's PIHP Network adequacy standards.
  - ii. Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all members on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least quarterly.
  - iii. Factors used to build the Network, including a description of the Network and how the PIHP uses the Medicaid Enrolled Provider Data supplied by the Department, or the Department's vendor, in its network development and provider contracting process and how the PIHP makes network contacting decisions on providers of BH and I/DD services.
  - iv. Process and methodology to understand the distribution of member health care needs against available providers and provider capacity to serve those needs.

- v. Plan to provide timely access to the tribal population to contracted services from a sufficient number of IHCPs.
  - vi. Plan to provide in-network access, compliant with the Department's PIHP network adequacy standards, to children to the full range of age-appropriate BH and I/DD providers, subspecialists, and facilities, including:
    1. Method for ensuring children's BH and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in pediatrics or in child health and development and approach to assure children's access to child psychologists, and child and adolescent psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomate status as a child/adolescent psychiatrist), and
    2. Report annually to Department on the number of members under age eighteen (18) who are prescribed an antipsychotic medication and the proportion who have been assessed at least once in the preceding twelve (12) months in the outpatient setting by a child/adolescent psychiatrist (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).
  - vii. Approach to assure Members residing outside the PIHP's catchment area, including at CASPs, have access to BH and I/DD providers including through collaboration with the PIHP that covers the catchment area where the member is located. Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
  - viii. Geographical location of providers in the Network in relation to where members reside.
  - ix. The PIHP shall describe how it will address Cultural and Linguistic Competency for specific populations, such as people with TBIs, people with disabilities, people who are blind or visually impaired, people who are deaf or hard of hearing, members who are in the Armed Services, veterans and their families, pregnant women with SUD, people who identify themselves as LGBTQ, people who are in jails or prisons, youth in the juvenile justice system, justice-involved populations more broadly, Historically Marginalized Populations, and other vulnerable populations.
  - x. Strategies to ensure access and availability of services and build sufficient provider capacity.
  - xi. First episode psychosis programs (FEP), including how the PIHP shall: analyze and monitor utilization of FEPs, develop clinical practice guideline(s) related to appropriate utilization of FEP and education and training of providers, and pursue efforts to enhance access and develop FEP capacity with a focus on members between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect individuals to existing programs, conduct active surveillance of those at-risk).
2. The Network Access Plan must be provided as follows:
- i. Thirty (30) Calendar Days after Contract Execution;

- ii. As specified by the Department;
  - iii. Annually; and
  - iv. Within thirty (30) Calendar Days of a Significant Change, including merger or county disengagement.
- 3. The demonstration that the PIHP has the capacity to serve the expected enrollment shall be on a county basis for every county in the PIHP's catchment area.
- 4. The Network Access Plan shall be subject to Department review and approval. The PIHP shall amend the Network Access Plan as directed by the Department.
- 5. Format of Network Access Plan
  - i. Shall use the format provided by the Department.
  - ii. The Department will provide the template no later than seven (7) Calendar Days after execution.
  - iii. Future revisions to the template will be issued no less than thirty (30) Calendar Days' notice.
- ii. The PIHP and its Network providers shall comply and cooperate with EQRO network adequacy validations and activities including:
  - 1. Annual validation of PIHP's network adequacy and compliance with state and federal network requirements.; and
  - 2. Telephone surveys of Network providers to verify accuracy of reported data or other aspects of program requirements or performance.
- iii. The PIHP shall provide the Department with the Network Data Details Extract Report quarterly, as requested by the Department, and anytime there is Significant Change that impacts network adequacy and the ability to provide services. The Department shall prescribe the standardized file format and content. The standardized detailed file layout must include, but is not limited to, the following data elements:
  - 1. Provider names (first, middle, last);
  - 2. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
  - 3. Street address(as) of service location(s);
  - 4. County(ies) of service location(s);
  - 5. Telephone number(s) at each location;
  - 6. Provider specialty;
  - 7. Provider NPI or API;
  - 8. NPI type (individual or organization/facility providers);
  - 9. Taxonomy Code(s);
  - 10. Whether provider is accepting new members and the conditions if applicable;
  - 11. Identification as an IHCP;
  - 12. Identification of limitations on age of members seen by provider;
  - 13. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
  - 14. Whether provider has completed Cultural and Linguistic Competency training; and
  - 15. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.
- iv. Ongoing Monitoring and Significant Changes in the Provider Network
  - 1. At least once a calendar quarter, the PIHP shall monitor its Provider Network for a Significant Change that would affect adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *Section VI. Attachment E. PIHP Network Adequacy Standards*.

2. The PIHP shall report the results of the monitoring for Significant Change performed during a calendar quarter in the quarterly submission for that calendar quarter of the Network Data Details Extract Report described in *Section VI. Attachment I. Reporting Requirements*.
  3. If the PIHP determines a significant change has occurred that negatively affects adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards, the PIHP shall prepare and concurrently submit the following information to the Department when the PIHP submits the quarterly Network Data Details Extract Report that documents the significant change:
    - i. An updated Network Access Plan, including an updated attestation of compliance with the time/ distance and/or appointment wait time standards established by the Department; and
    - ii. Any new or updated requests for an exception to a network adequacy standard , as appropriate.
2. Provider Network Management
- a. The PIHP shall manage its Network to meet availability, accessibility, and quality goals and requirements.
    - i. In developing its network for BH and I/DD services, the PIHP shall ensure network adequacy and has the authority to maintain a closed network for these services as set forth in N.C.G.S. § 108D-1(2).
    - ii. The PIHP shall have a provider monitoring program to ensure providers are meeting Member needs and program requirements.
  - b. To help recognize the Department’s aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the PDM/CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience, and competency. The period before the PDM/CVO has achieved full implementation will be considered the “Provider Credentialing Transition Period”. The Medicaid Enrolled provider information gathered by the Department will be shared with the PIHP who will use that information for network contracting.
  - c. Provider Contracting
    - i. The PIHP contracts with providers shall comply with the terms of this Contract, State and federal law, and include required standard contracts clauses listed in Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts.
    - ii. The PIHP shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) Calendar Days after the Contract Execution.
      1. The PIHP may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
      2. Upon approval by the Department, the PIHP shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The PIHP shall discontinue use of previously submitted contract templates once an amended version is approved.

3. After launch of the Medicaid Direct health plan, the PIHP shall submit newly developed contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers.
- i. During contract negotiations with a provider, the PIHP may, without the Department's prior approval, make amendments to a previously approved provider contract template.
    - i. Any change to a standard provision required by *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*, is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.u., 1.v., 1.w., or 1.x., which must be prior approved by the Department.
    - ii. Any change to a standard provision required in Section 2 of *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*, must be prior approved by the Department.
    - iii. Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.
    - iv. The PIHP shall submit an unapproved contract template to the Department for approval at least ninety (90) Calendar Days before use with providers, including amended previously approved templates with significant changes.
  - ii. The PIHP may only make changes to the provisions required in Section 3. of *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*, when directed to do so by the Department.
  - iii. The PIHP shall not include any provider (including ordering, prescribing, or referring only providers) in its Closed Network that is not enrolled in North Carolina Medicaid.
  - iv. The PIHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done at least monthly thereafter.
  - v. The PIHP shall not employ or contract with any person or entity appearing on one of the Exclusion Lists.
  - vi. Require that contracted facilities, with the exception of the residential provider facilities noted below, implement a tobacco-free policy covering any portion of the property on which the participating provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting participating providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve. However, contracted facilities that are owned or controlled by the provider and which provide ICF-IID services or residential services that are subject to the HCBS final rule are exempt from this requirement. In these settings:
    1. Indoor use of tobacco products shall be prohibited in all provider-owned or -operated contracted settings.
    2. For outdoor areas of campus, providers shall:
      - a. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and

- b. Prohibit staff/employees from using tobacco products anywhere on campus.
- 3. The PIHP shall offer to contract with a provider interested in joining the Closed Network in writing.
- 4. All offers shall include the standard provisions for provider contracts found in *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*, including the prescribed provisions located therein.
- 5. If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the PIHP may consider the request for inclusion in the Medicaid network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the PIHP shall not consider the request rejected.
- 6. The PIHP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other PIHP.
- vii. The PIHP shall not require individual practitioners, as a condition of contracting with PIHP, to agree to participate or accept other products offered by the PIHP nor shall the PIHP automatically enroll the provider in any other product offered by PIHP. This requirement shall not apply to facility providers. Notwithstanding the foregoing, this requirement shall not preclude the PIHP from requiring individual practitioners, as a condition of contracting with the PIHP, to provide BH I/DD Tailored Plan Services.
- viii. The PIHP shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the PIHP's final decision in accordance with 42 C.F.R. § 438.12(a)(1).
- ix. The PIHP shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Direct rates:
  - 1. The PIHP shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department.
  - 2. The PIHP shall implement applicable rate changes within agreed upon timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable provider.
- x. The PIHP shall, with regard to payment to any provider or Subcontractor that is "related to" the PIHP, comply with the requirements in *Section IV.A.3. Readiness Review Requirements* and *Section IV.K.2. Medical Loss Ratio*.
- xi. The PIHP shall include a provision in the provider contract regarding a provider's right to file a Grievance or Appeal (as described in *Section IV.H.5. Provider Grievances and Appeals*) in its contract with providers. The PIHP shall include a notice in all provider contracts that the internal Appeal process with the PIHP must be exhausted before seeking other legal or administrative remedies under state or federal law.
- xii. The PIHP shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:



1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  2. Any information the Member needs to decide among all relevant treatment options.
  3. The risks, benefits, and consequences of treatment or non-treatment.
  4. The member'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. Section 1932(b)(3)(A) of the SSA; 42 C.F.R. § 438.102(a)(1)(i)-(iv).
- xiii. The PIHP shall include a provision in the provider contract that requires providers notify the PIHP when a Member in a high acuity clinical setting is being discharged.
- xiv. The PIHP may utilize evergreen contracts, i.e., a contract that automatically renews, with providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed.
- xv. In contracting with providers, the PIHP shall comply with all applicable provisions in accordance with *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*.
- xvi. The PIHP shall include in provider contracts that participating providers shall not submit claim or encounter data for services covered by Medicaid and PIHPs directly to the Department.
- xvii. DSOHF Facilities
- 1.The PIHP shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the DSOHF facilities:
    - i. Julian F Keith ADATC,
    - ii. R.J. Blackley ADATC,
    - iii. Lakeside,
    - iv. Woodside Treatment Center (State funded),
    - v. Cherry Hospital,
    - vi. Broughton Hospital,
    - vii. Central Regional Hospital,
    - viii. Caswell Developmental Center,
    - ix. Iverson Riddle Developmental Center,
    - x. Murdoch Developmental Center, and
    - xi. Whitaker Psychiatric Residential Treatment Facility.
  - 2.The PIHP shall consider these DSOHF facilities to as having successfully completed the State's Centralized Credentialing and Re-credentialing Process (CCRP) and be enrolled as a provider in the NC Medicaid program.
  - 3.The PIHP shall use a Department-developed contract template to contract with these DSOHF facilities, to be delivered by the Department after contract execution
- xviii. The PIHP shall contract with all Cross-Area Service Programs (CASPs) located throughout the State that will be listed in forthcoming Department guidance. The PIHP shall use a standard contract for all providers who are CASPs.
- xix. The Department may at its discretion require the PIHP to use a Department-developed contract template of other state-owned providers.

- xx. For any provider subject to a rate floor as outlined in *Section IV.H.4. Provider Payments*, a PIHP may include a provision in the provider’s contract that the PIHP will pay the lesser of billed charges or the rate floor only if the provider and the PIHP have mutually agreed to an alternative reimbursement amount or methodology which includes a “lesser than” provision. A PIHP shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider’s refusal to agree to a “lesser than” provision.
- d. Provider Preventable Conditions
    - i. The PIHP shall comply with 42 C.F.R. § 438.3(g), which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. The PIHP shall provide a report on all identified provider preventable conditions in a form or frequency as described in *Section VI. Attachment I. Reporting Requirements*.
    - ii. The PIHP shall include a provision in all provider contracts that requires the provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the PIHP.
  - e. Critical Incident Reporting
    - i. The PIHP shall establish a process for timely identification, response, reporting, and follow-up to member incidents.
    - ii. The PIHP shall require Network providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G.0602, in the NC Incident Response Improvement System.
    - iii. The PIHP shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G.0608 and ensure the health and safety of members.
    - iv. The PIHP shall report information on incidents and deaths in accordance with Department procedures.
    - v. The PIHP shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VI. Attachment F. Required Standard Provisions for PIHP and Provider Contracts*.
    - vi. The PIHP shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
    - vii. The PIHP shall adhere to the critical event reporting requirements for members obtaining services in DSOHF facilities as detailed in *Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities Providers*.
  - f. Indian Health Care Providers
    - i. The PIHP shall use the Addendum for IHCPs when contracting with IHCPs as described in Section VI. Attachment G. Addendum for Indian Health Care Providers and adhere to the Tribal Payment Policy (*Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities*).
    - ii. The PIHP shall not include any additional special terms and conditions to the IHCP Addendum or Tribal Payment Policy (*Section VI. Attachment M. Addendum for Division of State Operated Healthcare Facilities*) when contracting directly with IHCPs without mutual consent of both PIHP and the IHCP due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. For any mutually agreed upon additional special terms and conditions, the PIHP shall:

1. Within thirty (30) Calendar Days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.
  2. Recognize that the IHCP Addendum provisions supersede any conflicting terms of the contract between PIHP and IHCP.
- iii. As long as the Additional Special Terms with IHCP policies and procedures clearly state they apply to Medicaid Direct, the PIHP may use Additional Special Terms with IHCP policies and procedures developed either for the PIHP or the BH I/DD Tailored Plan contract.
  - iv. The PIHP must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148. IHCPs are not subject to licensure and credentialing of the Department.
  - v. The PIHP shall honor all NC Medicaid EPSDT approved services under NC Medicaid Direct or In-Lieu of services including but not limited to the Tribal Integrated Classroom, Family Safety, Tribal Therapeutic Foster Care, and Tribal Peer Support.
- g. Program Integrity
- i. The PIHP shall develop policies and procedures to perform monitoring and auditing of provider payments. The PIHP shall provide those policies and procedures to the Department upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution for review or as otherwise required by this Contract.
  - ii. As long as the Provider Payment Monitoring and Audit policies and procedures clearly state they apply to the Medicaid Direct, Provider Payment Monitoring and Audit policies and procedures may apply to other Contractor operations, including without limitation the BH I/DD Tailored Plan contract.
  - iii. The PIHP shall require Network providers and Subcontractors to have compliance program that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
  - iv. The PIHP shall require Network providers and out-of-network providers to have policies and procedures that recognize and agree that Medicaid as “the payer of last resort.”
  - v. The PIHP shall prohibit providers and referral providers from billing members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. §§ 438.106(c) and 438.108. 42 C.F.R. § 438.106(c); 42 C.F.R. § 438.3(k); 42 C.F.R. § 438.230; section 1932(b)(6) of the SSA.
- h. Credentialing and Re-credentialing Process
- i. The PIHP shall follow the Department’s uniform credentialing and recredentialing policy.
  - ii. The PIHP shall follow documented process for credentialing and re-credentialing Network Providers. .42 CFR § 438.214.
  - iii. The PIHP shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department’s written prior approval. The PIHP is not prohibited from collecting other information from providers necessary for the PIHP’s contracting process.
  - iv. The PIHP shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section IV.H. Providers*.
  - v. The PIHP is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid without the express, written consent of the provider and the Department.

- vi. Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all PIHP Network providers as Medicaid enrolled providers. 42 C.F.R. § 438.602(b)(1).
- vii. The PIHP may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, for up to one hundred twenty (120) Calendar Days but must terminate a Network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) Calendar Day period without enrollment of the provider, and notify affected members. 42 C.F.R. § 438.602(b)(2).
- viii. The PIHP shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.
- ix. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section IV.J.2. Encounters*, DHHS shall indemnify, defend, and hold harmless the PIHP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the PIHP by the Department, Contract Verification Organization, or other Vendor providing such information to the PIHP and relied upon by the PIHP in credentialing a provider for participation in the PIHP's Network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The PIHP shall have the option to participate at its own expense in the defense of such claims or actions filed and the PIHP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the PIHP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The PIHP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PIHP's use of and reliance on such credentialing information.
- i. Network Provider System Requirements
  - i. The PIHP shall accurately and timely load into the PIHP's claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.
  - ii. Unless otherwise written in the contract, the PIHP shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a member and billed to the PIHP by the provider:
    1. New Medicaid Enrolled provider within ten (10) Business Days after completing contracting;
    2. New Medicaid Enrolled hospital or facility provider within fifteen (15) Business Days after completing contracting;
    3. New Medicaid Enrolled provider attached to an existing contract within five (5) Business Days after completing contracting;
    4. Changes for a re-enrolled Medicaid provider, hospital, or facility attached to an existing contract within five (5) Business Days after completing receipt of notification of the change through the Medicaid Enrolled Provider data from the Department;
    5. Change to existing contract terms within ten (10) Business Days of the effective date after the change; and

- 6.Changes to a provider’s service location or demographic data or other information related to a member’s access to services must be updated no later than thirty (30) Calendar Days after the PIHP receives updated provider information.
- iii. Payment should be made to the provider for previously rendered services on the next payment cycle following the requirement outlined above.
  - iv. The PIHP shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2); 42 C.F.R. § 438.214(a). PIHP shall apply these criteria consistently to all providers.
  - v. Network Contracting Decisions
    - 1. The PIHP shall establish and maintain a process to make network contracting decisions in accordance with the State’s Credentialing and Re-credentialing Policy.
    - 2. The PIHP shall provide written notice of network contracting decisions to providers within five (5) Business Days of determination of the provider's status as an active Medicaid Enrolled provider.
  - vi. Provider Disenrollment and Termination
    - 1.Payment Suspensions:
      - i. The PIHP shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise fail to meet Department specifications.
      - ii. The PIHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) Calendar Days of suspension, the Department will terminate the provider from Medicaid.
      - iii. The PIHP shall not be liable for interests or penalties for late claim payment related to payment suspension.
    - 2.Termination as a Medicaid Provider by the Department:
      - i. The PIHP shall remove any provider from claims payment system and terminate the provider’s contract consistent within one (1) Business Day of receipt of a notice from the Department that the provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider’s network status.
      - ii. If the PIHP suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the PIHP shall release applicable claims and deny payment for dates of service after the date of termination from Medicaid.
      - iii. There are no appeal rights against the PIHP for a provider terminated or sanctioned, including suspension of provider payment, by the Department.
    - 3.PIHP Provider Termination
      - i. The PIHP may terminate all or part of a Network Provider contract with or without cause. Any decision to terminate must comply with the requirements of this Contract. Termination is not an adverse determination as that term is defined in N.C. Gen. Stat. § 108C-2(1). Termination by a PIHP of all or part of a Provider contract is not termination or disenrollment from the Medicaid Program by the Department.
      - ii. The PIHP shall comply with the Program Integrity Provider Termination Requirements outlined in *Section IV.C.2. Program Integrity (PI)*.
      - iii. The PIHP must provide written notice to the Network provider of the decision to terminate the provider including the effective date of termination. The notice for a for-cause termination, at a minimum, must include:

- i. The reason for the PIHP’s decision;
  - ii. The effective date of termination;
  - iii. The provider’s right to appeal the decision; and
  - iv. How to request a PIHP-level appeal.
- iv. The PIHP shall provide a report on the number of providers terminated by provider type in a form and frequency as described in *Section VI. Attachment I. Reporting Requirements*. If a waiver provider has been terminated due to HCBS issues, the PIHP shall notify Department waiver administrators.
- vii. Member Notice of Provider Disenrollment/Termination
  1. The PIHP shall notify each member who, at a minimum was seen in the previous twelve (12) months by a terminated provider, of the provider’s termination from the Network. PIHP shall:
    - i. Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the PIHP. 42 C.F.R. 438.10(f)(1).
    - ii. Describe the PIHP’s efforts to support transition of care for the member to the new provider.
    - iii. If the terminated provider was a specialist, assist impacted members with transition of care.
- viii. Provider Directory
  1. The PIHP shall develop a Member-facing provider Network Directory of all Network providers including the required information for all such providers, except providers of types which the Department has permitted the PIHP to suppress based upon industry practices or provider characteristics.
    - a. The PIHP may use best practices to exclude a Network Provider from the Member-facing directories if the PIHP includes in a Provider Directory Policy, or other policy as appropriate, an explanation of the process and rules used by the PIHP when deciding whether to include a provider in a consumer-facing directory.
    - b. The PIHP shall provide the Provider Directory Policy, or other policy as appropriate, to the Department for review at the request of the Department.
    - c. As used in this section, best practices specifically include, but are not limited to:
      - i. A provider opts out of being in the directory, such as when the provider is not open to the general public (e.g., a student health center open only to students of the educational organization).
      - ii. A provider cannot traditionally be contacted directly for making appointments, such as facility-based providers like anesthesiologists or radiologists.
      - iii. Provider is otherwise outside the scope of what would normally be included in a provider directory, such as Value-added service.
  2. The Network Directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by Department.
  3. The PIHP shall ensure that the Network Directory:
    - i. Be in a format that is machine-readable and readily accessible;
    - ii. Is placed in a location on the PIHP’s website that is prominent and readily accessible by members;
    - iii. Includes accurate and updated provider information consistent with Contract requirements;

- iv. Is provided in an electronic form which can be electronically retained and printed; and
  - v. Is available in paper form without charge upon member request and if requested, is provided within five (5) Business Days.
4. In accordance with 42 C.F.R. § 438.10(h)(3)(i)-(ii):
    - i. The PIHP shall update the paper directory at least monthly and clearly identify the date of the update. The paper directory can be updated once per quarter if a mobile directory is enabled.
    - ii. The PIHP shall update the electronic version of the Network Directory no later than thirty (30) Calendar Days after the PIHP receives updated provider information and clearly identify the date of the update.
  5. The PIHP shall provide the Department with a copy of both the electronic and paper versions of the Network Directory as follows:
    - i. At the request of the Department during the Readiness Review;
    - ii. Annually; and
  6. Any time there has been a Significant Change in PIHP operations that impacts the content of the directory.
  7. The member facing provider directory must comply with 42 C.F.R. § 438.10(h)(1)(i) -(viii) and 42 C.F.R. § 438.10(h)(2). and shall include the following information, at a minimum:
    - i. Provider name;
    - ii. Provider demographics (first, middle, and last name, gender);
    - iii. Provider DBA Name;
    - iv. Provider Service Location Name;
    - v. Provider type (including if the provider is also an AMH+ or CMA);
    - vi. Provider type effective date;
    - vii. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
    - viii. Street address(as) of service location(s);
    - ix. County(ies) of service location(s);
    - x. Telephone number(s) at each location;
    - xi. After hours telephone number(s) at each location;
    - xii. Provider specialty by location;
    - xiii. Whether provider is accepting new Medicaid-covered patients
    - xiv. Whether provider serves Medicaid and NC Health Choice beneficiaries;
    - xv. Whether a BH provider is serving children and adolescents;
    - xvi. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
    - xvii. Whether provider has completed Cultural and Linguistic Competency training;
    - xviii. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment; and
    - xix. A telephone number at the PIHP where a member can call to confirm the information in the directory.
    - xx. In no case shall a provider be loaded into the provider directory which cannot receive payment on the PIHP's current payment cycle.
    - xxi. The PIHP shall provide the provider directory to NCTracks for inclusion in the Consolidated Provider Directory made available the Enrolment Broker as described in Section IV.L. Technical Specifications.

- xxii. As long as the PIHP Provider Directory clearly identifies which providers are available under which health plan, a unified Provider Directory may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

3. Provider Relations and Engagement

- a. Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to members. The PIHP shall engage and support providers through a call center and provider web portal as well as provide training and education on the Medicaid program and their rights within the program.
- b. Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
  - i. The PIHP shall operate a Provider Relations function, that includes a Provider Support Service Line consistent with the applicable standards found in *Section IV.B. Program Operations*. The Provider Support Service Line should comply with the parameters laid out in *Section IV.A.3. Readiness Review Requirements* if PIHP utilizes a Subcontractor to provide or operate the service line (see *Section IV.B.1. Service Lines*). The Provider Support Service Line apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - ii. The PIHP shall ensure that the Provider Support Service Line is staffed with personnel specifically trained on the requirements, policies, and procedures of the PIHP operating in North Carolina and are able to respond to all areas within the Provider Manual, including resolving claims payment inquires, in “one-touch.”
  - iii. The PIHP shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web portal shall include access to the Provider Manual. The provider web portal may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - iv. The PIHP shall send a Provider Welcome Packet and enrollment notice to providers within five (5) Calendar Days of executing a contract with the provider for participation within its network for this contract. The Provider Welcome Packet must include orientation information and instructions on how to access the PIHP’s Provider Manual.
  - v. The PIHP shall develop and maintain a Provider Support Plan as described in *Section IV.I.1. Quality Management and Quality Improvement* and make it available to Department upon request.
  - vi. The Provider Welcome Packet shall be submitted to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution.
- c. Provider Education and Training
  - i. The PIHP shall provide periodic and reasonable education, specific to PIHP requirements, policies, including the Department’s Medicaid Direct BH/I/DD Billing Guide, and procedures, training and technical assistance on all PIHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.
  - ii. The PIHP shall communicate with Network providers, or include in its training and technical assistance, information as requested by Department.
  - iii. The PIHP shall provide training to Network providers within thirty (30) Calendar Days of provider joining the Network. Additional training will be provided as determined by the PIHP and as requested by Department.
  - iv. The PIHP shall make training materials available on the provider Web portal as determined appropriate by the PIHP and upon request by network providers or Department.
    - 1. The PIHP shall submit training materials to the Department for review due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution.



2. As long as the Provider Training Materials policies and procedures clearly state they apply to the PIHP, Provider Training Materials policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- v. The PIHP shall develop a Provider Training Plan that outlines training topics and dates. The PIHP Provider Training Plan shall reference and acknowledge the broader role the PIHP has in supporting Department initiatives. Training must include:
    1. Annual EPSDT training, where EPSDT is relevant to the provider's area of practice, and within the scope of this contract;
    2. PIHP prevention and population health management programs;
    3. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings;
    4. Differences between NC Medicaid Direct, including the PIHP, and the Department's Medicaid Managed Care Program;
    5. Any other training topics required under this Contract; and
    6. How the PIHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.
  - vi. The Provider Training Plan shall be due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Provider Training Plan policies and procedures clearly state they apply to Medicaid Direct, Provider Training Plan policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - vii. The PIHP shall submit the Provider Training Plan to the Department as follows:
    1. Due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution;
    2. When material changes are made to the Training Plan; and
    3. Annually.
- d. Provider Manual
    - i. The PIHP shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the PIHP and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:
      1. Clinical practice standards and UM Program;
      2. Covered services and additional benefits by the PIHP;
      3. All services covered by NC Medicaid Direct;
      4. State-funded Services covered by BH I/DD Tailored Plans;
      5. Eligibility for State-funded Services, including federal funding restrictions and requirements;
      6. Care management (including in-reach, transition management and diversion) delivered through the PIHP;
      7. Provider responsibilities;
      8. Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
      9. Telehealth;
      10. Network adequacy and access standards;
      11. Billing, claim editing, SNIP editing and clearinghouse requirements;

12. Cultural and Linguistic Competency and accessibility requirements;
  13. Authorization, utilization review, and care management requirements;
  14. Care coordination, care management, and discharge planning requirements;
  15. Department-required documentation requirements;
  16. Provider Appeals and Grievance process;
  17. Complaint or Grievance investigation and resolution procedures;
  18. Performance improvement procedures including member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
  19. Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
  20. Interest and penalty provisions for late or under-payment by the PIHP;
  21. Member rights and responsibilities;
  22. Member cost sharing requirements;
  23. Provider Program Integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other federal and state requirements; and
  24. Disaster and emergency relief planning and response in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease.
- ii. The PIHP shall also include in the Provider Manual providers' obligations to:
    1. Monitor and audit provider's own activities to ensure compliance and prevent and detect fraud, waste, and abuse;
    2. Monitor and report on provider preventable conditions;
    3. Retain patient records for the mandated period;
    4. Ensure that all documentation regarding services provided is timely, accurate, and complete;
    5. Ensure PIHP is the payer of last resort; and
    6. To report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment.
  - iii. The PIHP shall include standardized language in the Provider Manual as requested by the Department.
  - iv. The PIHP shall submit the Provider Manual to Department for approval ninety (90) Calendar Days after Contract Execution. The PIHP shall not use or distribute the Provider Manual prior to approval by Department.
  - v. The PIHP shall regularly review and update the Provider Manual annually, with submission due July 1st, or upon request by the Department 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. Within the provider manual, the PIHP shall track and maintain a list of revisions made to manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.
  - vi. The PIHP may update the provider manual once per quarter in the event of substantive updates or revisions that impact providers or PIHP business. Unless directed by the Department, the PIHP shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by the PIHP during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

- vii. When seeking review and approval of the provider manual, the PIHP shall submit the provider manual to Department for approval within fifteen (15) Calendar Days of making substantive updates. The PIHP shall not post, print, or enforce the updates until the PIHP has received approval from the Department.
  - viii. The PIHP shall have fifteen (15) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process. The PIHP shall make the provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
- e. Provider Survey
- The PIHP shall conduct ongoing quality assurance of its provider relations staff via standardized provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary. This survey may be conducted concurrently with any provider surveys required under the BH/I/DD Tailored Plan Contract.
- i. Provider surveys shall be made available after each web, call center or in-person interaction;
  - ii. Conduct surveys and internal audits intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness; and
  - iii. Provide reports, including the results of provider surveys and PIHP's evaluation of survey results and recommendations for engagement/education approach adjustments, to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- f. Provider Recruitment
- i. The Department views recruitment activities as a method to help publicize Medicaid, educate potential Providers about health plan contracting options and recruit new providers for contracting with the PIHP, while ensuring the protection of Providers from coercive or misleading practices.
  - ii. The PIHP shall comply with all recruitment requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the PIHP to ensure that Providers receive accurate oral and written information.
  - iii. The PIHP shall not market nor distribute any recruitment materials without obtaining written approval from the Department.
  - iv. The PIHP shall ensure that recruitment materials are accurate and does not mislead, confuse, or defraud Providers or the Department.
  - v. The PIHP shall establish and maintain, a system of control over the content, form, and method of dissemination of all recruitment materials. All recruitment materials, regardless by whom written, produced, created, designed, or presented shall be the responsibility of the PIHP.
  - vi. The PIHP chooses to market, the PIHP shall distribute recruitment materials to the entire catchment area served by the PIHP.
  - vii. The PIHP shall ensure that all recruitment materials comply with the language, accessibility, and cultural competency requirements and the Provider materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.

- viii. The PIHP shall ensure that all recruitment materials and recruitment strategies shall abide by the PIHP's Non-discrimination Policy.
  - ix. The PIHP shall assign a unique recruitment code to all recruitment materials distributed to Providers.
  - x. Department Approval of Recruitment Materials
    - 1. The PIHP shall submit recruitment materials to the Department for review at least thirty (30) Calendar Days before the proposed use of the material.
    - 2. If the PIHP makes a significant change to recruitment materials that have been previously approved by the Department, the PIHP must resubmit the materials, in accordance with this section, for Department review and approval.
- 4. Provider Payments
  - a. Provider payment requirements are established to comply with State law, encourage continued provider participation in the Medicaid program to ensure member access, and support safety-net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of PIHP steerage to other providers. Nothing in this section is meant to preclude the PIHP from using different reimbursement amounts for different specialties or for practitioners in the same specialty. 42 C.F.R. § 438.12(b)(2)
  - b. The PIHP shall support the Department in complying with all federal laws, state laws, State Plans, waivers, PI or audit requirements, investigations, findings, or corrective action plans related to provider payments.
  - c. The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.
  - d. Physician and Physician Extender Payments
    - i. The PIHP shall reimburse all in-network specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.
    - ii. The PIHP shall not refuse to reimburse for a covered service provided by a physician assistant if services were rendered through a physician assistant acting under the authority of applicable rules adopted by the North Carolina Medical Board.
  - e. Hospital Payments for BH Claims
 

The PIHP shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims to be defined by the Department.
  - f. Indian Health Care Provider (IHCP) Payments
 

In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PIHP shall reimburse IHCPs as follows:

    - i. Those IHCPs that are not enrolled as an FQHC, regardless of whether they participate in the PIHP's Network;
    - ii. The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
    - iii. The Medicaid Fee for Service rate for services that do not have an applicable encounter rate.

- g. The PIHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
- h. State Owned and Operated Facilities Payments: The PIHP shall reimburse facilities that are state-owned and operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by the Department according to the rates and their respective effective dates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).
- i. Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management
  - i. For Tailored Care Management, the PIHP shall pay AMH+ practices and CMAs;
  - ii. Tailored Care Management payment for each Medicaid month in which the AMH+ practice or CMA performed Tailored Care Management for each member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. This Tailored Care Management payment shall not be placed at risk. For NC Health Choice members, the fixed rates were incorporated in capitation rates and the Department expects that the BH I/DD Tailored Plan will pay the same rate as for Medicaid members. The PIHP shall pay AMH+ practices or CMAs the Tailored Care Management payment for any month in which the Medicaid or NC Health Choice member is assigned to the AMH+/CMA and the AMH+/CMA delivers at least one (1) care management contact. The PIHP shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact, even if the AMH+/CMA has not delivered the minimum number of contacts during the month based on the member's acuity tier; and
  - iii. PIHPs may, but are not required to, make performance incentive payment AMH+ or CMAs. The Department encourages PIHPs to base performance incentive payments on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual, once released. The Department also intends to develop a mandatory performance incentive program for Contract Year 2. The Department will release additional guidance on this program once developed.
- j. Payment Limitations

Upon request by the Department, the PIHP shall submit information on payments to related providers and Subcontractors and provide a demonstration of how payment levels for related providers and Subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are Value-Based Payment arrangements in place.
- k. Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)
  - i. With the exception of out-of-network emergency services, post-stabilization services and services provided during transitions in coverage, the PIHP shall be prohibited from reimbursing an out-of-network provider more than ninety percent (90%) of the Medicaid Fee for Service rate if the PIHP has made a good faith effort to contract with the provider, but the provider has refused that contract.
  - ii. The PIHP shall develop Good Faith Provider Contracting Policy that includes a description of how the PIHP will conclude that a "good faith" contracting effort has been made. The PIHP shall submit the policy to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Good Faith Provider Contracting policies and procedures clearly state they apply to the PIHP, Good Faith Provider Contracting policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

- iii. The PIHP shall consider all facts and circumstances surrounding a provider’s willingness to contract before determining that the provider has refused the plan’s “good faith” contracting effort.
- iv. The PIHP shall reimburse an out-of-network provider who is providing services to a member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee for Service rate the predominant rate [as established by LME/MCO] for applicable behavioral health service.
- v. Unless an agreement has been negotiated, the PIHP shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate for: BH,I/DD, and TBI services when the PIHP has not made a “good faith” effort as defined in the Contract with the provider in accordance with the PIHP’s Good Faith Provider Contracting Policy or the PIHP has exercised its authority to maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23.
- vi. The PIHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee for Service rates specified in SPAs 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:
  - 1.Are more reasonably available than can be provided by an in-state Network provider; or
  - 2.The care and services are provided in any one of the following situations:
    - i. In response to an Emergency Medical Condition;
    - ii. The health of the member would be endangered if the care and services were postponed until the member returns to North Carolina; or
    - iii. The health of the member would be endangered if travel were undertaken to return to North Carolina.
- vii. In accordance with 42 C.F.R. § 438.206(b)(5), the PIHP shall coordinate payment with the out-of-network provider to ensure that the cost to the member is no greater than it would be if services were provided by a provider in the Network.
- I. Out-of-Network Emergency Services and Post-Stabilization Services Payments
  - i. In accordance with 42 C.F.R. § 438.114, the PIHP shall be subject to the following requirements:
    - 1.The PIHP shall cover and pay for emergency services without regard to prior authorization or whether the provider that furnishes the service has a contract with the PIHP.
    - 2.The PIHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the member having been instructed by a representative of the PIHP to seek emergency services.
    - 3.Likewise, the PIHP shall not hold a member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
    - 4.The PIHP shall provide coverage and payment of services until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on the PIHP. Section 1932(b)(2) of the SSA; 42 C.F.R. § 438.114(c)(1)(i); 42 C.F.R. § 438.114(c)(1)(ii)(A)-(B).
  - ii. In accordance with SSA 1932(b)(2)(D), the PIHP shall pay out-of-network providers who provide emergency services or post-stabilization services to a member no more than the applicable Medicaid Fee for Service rates.

- iii. The PIHP shall reimburse out-of-state hospitals that are also out-of-network for emergency and post-stabilization care services according to the applicable Medicaid Fee for Service rates.
- iv. In accordance with 42 C.F.R. § 422.113(c), the PIHP shall be subject to following requirements:
  - 1. The PIHP shall be required to reimburse for out-of-network post-stabilization care services that are pre-approved by a PIHP representative.
  - 2. The PIHP shall be financially responsible for post-stabilization care services that are not pre-approved but are administered to maintain the member's stabilized condition within one (1) hour of a request to the PIHP for pre-approval of further post-stabilization care services.
  - 3. Additionally, the PIHP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the member's stabilized condition in the following instances:
    - i. If the PIHP cannot be contacted;
    - ii. If the PIHP does not respond to request for pre-approval within one (1) hour;
    - iii. If the PIHP representative and the treating physician cannot reach an agreement concerning the member's care and a PIHP physician is not available for consultation; or
    - iv. If the PIHP representative and treating physician cannot reach an agreement concerning the member's care and a PIHP physician is not available for consultation, the PIHP shall give the treating physician the opportunity to consult with a PIHP physician and the treating physician may continue with the care of the member until the PIHP physician is reached or one of the other post-stabilization care services criteria is met. 42 C.F.R. § 438.114(e); 42 C.F.R. §§ 422.113(c)(2)(i)-(ii) and (iii)(A)-(C).
  - 4. The PIHP shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:
    - i. Once a Network physician with privileges at the treating hospital assumes responsibility for the member's care;
    - ii. Once a Network physician assumes responsibility for the member's care through transfer;
    - iii. Once a PIHP representative and the treating physician reach an agreement regarding the member's care; or
    - iv. Once the member is discharged. 42 C.F.R. 438.114(e); 42 C.F.R. 422.113(c)(3)(i)-(iv).
  - 5. The PIHP shall limit charges to members for post-stabilization care services to an amount no greater than what the PIHP would charge the member if he or she obtained the services through the PIHP in-network provider. 42 C.F.R. 438.114(e); 42 C.F.R. 422.113(c)(2)(iv).
- m. Payments under Locum Tenens Arrangements
  - i. The PIHP shall recognize locum tenens arrangements to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 45 C.F.R. § 455.410(b).
  - ii. The PIHP shall establish and maintain a Locum Tenens Policy that allows a patient's regular physician to submit a claim and, if the claim is accepted, receive payment for covered visit services that the regular physician or a locum tenens agency arranges to be provided by a locum tenens physician, and otherwise meets the requirements of this Contract. The PIHP shall submit the Locum Tenens Policy to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. As long as the Locum Tenens Policy clearly states that it applies to Medicaid Direct, the Locum Tenens Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.

1. PIHP payment for covered services provided by a locum tenens physician are allowed if the following are true:
    - i. The regular physician is unavailable to provide the covered services, or the locum tenens physician is assisting the regular physician in providing covered services.
    - ii. The member has arranged or seeks to receive the covered services from the regular physician.
    - iii. The locum tenens physician does not provide the covered services to patients of a single regular physician for more than ninety (90) consecutive Calendar Days.
    - iv. The regular physician identifies the covered services as locum tenens physician services by entering the proper code required by the PIHP after the procedure code.
    - v. The regular physician pays for the locum tenens physician's covered services on a per diem or similar fee-for-time basis.
    - vi. The regular physician maintains a record of each covered service provided by the locum tenens physician and makes this record available to the PIHP upon request.
  2. The PIHP shall develop and maintain a Provider Reimbursement Policy that sets forth the criteria and process for payment of Clean Claims to providers, including claims bundling and other claims editing processes, recognition or non-recognition of CPT code modifiers, and down coding of services or procedures, and otherwise meets the requirements of this Contract.
  3. The PIHP shall submit the Provider Reimbursement Policy to the Department upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution, for review. As long as the Provider Reimbursement Policy clearly states that it applies to Medicaid Direct, the Provider Reimbursement Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
5. Provider Grievances and Appeals
- a. The PIHP shall handle provider Appeals and Grievances promptly, consistently, fairly, and in compliance with State and federal law and Department requirements. The PIHP shall have in place a provider Appeals and Grievance system, distinct from that offered to Members, that includes a Grievance process for providers to bring issues to the PIHP, an Appeals process for providers to challenge certain PIHP decisions.
  - b. The PIHP shall be transparent with providers regarding its Appeals and Grievance processes and procedures. The PIHP shall ensure the Grievance and Appeals system comply with *Section IV.A.3. Readiness Review Requirements*, if PIHP has contracted with a Subcontractor for the Grievance and Appeals system.
  - c. The PIHP shall submit the PIHP Provider Grievances and Appeals Policy to the Department for review upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. The PIHP shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes. As long as the Provider Grievance and Appeals policies and procedures clearly state they apply to the PIHP, Provider Grievance and Appeals policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - d. The PIHP shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience.
  - e. The PIHP shall not discriminate against or retaliate against any provider based on any action taken by the provider under Provider Grievances and Appeals Section of the Contract (*Section IV.H.5. Provider Grievances and Appeals*) or under Member Grievances and Appeals Section of the Contract (*Section IV.E.6. Member Grievances and Appeals*) taken on behalf of a member.



- f. Grievances
  - i. The PIHP shall have a process in place to receive and resolve Grievances with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
  - ii. The PIHP shall accept and resolve provider Grievances regarding the PIHP referred from the Department.
  - iii. The PIHP shall have a method of allowing providers to submit Grievances through the PIHP provider web portal.
  - iv. The PIHP shall provide a report on provider Grievances in a form and frequency as described in *Section VI. Attachment I. Reporting Requirements* and upon request.
- g. Appeals
  - i. The PIHP shall offer providers Appeal rights as described in *Section VI. Attachment H. Provider Appeals*.
  - ii. The PIHP shall provide written notice of provider's right to Appeal with the notice of decision giving rise to the provider's right to Appeal.
  - iii. The PIHP shall have a method of allowing providers to submit Appeals through the PIHP provider web portal.
  - iv. The PIHP shall accept a written request for an Appeal from the provider within thirty (30) Calendar Days on which:
    - 1. Provider receives written notice from the PIHP of the decision giving rise to the right to Appeal; or
    - 2. PIHP should have taken a required action and failed to take such actions.
  - v. The PIHP shall acknowledge receipt of each Appeal request within five (5) Calendar Days of receipt of the request.
  - vi. The PIHP shall extend the timeframe by thirty (30) Calendar Days for providers to request an Appeal for good-cause shown as determined by the PIHP.
    - 1. PIHP shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an Appeal request.
    - 2. PIHP shall consider the voluminous nature of required evidence/supporting documentation, as good-cause reasons to extend the timeframe.
  - vii. The PIHP shall provide information regarding provider Appeals to Department upon request.
  - viii. The PIHP Grievances and Appeals Policy shall provide that a provider must exhaust the PIHP internal Appeals process before seeking recourse under any other process permitted by contract or law.
- h. Resolution of Appeal
  - i. The PIHP shall establish a committee to review and make decisions on provider Appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.
  - ii. The PIHP shall provide written notice of decision of the Appeal within thirty (30) Calendar Days of receiving a complete Appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the PIHP. Notice shall include information regarding further Appeal rights, if any.
  - iii. The PIHP shall allow providers to be represented by an attorney during the Appeals process.
- i. Appeals of Suspension or Withhold of Provider Payment
  - i. The PIHP shall limit the issue on Appeal in cases of suspension or withhold or provider payment to whether the PIHP had good cause to commence the withhold or suspension of provider payment. PIHP shall not address whether the provider has or has not committed fraud or abuse.

- ii. The PIHP shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.
  - iii. The PIHP shall offer the provider an in person or telephone hearing when provider is Appealing whether PIHP has good cause to withhold or suspend payment to the provider.
  - iv. The PIHP shall schedule the hearing and issue a written decision regarding whether PIHP had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's Appeal. Upon a finding that PIHP did not have good cause to suspend or withhold payment, PIHP shall reinstate any payments that were withheld or suspended within five (5) Business Days.
  - v. The PIHP shall pay interest and penalties for overturned denials, underpayment, or findings it did not have good cause to suspend or withhold payment from the original date of payment, suspension, withhold or denial.
- j. Notice to Department
- i. The PIHP shall provide notice to the Department of any provider Appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by PIHP, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.
  - ii. The PIHP shall notify Department if a provider has sued PIHP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.
    - 1. Payment for Crisis Providers
 

The PIHP shall reimburse in-network providers for mobile crisis services and facility based crisis services no less than the Department's Enhanced Behavioral Health Fee Schedule unless the PIHP and provider have mutually agreed to an alternative reimbursement arrangement.
    - 2. Provider Hardship Payments
      - a. The PIHP shall have the capability to process Hardship Payment requests from a provider within seven (7) Calendar Days of receipt of a hardship request or three (3) Calendar Days of receipt of an urgent hardship request.
      - b. The PIHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval within thirty (30) Calendar Days of Contract execution. The Provider Hardship Payment Policy shall include:
        - i. Method for providers to submit hardship payment requests;
        - ii. Description of timeline for payment for standard and urgent requests, including integration into check write schedule;
        - iii. Criteria for requests to be reviewed and approved by the PIHP; and
        - iv. Description of how providers and Department will be notified of status of the request and payment, if applicable.

## I. Quality and Value

- 1. Quality Management and Quality Improvement
  - a. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. Where noted in the section, the PIHP may utilize the same staff and services as it does for BH I/IDD Tailored Plan to perform the operations described in this Section.

- b. The Department will work with the PIHP to develop a data-driven, outcomes-based continuous QI process. The QI process focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PIHPs and, in turn, providers for advancing quality goals and health outcomes.
  - c. The PIHP shall have an IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement, and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations. The PIHP shall engage with the Department and its designees to share quality data reported by the PIHP and receive quality data calculated by the PIHP or its designees.
  - d. The PIHP shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan, and comply with the quality management and quality improvement assurances and other requirements contained in North Carolina's federal Medicaid waivers (e.g., Section 1915(i) and 1915(c), and other active waivers relevant for the PIHP).
- i. Quality Assessment and Performance Improvement (QAPI) Plan (42 C.F.R. § 438.330)
    - 1. The PIHP shall submit an annual combined QAPI Plan for Medicaid and NC Health Choice delineating the PIHP's plans for performance improvement programs and other quality improvement efforts as part of the QAPI Plan due , but no later than sixty (60) Calendar Days after Contract Execution. As long as the QAPI clearly states that it applies to the PIHP, the QAPI may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
    - 2. The PIHP shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
    - 3. The QAPI Plan shall include the following elements:
      - i. Completion of PIPs specified by the Department;
      - ii. Collection and submission of all quality performance measurement data required by the Department;
      - iii. Mechanisms to detect both underutilization and overutilization of services:
        - a. Use of congregate care settings (both FC Plan-funded and DSS-funded), including county-by-county and Member demographic-based monitoring where available;
        - b. Use of EDs (inclusive of lengths of stay) for crisis (including behavioral health);
        - c. Out of home placements greater than thirty (30) miles/ thirty (30) minutes (urban) or sixty (60) miles/ sixty (60) minutes (rural) away from a Member's/family's home, including out of state placements;
        - d. Time to service initiation from request of service or determination of service need by a provider, and lengths of stay in inappropriate settings while awaiting access to appropriate services;
        - e. Use of community/home-based services for youth residing in foster care settings who have behavioral health diagnoses; and
        - f. 30/60/180 day readmissions to congregate care settings and ED settings following discharge from any congregate care setting;
      - iv. Mechanisms to assess the quality and appropriateness of care for Members' special health care needs;

- v. Mechanisms to assess the quality and appropriateness of care provided to Members needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;
  - vi. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS, Members transitioning out of State hospitals and transitioning out of or diverted from adult care homes);
  - vii. Mechanisms to incorporate population health programs targeted to improve outcome measures;
  - viii. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS and programs;
  - ix. Mechanisms to assess and address health disparities, including findings from the DHHS disparity report;
  - x. The PIHP's contributions to Health-Related Resources that can support or align with broader improvement in particular health outcomes outlined in the Quality Strategy(e.g., through engagement with the Department around understanding state performance on the Behavioral Risk Factor Surveillance System survey); and
  - xi. Mechanisms to assess and address health equity including access to culturally and linguistically appropriate services and a diverse provider pool.
- 4.The Quality Assessment and Improvement Program (QAPI) reporting shall also include Consumer and Family Advisory Committee (CFAC) activity, result summaries, and program assessments of the following:
- i. Mechanisms to collect and assess feedback from the PIHP's CFAC;
  - ii. The PIHP's actions/initiative taken based on CFAC feedback in alignment with improvement and appropriateness of care provided to Members;
  - iii. Mechanism to review Member satisfaction and feedback on the Member experience with PIHP responsiveness to Member issues/comments/concerns; and
  - iv. The PIHP shall submit an updated CFAC roster of committee members when there are modifications made to the CFAC representatives (reference PIHP CFAC Guidance for CFAC member composition requirements). This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUD), etc.
- e. The PIHP shall participate in monthly PIHP Quality Director Meetings. The Quality Director may perform functions for both this product and the BH I/DD Tailored Plan. Monthly Quality Director Meetings for the PIHP and BH I/DD Tailored Plan may be combined.
  - f. The PIHP shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually. The PIHP may develop a single process, inclusive of this product and the BH I/DD Tailored Plan.
  - g. The PIHP shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of each PIHP's overall QAPI program design as directed by the Department.
  - h. Quality Measures
    - i. The PIHP will be held accountable for performance on all measures listed NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website, that are meant to provide the Department with a complete picture of the PIHP's processes and performance. The PIHP's accountability may include: public reporting of measure performance by the Department, requirements to engage

with Department staff around measure performance, and, beginning in Contract Year 2, financial accountability for a select set of measures to be specified by the Department.

- ii. The Department will monitor other measures that are not designated as in *Section VI. Attachment D. PIHP Quality Metrics* and may elect to report performance on these measures or engage with PIHPs around these performance reports. The PIHP shall reference up-to-date information on quality measures and specifications in the NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website.
  - iii. The PIHP shall submit to the Department all data necessary for the Department to calculate the PIHP's performance on measures listed in the NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website.
  - iv. Detailed specifications regarding measure reporting, stratification, and data submission will be supplied to the PIHPs prior to launch and annually thereafter.
- i. The PIHP shall incorporate Department identified measures into the PIHP's QAPI and quality improvement activities. Department identified measures are indicated in *Section VI. Attachment D. PIHP Quality Metrics*. The Department reserves the right to change the quality measures identified for PIHP's QAPI and quality improvement activities.
    - i. Beginning in Contract Year 2, the Department may implement a quality withhold/incentive program based on a priority set of quality measures used to evaluate the administration of BH I/DD Tailored Plan. A subset of the priority set may be included in the Withhold/Incentive Program. The Department reserves the right to add and remove measures from the priority set that may be subject to future withholds
    - ii. The Department intends to monitor CMS' development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS' Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.
  - j. Measurement of Outcomes
    - i. The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas of quality of life, functional status, and Member satisfaction. This measurement may involve the use of surveys that may be administered by providers or third-party contractors and may involve the development and piloting of novel survey instruments.
    - ii. The PIHP shall support the administration of surveys as requested by the Department. This support may include conducting outreach to Members and providers, incorporating in provider contracting requirements related to survey administration, and conducting analysis of internal data to support survey piloting.
    - iii. The PIHP shall ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department.
    - iv. The Department is also exploring administrative data from other State agencies to support measurement of outcomes outside of the health care system for Medicaid beneficiaries.
  - k. Disparities Reporting and Tracking
    - i. The PIHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
    - ii. Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the PIHP after Contract Execution and annually thereafter.

- iii. The PIHP shall address disparities as determined by the Department during review of the PIHP's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.
- iv. The Department will define the strata to be applied to each measure after Contract Execution and annually thereafter.
- I. Public Health Reporting and Tracking
  - i. The PIHP shall work with the Department to target areas of collaboration and develop programs as part of QI efforts that can:
    - 1.Remove barriers (e.g., benefit coverage, implementation challenges, Member education);
    - 2.Align incentives by targeting withholds for measures that will affect public health priorities; and
    - 3.Require select quality initiatives to be embedded in QAPIs, including PIPs and contributions to health-related resources.
  - ii. The PIHP shall be an active partner in Healthy NC 2030 (<https://nciom.org/healthy-north-carolina-2030/>) goals planning by participating at a minimum as follows:
    - 1.Joining planning meetings;
    - 2.Designating a senior level clinical staff person to engage in public health issue discussions; and
    - 3.Aligning QI activities to support Healthy NC 2030 goals.
- m. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)
  - i. The PIHP shall include no less than three (3) PIPs as part of the annual QAPI program and may be required to develop additional performance improvement projects for specific focus areas and/or clinical measures as directed by the Department. The PIHP's PIPs must be approved by the Department annually as part of the PIHP's QAPI program due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in this document. The QAPI program and PIPs may be shared across and inclusive of both this product and the BH I/DD Tailored Plan. The PIHP must describe in the QAPI how PIPs will cover the Medicaid Direct population.
  - ii. As long as the Performance Improvement Projects policies and procedures clearly state they apply to the PIHP, Performance Improvement Projects policies and procedures may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
  - iii. The PIHP shall develop a PIP that is:
    - 1.Designed to achieve significant improvement in health outcomes as part of the annual PIHP QAPI program review; and
    - 2.Includes measurement of performance using quality indicators as part of the annual PIHP QAPI program review.
  - iv. Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
  - v. The PIHP shall conduct at least one (1) non-clinical performance improvement project on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
  - vi. The PIHP shall be required to develop or maintain and execute two (2) clinical performance improvement project annually.

- vii. If the PIHP performs below seventy-five percent (75%) for overall CMS 416 rates for EPSDT screening, the PIHP shall submit one (1) PIP on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical PIPs annually.
- n. External Quality Review (42 C.F.R. §§ 438.350-364)
  - i. The PIHP shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO. This may include a consolidated approach assessing Medicaid services.
  - ii. The PIHP shall participate in the annual Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS), the Provider Survey, the Consumer Perception of Care survey, the National Core Indicators (NCI) survey, and other surveys as required by the Department.
  - iii. The PIHP shall comply with validation and research activities related to surveys, including survey instruments under development, that are required by the Department.
- o. Quality Improvement - Provider Supports
  - i. The PIHP shall provide support to providers tailored to advance State interventions and ensure providers' ability to achieve the goals outlined in the Quality Strategy.
  - ii. The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.
  - iii. The PIHP shall develop and maintain a PIHP Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the PIHP Provider Support Plan. As long as the Provider Support Plan clearly states that it applies to Medicaid Direct, the Provider Support Plan may apply to other PIHP operations, including, without limitation, the BH I/DD Tailored Plan contract.
  - iv. The Provider Support Plan shall be developed as a component part of the QAPI, and provider support activities should relate to improvement in specific health outcomes.
  - v. The PIHP Provider Support Plan shall include:
    - 1. All planned technical support activities;
    - 2. Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy;
    - 3. An overview of which metrics the PIHP will use to evaluate its provider engagement progress over time; and
    - 4. How the PIHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.
  - vi. The PIHP shall provide QI support to Network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
    - 1. Opioid and SUD strategy;
    - 2. The Tailored Care Management model;
    - 3. VBP;
    - 4. Health Equity;
    - 5. Accreditation;
    - 6. Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
    - 7. Provider Supports; and
    - 8. Support for other activities such as response to or recovery from COVID-19, or future resilience efforts, as indicated by the Department.
- 2. Value-Based Payments (VBP)
  - a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to

value included in the PIHP Quality Strategy, the Department is requiring adoption of VBP arrangements between the PIHP and providers. The Department will issue additional guidance and details on VBP requirements for PIHPs.

- b. The Department defines VBP arrangements as payment arrangements between the PIHP and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>. The Department reserves the right to narrow the definition of VBP and the range of acceptable PIHP VBP arrangements with providers in the future.
  - i. Payments to AMH+ and CMA providers will be considered VBP only when these contracts include a performance incentive payment, as described in *Section IV.H.4. Provider Payments*.
  - ii. All VBP arrangements must be aligned with the PIHP Quality Strategy and related measures.
  - iii. The PIHP shall re-submit contract templates to the Department for review at least ninety (90) Calendar Days before use in the market when any new VBP arrangements (excluding to AMHs, which is covered in *Section IV.H.4. Provider Payments*), or changes to VBP arrangements, are added.
- c. The PIHP shall have IT infrastructure and data analytic capabilities to support the Department's vision in moving toward VBP, including having systems that can support alternative payment arrangement models which require data-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.
- d. The PIHP shall complete a VBP Assessment based on the categories developed by HCP-LAN, as described in *Section VI. Attachment I. Reporting Requirements*. The Department will provide specifications on the assessment methodology following Contract Execution.
  - i. The Department shall use the VBP Assessment to demonstrate the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the amount of total medical expenditures and covered lives under these VBP payment arrangements and compare documented progress to the PIHP's final VBP Strategy on an annual basis.
  - ii. The PIHP shall report the initial results of its VBP Assessment focused on VBP contracts in place to date due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
  - iii. As long as the VBP Assessment clearly state it applies to the PIHP, VBP Assessment may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
  - iv. The PIHP shall update the VBP Assessment on an annual basis, within ninety (90) Calendar Days of the end of each contract year.
- e. To ensure the PIHP's response aligns with the Department's strategy and goals, the PIHP shall develop a PIHP VBP Strategy for Contract Years 1-3, in alignment with the Department's short- and long-term goals to shift from a fee for service system to VBP.
  - i. The PIHP VBP Strategy must be submitted to the Department due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution.
  - ii. As long as the VBP Strategy clearly state that it applies to the PIHP, the VBP Strategy may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract. and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract
  - iii. All sections of the PIHP VBP Strategy must be updated on an annual basis, within ninety (90) Calendar Days of the end of each Contract Year.



- iv. The VBP Strategy shall contain the following elements:
  - 1.A narrative description addressing:
    - i. The PIHP's goals, strategies, and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the PIHP will involve BH and intellectual and developmental disability providers in its VBP arrangements.
    - ii. A description of the VBP model(s) that will be pursued by the PIHP and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers.
    - iii. The PIHP's plan for measurement of outcomes and ROI related to VBP by year.
    - iv. The PIHP's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes.
    - v. A description of the PIHP's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the PIHP VBP programs. Specific functionalities to address include:
      - i. Risk adjustment;
      - ii. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
      - iii. Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
      - iv. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
      - v. Reporting capabilities; and
      - vi. Payment functions.
    - vi. The PIHP's approach to address health disparities and incorporate health equity into their internal and external policies, and procedures.
  - 2.The PIHP's projected annual targets for the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the percent of total medical expenditures and covered lives under these VBP payment arrangements, in a format to be determined by the Department.
- f. Additionally, the PIHP shall participate in any VBP stakeholder meeting process initiated by the Department. The PIHP will be responsible for meeting any requirements outlined by a Departmental VBP stakeholder group for future contract years.

## **J. Claims and Encounter Management**

- 1. Claims
  - a. In order to incentivize successful delivery of Medicaid benefits and increase provider participation, the PIHP shall pay all providers on a timely basis upon receipt of any Clean Claims for covered services rendered to members who are enrolled with the PIHP in accordance with State and Federal statutes. To maximize Federal match and ensure accurate reporting, the PIHP shall comply with the Department's Managed Care Provider Billing Guide or as otherwise directed by the Department.

- b. Incorrect Claim payments or inappropriate Claim denials result in increased administrative costs to both the Provider and the PIHP and by extension, increase the program costs of North Carolina's Medicaid program. Therefore, the PIHP shall develop, maintain, and operate a Claims payment, review and Program Integrity process which minimizes incorrect Claim payments and inappropriate Claim denials due upon request but no sooner than one hundred eighty (180) Calendar Days after contract execution
- c. Claims Processing and Reprocessing Standards
  - i. The PIHP shall have the automated capability to identify, process, and reprocess Claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing Claims as directed by the Department, or when Department decisions are made that would warrant reprocessing (i.e., member retrospective eligibility determinations or plan enrollment changes).
  - ii. In addition to processing Claims for all covered services, the PIHP shall have the operational and administrative capability to process ILOS, Value-Added Services, value-based payments and qualifying EPSDT services which may be otherwise non-covered.
  - iii. The PIHP shall process and reimburse Providers in accordance with the Department's prompt payment standards regardless of provider contracting status.
    - 1. Prior to paying a claim, the PIHP shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of provider contracting status.
    - 2. For the purposes of this requirement, the Provider is deemed eligible to be paid if they are currently enrolled as a Provider in the North Carolina Medicaid and NC Health Choice programs, enrolled in the PIHP closed network and contracted with the PIHP or have a valid out of network agreement to deliver services to PIHP Members or submitting a claim for Emergency Services, are subject to an out-of-state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.
  - iv. The PIHP shall adhere to the following specifications when reimbursing Claims, except for specific standards specified:
    - 1. The PIHP shall process Claims in accordance with requirements set forth in the Contract relating to the timeliness of claim payment.
    - 2. The PIHP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes.
    - 3. The PIHP shall capture and retain the IP address/location and the user login/user name for all claims submitted via the online provider portal(s).
    - 4. The PIHP shall ensure subcontractors and partners have established procedures for maintaining the original IP address/location and the user login/user name for all claims submitted to the PIHP; and this information shall be made available within thirty (30) Calendar Days of request by the Department.
  - v. In instances where a provider submits an adjustment to a previously adjudicated Claim, the PIHP shall adjudicate the adjusted Claim within the same timeframes as required for the initial Clean Claim.
  - vi. The PIHP shall provide an Electronic Remittance Advice or Standard Remittance Advice to the Provider as explanation of the adjudication results and reimbursement of each Claim.
  - vii. The PIHP shall ensure the Claim processes align with the parameters laid out in *Section IV.A.3. Readiness Review Requirements*, if PIHP has delegated Claims processing to a Subcontractor.

d. Prompt Payment Standards

- i. The PIHP shall promptly pay Clean Claims to the Provider's in a timely and accurate manner.

1. Claims

- i. The PIHP shall, within eighteen (18) Calendar Days of receiving a claim, notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to timely process the claim.
- ii. The PIHP shall pay or deny a Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Clean Claim or the first scheduled provider reimbursement cycle following adjudication.
- iii. A pending claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

2. If the requested additional information on a pending Claim is not submitted within ninety (90) Calendar Days of the notice requesting the required additional information, the PIHP may deny the Claim and shall include the specific reason or reasons for denial, including the fact that information that was requested was not provided. The PIHP shall inform the Provider in the notice that the Claim will be reopened if the information previously requested is submitted to the PIHP within one (1) year after the date of the denial notice closing the Claim.

- ii. The PIHP shall reprocess Claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
- iii. The PIHP may require that Claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. However, the PIHP may not limit the time in which Claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the PIHP and the Provider, failure to submit a Claim within the time required does not invalidate or reduce any Claim if it was not reasonably possible for the Provider to file the Claim within that time, provided that the Claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the Claim is otherwise required.

iv. Interest and Penalties

1. The PIHP shall pay interest on late payments to the Provider, including, but not limited to, AMH+ practices and CMAs, at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the Claim should have been paid as specified in the Contract.
2. In addition to the interest on late payments required by this Section, the PIHP shall pay the Provider, including, but not limited to, AMH+ practices and CMAs, a penalty equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid as specified in the Contract.
3. The PIHP shall not be subject to interest or penalty payments if failure to comply is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the PIHP's reasonable control, including Force Majeure. In addition, the PIHP is not subject to interest payments to the Provider if the PIHP has a reasonable basis to believe that the Claim was submitted fraudulently.
4. The PIHP shall implement fee schedule changes and reprocess all impacted Claims with dates of services from the effective date of the DHB fee schedule change with correct rates within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for

NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section beginning on the forty-sixth (46th) Calendar Day after the PIHP received notification from the Department.

- v. The PIHP shall maintain written or electronic records of its activities under this Section including records of when each Claim was received, paid, denied, or pending, and the PIHP's review and handling of each Claim under this section, sufficient to demonstrate compliance with this Section.
  - vi. For purposes of actions which must be taken by a PIHP as found in *Section IV.J.1. Claims*, if the referenced Calendar Day falls on a weekend or a holiday, the first Business Day following that day will be considered the date the required action must be taken.
  - vii. The PIHP shall comply with *Section VII Attachment L.5 Policies, Tribal Payment Policy*.
- e. Overpayment or Underpayment Recovery
- i. The PIHP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State. 42 C.F.R. § 438.608(a)(2).
  - ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), the PIHP may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this Section. Not less than thirty (30) Calendar Days before the PIHP seeks overpayment recovery or offsets future payments, the PIHP shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the PIHP has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents. The health care provider or health care facility may recover underpayments or non-payments by the PIHP by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the PIHP may include applicable interest under this section. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.
  - iii. The PIHP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
- f. System Standards
- i. The PIHP shall have a Claims Processing and Management Information System (MIS) capable of meeting North Carolina Medicaid Direct requirements and maintaining compliance throughout the term of the Contract.
  - ii. The PIHP shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a member.
- g. Mass Adjustment
- i. The PIHP shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
  - ii. The PIHP shall comply with the Department's policies and procedures on mass adjustment.

- h. National Correct Coding Initiative (NCCI)
    - i. The Department has opted to use the Compatible Medicaid NCCI Methodologies in the Medicaid Managed Care program and share the Non-public Medicaid NCCI Edit Files with the PIHPs for processing claims that are paid by the PIHP on a Fee-for-Service basis.
    - ii. The PIHP shall follow NCCI policies to control improper coding that may lead to inappropriate payments to providers by the PIHP
      - a) The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with the PIHP on a quarterly basis, when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
        - 1. Within three (3) Calendar Days of receipt of the edit files, the PIHP shall provide written notice to the Department confirming receipt of the files.
      - b) The PIHP shall incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the PIHP pays on a Fee-for-Service basis. The NCCI editing shall occur prior to current procedure code review and any other editing by the PIHP's claims payment systems.
      - c) The PIHP shall load the Non-public Medicaid NCCI Edit Files into its claims payment systems upon receipt of the edit files from the Department.
        - 1. The edit files shall be loaded and ready for use by the PIHP by no later than 12:00 am on the first day of the calendar quarter in which the edit files are effective.
        - 2. If the PIHP experiences issues loading the edit files into its claims payment systems or any other issues with the edit files that prevents the PIHP from properly loading the files into its systems, the PIHP shall notify the Department within twenty-four (24) hours of identifying the issue.
        - 3. The PIHP shall provide written notice to the Department no later than two (2) Calendar Days after the start of each calendar quarter acknowledging that the new Non-public Medicaid NCCI Edit Files in effect for that quarter were properly loaded into its claims payment systems.
        - 4. If the edit files are not properly loaded and ready for use by 12:00 am on the first day of the calendar quarter, the PIHP shall reprocess any claim processed without using the Non-public Medicaid NCCI Edits in effect for that quarter. All reprocessed claims are subject to the prompt pay standards, including interest and penalties, specified in the Contract.
        - 5. The PIHP shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
    - iii. The PIHP and its Subcontractors are subject to the terms and conditions of Attachment L.4. National Correct Coding Initiative Confidentiality Agreement
2. Encounters
- a. The Department collects and uses provider service encounter data for many purposes including, but not limited to, Federal reporting, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, quality improvement activity, fraud, waste, and abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.
  - b. The Department and its vendors, subcontractors, providers, and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with operating North Carolina's Medicaid program.

- c. Encounter data includes both service Claim lines paid and claim lines denied, voided Claims, interest paid or recovered, penalties and liquidated damages paid or recovered, incentive payments paid or recovered, “zero paid” claim lines, cost settlements, sub-capitated services, third-party liability denials, Claim line adjustments, and other financial activity associated with payments or recoveries made by the PIHP, its delegees or Subcontractors.
- d. Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPPA rejection and not a denied claim or claim line.
- e. Submission Standards and Frequency
  - i. The PIHP shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Companion Guides – 837I, 837P developed by the Department or its vendor(s) to be provided at Contract Execution.
  - ii. The PIHP shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
  - iii. The PIHP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department Encounter Data Submission Guide and Companion Guides – 837I, 837P.
  - iv. Encounter data submissions must contain adjustments made by PIHP due to payment errors and/or provider adjusted claims.
  - v. The PIHP shall submit a monthly certification from the PIHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
  - vi. The PIHP is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers enrolled with the Department. For atypical providers, who do not have an NPI, encounters shall contain an active Atypical Provider Identification (API) number issued by the Department).
  - vii. Specifications
    - 1. Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department’s two publications, Encounter Data Submission Guide and Companion Guides – 837I, 837P.
    - 2. Encounters are defined as:
      - i. BH;
      - ii. I/DD;
      - iii. ILOS;
      - iv. Value-Added services; and
      - v. Value-based services.
    - 3. The PIHP shall adhere to specifications for submitting encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
      - i. The PIHP shall have the capability to submit to the Department encounter data from:
        - a. Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
        - b. Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
    - 4. The PIHP shall reference the same edit codes as the Department's system, which are defined in the Department Encounter Data Submission Guide and Companion Guides – 837I, 837P.

- viii. The PIHP shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the PIHP submitted an encounter data file.
  - ix. Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
    - 1. Timeliness

Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim adjudication date.
    - 2. Completeness
      - i. The PIHP shall submit all claims processed as encounters, as defined in this Section.
      - ii. The PIHP encounter data submissions shall meet or exceed a monthly data acceptance rate of ninety-eight percent (98%) as compared to the PIHP's monthly certification.
      - iii. Encounter data completeness shall be measured as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
      - iv. If the PIHP encounter submission rate is less than one hundred percent (100%), the PIHP shall submit one hundred percent (100%) of omitted encounters from the initial encounter submission date.
    - 3. Accuracy
      - i. PIHP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
      - ii. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.
  - f. Initial Encounter Data at PIHP Launch

The PIHP shall include encounter data for claims which have a date of service on or after the PIHP launch date on which the PIHP becomes responsible for the administration of services.
  - g. To support the Department achieving efficient encounter data processing, the PIHP shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.
  - h. In the event the PIHP enters into a sub-capitated or other VBP reimbursement arrangement with a Provider, the PIHP shall be responsible for submitting all encounters to the Department, containing all the required data fields.
  - i. The PIHP shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.
  - j. The PIHP shall submit to NC Tracks, within thirty (30) Calendar Days of claim payment, an electronic Tailored Care Management Payment claim for the first Tailored Care Management contact service paid by the PIHP.
3. Encounter Data Resubmission Standards
- a. Following the Department's validation and processing of encounter data submissions, the PIHP shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.
  - b. The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial date of service.

- i. The PIHP shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
    - ii. The Department will work with a PIHP for any retroactive encounter denial longer than three (3) years after the initial date of service.
  - c. Timeliness
    - The PIHP will receive notification of encounter data errors requiring correction and resubmission within thirty (30) Calendar Days of the PIHP's initial encounter data submission date.
    - i. PIHP shall, where the PIHP submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.
    - ii. PIHP shall, where PIHP submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.
  - d. Completeness and Accuracy. Unless otherwise directed by the Department, the PIHP shall correct and successfully resubmit:
    - i. Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) Calendar Days from the date the XML Response File was generated;
    - ii. Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) Calendar Days from the date the XML Response File was generated; and
    - iii. Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) Calendar Days from the date the XML Response File was generated.
4. Data Validation and Processing
- i. The PIHP shall have the capability to access sufficient enrollment information to perform member and service provider matching on all claim and/or encounter transactions, if necessary.
  - ii. The Department shall utilize data validation protocols on encounter data files to assess PIHP encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).
  - iii. The PIHP shall perform testing with the Department prior to system changes when clinical policy changes that may impact operational transactions (i.e., encounter submissions) are identified by PIHP or by Department. The PIHP shall not implement any system changes until testing is approved by the Department.
  - iv. The PIHP shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.
  - v. The PIHP shall, in instances where the PIHP is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) Calendar Days prior to the date the modified file will be submitted to the Department production environment.
  - vi. The PIHP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.
  - vii. At the discretion of the Department, the PIHP may be prohibited from submitted a specific encounter type to the Department's Production Encounter Processing System if the



Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan to monitor necessary improvements from the PIHP. In addition, if the PIHP's access to the Production Encounter Processing System is revoked, the PIHP must actively test with the Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any liquidated damages incurred by the PIHP because of the loss of production access are the responsibility of the PIHP.

5. Denied Claims Submitted as Encounters

- i. The PIHP shall submit denied claims as encounters to support denial trend analysis, excluding claims rejected at the HIPAA or EDI level.
- ii. PIHP submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
- iii. On denied claims submitted as encounters, the PIHP shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
- iv. Denied claims submitted as encounters must also include the same data content, including provider, Member, and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
- v. The PIHP shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction.

6. Communication and Oversight

- i. If the PIHP experiences a technical issue preventing encounter data submission, the PIHP shall notify the Department via the approved communication method within the predefined timeline.
- ii. The PIHP shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the PIHP's system(s) or process(es) that prevents the PIHP from submitting encounter data files as scheduled.
- iii. The PIHP shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
- iv. The PIHP shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.

7. Testing

- i. The PIHP will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the PIHP to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The PIHP shall pass the testing phase for all encounter claim type submissions at a time specified by the Department
- ii. The PIHP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Data Submission Guide and Companion Guides – 837I, 837P.

8. In the event of Contract termination or non-renewal, the PIHP shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) Calendar Days following the Contract termination effective date for adjudicated claims with the date of service (DOS) on or before the Contract termination or non-renewal effective date.

9. In instances where the Contract has been terminated for greater than ninety (90) Calendar Days from the contract termination effective date, the PIHP shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

## **K. Financial Requirements**

1. Capitation Payments
  - a. Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of PIHPs. Capitation payments include monthly PMPM payments. The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates.
  - b. The Department shall set PIHP capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.
  - c. The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.
  - d. The PIHP shall supply, certify, and validate data to support rate setting, risk adjustment (applicable to Standard Plan PHPs) and the risk corridor program (as applicable), based on schedules to be provided by the Department after Contract Execution.
  - e. The Department has established a separate payment outside of the capitation rate for Tailored Care Management for Members enrolled in Medicaid. This payment will be made to the PIHP for any month in which the Member is engaged in Tailored Care Management. For Members enrolled in NC Health Choice, the cost of Tailored Care Management is incorporated in the capitation rate, and the Department will not make separate payments for Tailored Care Management for these Members.
  - f. The Department will make capitation payments in accordance with the Payment and Reimbursement term.
2. Medical Loss Ratio
  - a. The Medical Loss Ratio (MLR) standards are to ensure the PIHP is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.
  - b. The PIHP shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:
    - i. The PIHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
      1. The numerator of the PIHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the PIHP's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
      2. The denominator of the PIHP's CMS-defined MLR for a MLR reporting year shall equal the PIHP's adjusted premium revenue. The adjusted premium revenue shall be defined as the PIHP's premium revenue minus the PIHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
    - ii. The PIHP shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.

- iii. The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments: The PIHP is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:
  - 1. Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.
  - 2. Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.
  - 3. The PIHP is prohibited from including in the Department-defined MLR numerator any of the following expenditures: Payments to related providers that violate the Payment Limitations as required in the Contract.
  - 4. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR.
- c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
  - i. The PIHP's classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.
  - ii. The PIHP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
    - 1. Interest or penalty payments to providers for failure to meet prompt payment standards;
    - 2. Fines and liquidated damages assessed by the Department or other regulatory authorities;
    - 3. Rebates paid to the Department if the PIHP exceeds the minimum MLR threshold for a prior year;
    - 4. Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the PIHP exceeds the minimum MLR threshold for a prior year; and
    - 5. The PIHP shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations.
  - iii. The PIHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
  - iv. The PIHP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting year.
  - v. All revenue, payments to providers and PIHP expenditures related to Tailored Care Management shall be incorporated into the MLR except as otherwise excluded in *Section IV.K. Financial Requirements*.
  - vi. The PIHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.
- d. If the PIHP's Department-defined MLR is less than the minimum MLR threshold, the PIHP shall do one (1) of the following:

- i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
    - ii. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources, the remaining portion to a rebate to the Department, with amounts for each PIHP subject to review and approval by the Department; or
    - iii. Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy, subject to approval by the Department.
  - e. The minimum MLR threshold for the PIHP shall be eighty-eight percent (88%).
  - f. The PIHP must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).
  - g. The PIHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PIHP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year or within thirty (30) Calendar Days of being requested by the PIHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).
  - h. In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the PIHP shall:
    - i. Re-calculate the MLR for all MLR reporting years affected by the change, and
    - ii. Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m); 42 C.F.R. § 438.8(k).
3. Financial Management
- a. The Department's financial management requirements were developed to monitor and promote program sustainability. PIHP shall be a good steward of Medicaid resources, focusing expenditures on services and benefits that improve member health. The Department will pay the PIHP a capitation payment that is set in an actuarially sound manner. The PIHP shall manage PIHP expenditures within the capitation payments and have access to sufficient capital to cover any losses the PIHP experiences.
  - b. The PIHP shall closely track and report their revenue and expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor PIHP expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.
  - c. Any financial arrangements between PIHPs and third parties should align with the parameters outlined in *Section IV.A.3. Readiness Review Requirements*.
  - d. Managing and Monitoring Cost Growth
    - i. The PIHP shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
    - ii. The Department shall monitor annual cost growth of PIHP expenditures by catchment area and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
    - iii. The PIHP shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth as outlined in *Section VI. Attachment I. Reporting Requirements*. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.

e. Reinsurance

- i. The PIHP shall have and maintain at all times an adequate plan for protection against insolvency, pursuant to the terms of this contract and N.C. Gen. 122C. Any reinsurance or alternative arrangement proposed by the PIHP is subject to review and approval by the Department due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. The agreement must provide that the Department will be notified no less than sixty (60) Calendar Days prior to cancellation or reduction of coverage. As long as the Plan for Protection Against Insolvency policies and procedures clearly state they apply to the PIHP, Plan for Protection Against Insolvency policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- ii. The PIHP shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk due upon request but no sooner than one hundred eighty (180) Calendar Days after Contract Execution. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify the PIHP of any required changes to the proposed reinsurance arrangement or alternative mechanism. The PIHP shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.
- iii. As long as the Reinsurance Arrangement policies and procedures clearly state they apply to the PIHP, Reinsurance Arrangement policies and procedures may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan contract.
- iv. The PIHP shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. The Department may require additional protections and documentation at any time.
- v. The Department reserves the right to revisit reinsurance requirements annually and to modify or establish the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that a specific threshold is deemed warranted by the Department.
- vi. The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a PIHP or its reinsurer within forty-five (45) Calendar Days of the request by the PIHP.
- vii. The PIHP shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the PIHP or the reinsurance carrier, the PIHP shall be fully responsible for all pending and unpaid claims.
- viii. Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include PIHP members as a covered class.
- ix. The PIHP shall notify the Department when the PIHP incurs a claim against the reinsurance policy.

f. Financial Viability

- i. The PIHP must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of this contract and N.C. Gen. 122C.
- ii. The PIHP must, by Day 1 of PIHP launch, fully fund PIHP capital reserves at twelve and a half percent (12.5%) of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined.
  - 1.If a PIHP fails to meet the Medicaid twelve and a half percent (12.5%) reserves requirement outlined in *Section IV.K.3. Financial Management* by Day 1 of PIHP launch,

- the PIHP must submit a viable plan outlining how the PIHP will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section IV.A.3. Readiness Review Requirements*.
2. For a PIHP to be considered viable at the time of readiness review and subsequently have their solvency plan evaluated, a PIHP must document capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined by Day 1 of PIHP launch.
- iii. The PIHP shall maintain capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined as determined from the monthly, quarterly, and annual financial reporting schedules.
    1. If a PIHP's capital reserves fall below 9.0% of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined in any quarterly statement, the PIHP must submit a report to the Department that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves, and projections of the impact of the corrective actions on the capital reserve levels.
    2. If a PIHP's capital reserves fall below 6.25 % of total expected annual BH IDD Tailored Plan and PIHP Medicaid capitation combined in any quarterly statement, the PIHP must submit a report to the Department as described in *Section IV.J.2. Encounters* for Department review. The Department reserves the right to stipulate required corrective action for the PIHP.
    3. If a PIHP capital reserves fall below 4.0 % of total expected annual BH I/DD Tailored Plan and PIHP Medicaid capitation combined in any quarterly statement, the Department reserves the right to place under the control of the regulator or initiate actions outlined in *Section IV.J.2. Encounters*.
  - iv. The Department will provide expected annual PIHP Medicaid Capitation revenue for use in these calculations. Medicaid capitation revenue will include monthly PMPM capitation payments but exclude all other managed care payments defined in *Section IV.G.2. Tailored Care Management* (i.e. Tailored Care Management payments.)
  - v. For purposes of the capital requirements, capital reserves are defined as unobligated assets net of liabilities.
  - vi. The LME/MCO must, be licensed as a PIHP as set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-25, if required by legislation.
  - vii. The PIHP shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current Assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%).
  - viii. If a PIHP's Current Ratio falls below 1.0 at any point in time, the PIHP must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.
  - ix. The PIHP shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the period measured in days.
  - x. If a PIHP's Defense Interval Ratio falls below thirty (30) Calendar Days at any point in time, the PIHP must submit a report to the Department that describes the reason for the decline,

proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.

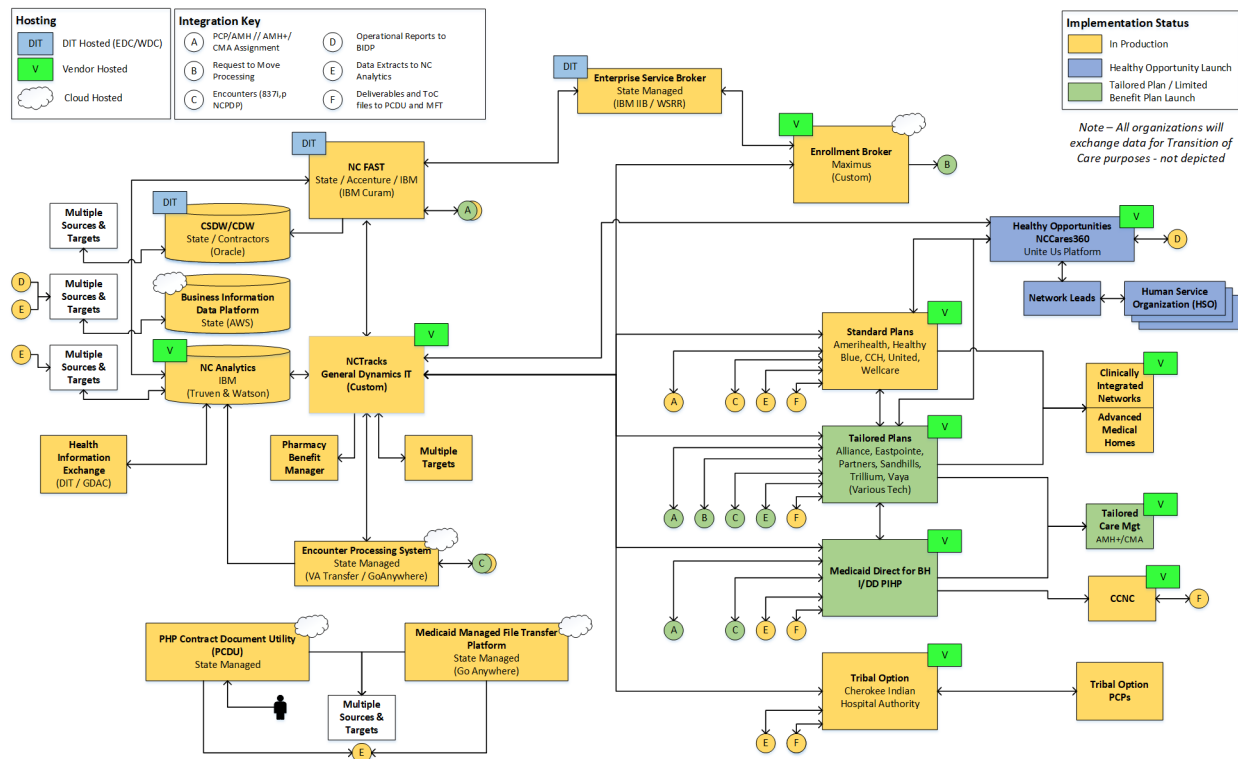
- xi. The PIHP shall comply with financial viability standards related to liquidity to pay Medicaid claims established by the Department.
  - xii. The Department may, at its discretion, implement a risk corridor program to provide additional protection to the PIHP and the Department to address any uncertainty associated with pricing or enrollment. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.
- g. Financial Accounting and Audit
- i. The PIHPs accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and this Contract. The Department will not recognize or pay services that cannot be properly substantiated by the PIHP and verified by the Department. The PIHP shall:
    - 1. Maintain accounting records for this Contract separate and apart from other corporate accounting records;
    - 2. Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
    - 3. Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the PIHP. The PIHP must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the PIHP;
    - 4. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts;
    - 5. Provide copies of the most recent annual audit within thirty (30) Calendar Days of certification, to verify the PIHP's financial status, solvency, and viability; and
    - 6. Provide copies of the PIHP's annual cost allocation plan for the Department's review at least sixty (60) Calendar Days prior to the start of the state fiscal year.
  - ii. The annual financial audit and cost allocation plans shall be subject to annual independent verification and audit by the Department or a firm(s) of the Department's choosing, in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A-87, as amended or superseded by 2 CFR Part 200—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (December 2013). All such audits shall be arranged to occur at dates and times that are mutually agreeable, and the PIHP shall be provided with reasonable notice of the Department's intent to perform, or cause to be performed, any such audits. The costs for such audits shall be the responsibility of the Department.
  - iii. The PIHP shall reimburse the Department, if reimbursement is sought, for reasonable costs incurred by the Department to perform examinations, investigations, audits, or other types of attestations the Department reasonably determines are necessary to ensure PIHP compliance with this Contract. The use and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are at the Department's sole discretion.

- iv. If, as a result of an audit or review of payments made to the PIHP, the Department discovers a payment error or overcharge, the Department will notify the PIHP of such error or overcharge. The Department will be entitled to recover such funds as an offset to future payments to the PIHP, or to collect such funds directly from the PIHP.
  1. The PIHP must return funds owed to the Department within thirty (30) Calendar Days after receiving notice of the error or overcharge, or interest will accrue on the amount due.
  2. The Department will calculate interest at twelve percent (12%) per annum, compounded daily. If an audit reveals that errors in reporting by the PIHP have resulted in errors in payments to the PIHP, the PIHP will indemnify the Department for any losses resulting from such errors, including the reasonable cost of audit.

## **L. Technical Specifications**

1. Data Exchange Model
  - a. The following diagram and matrix below provides a point in time, high-level view of the primary data exchanges associated with the PIHP, the Department, and Department Vendors. This is not the complete list of data that will need to be exchanged between the PIHP, NC DHHS, and NC DHHS vendors. As the program evolves and technical designs are finalized, the data exchanges included below will change. The PIHP will be responsible for implementing the data exchanges as defined by the Department. The Department anticipates changes to its Information Technology Systems. The PIHP will update its Information Technology Systems to conform with any updates to the Department's Information Technology System changes including, but not limited to, data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e., number of records per file). The Department will provide test environments to allow adequate testing time.
  - b. NC DHHS will require reporting on interfaces based on the priority of the interface (which is determined by the business units). This reporting will be in a standard format and facilitated thru Tech Ops. NC DHHS may require the reporting to be automated as part of the execution of the interface and delivered to NC DHHS via MFT or email, in a CSV or other pipe delimited format. The PIHP will comply with the requirements as defined by NC DHHS.





No.	Data Exchange Description – For Informational Purposes
1.	<p>The Department will send the PIHP the following data:</p> <ul style="list-style-type: none"> <li>a) Member Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records including validated and member selected PCP assignments. This file will be provided daily and weekly (for reconciliation purposes)</li> <li>b) Provider data including all Medicaid providers as well as affiliation data</li> <li>c) AMH+/CMA assignment data</li> <li>d) Acuity Tier data</li> <li>e) Lock-in Data – Member lock-in data (including pharmacy and prescriber) Managed Care Payments</li> <li>f) Member claims history including prior authorizations, claims, encounters, and other information as needed to support the enrollment and care of the member by the PIHP</li> <li>g) Managed Care Payments including an 820 and monthly 834 for payment reconciliation purposes</li> <li>h) Specialized data as needed for member care</li> <li>i) Member Acuity data for the provision of tailored care management</li> </ul>
2.	<p>The PIHP will send to the Department or its Vendors the following data:</p> <ul style="list-style-type: none"> <li>a) Encounter Data – Medical encounter data</li> <li>b) AMH/PCP Assignment – The PIHP will submit to the Department the Member’s assigned AMH/PCP</li> <li>c) Lock-in Data – Member lock-in data (including pharmacy and prescriber)</li> <li>d) Provider Network Data including All Contracted Medicaid Managed Care providers – The PIHP will send its network of Medicaid Managed Care providers to NCTracks to be used by NC DHHS</li> <li>e) Member Enrollment – On a monthly basis (or at the request of NC DHHS), the PIHP will send a complete roster of its Medicaid Managed Care Members in the format dictated by NC DHHS</li> </ul>

No.	Data Exchange Description – For Informational Purposes
	<ul style="list-style-type: none"> <li>f) Member Claims history including prior authorizations, claims, encounters, and other information as needed to support the enrollment and care of the Member by the PIHP as Member transition from the PIHP to other NC DHHS vendors, or to NC DHHS</li> <li>g) Member Risk Stratification Data</li> <li>h) Member Insurance Data</li> <li>i) Operational Data Extracts and Reports as dictated by NC DHHS</li> <li>j) Data to support Transition of Care as specified in the Transitions of Care requirements</li> </ul>
3.	<p>The PIHP will send the following data to the AMH+/CMA:</p> <ul style="list-style-type: none"> <li>a) Member Assignments</li> <li>b) Transition of care data as needed</li> </ul>
4.	<p>The PIHP and the Provider will exchange the following data:</p> <ul style="list-style-type: none"> <li>a) Claims Data – The contracted Providers will send claims data for payment to the PIHP.</li> <li>b) Payment Data – The PIHP will send payments to the provider.</li> </ul>
5.	<p>The PIHP will send data to the AMH+s/CMA/s or CINs or Other Partners on their behalf as described in <i>Section IV.G.2. Tailored Care Management.</i></p>

2. Electronic Data Submission

a. Electronic Data Interchange (EDI) and Other Integrations

- i. Integrations between the PIHP, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Execution. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.
- ii. The PIHP shall not transmit protected health information (PHI), or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 C.F.R. § 142.308(d).
- iii. If the PIHP stores, transmits, or maintains data or information in an encrypted format, the PIHP will, at the Department’s request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
- iv. The PIHP will work with the Department or its designated Vendor to establish and manage all integration.
- v. The PIHP will comply with all NC DHHS Technical Operations team processes and procedures. The following is a high-level overview of the Tech Ops processes and procedures. Upon Contract execution and prior to implementation, the Tech Ops team will provide an onboarding process which will detail all specific process and procedures PIHP will need to follow:
  - 1. Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. of the PIHP’s discovery of such. If the failure impacts the PIHP’s ability to deliver Member services, it must be reported immediately. NC DHHS provides a 24/7/365 number for incidents that require immediate response.
  - 2. The PIHP will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72)

hours after the resolution of the failure in a format defined by NC DHHS. The Department may require additional information if the initial RCA does not include adequate information.

3. The Department at its discretion will track issues reported by the PIHP and may require a more comprehensive corrective action plan if the Department identifies trends in the PIHP's performance.

b. Retransmissions

- i. If the PIHP receives an unintelligible transmission from the Department or Department vendor, the PIHP will immediately notify the Department via the Tech Ops team and the Department shall retransmit as soon as the errors are remediated.
- ii. If the PIHP is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the PIHP shall retransmit as soon as the errors are remediated.
- iii. For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e., corrupt data, unparseable xml, etc.), or is incomplete.

c. Test Data Transmission

The PIHP will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for Member enrollment prior to open enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the PIHP, or between the PIHP and other Department or PIHP vendors such as the other PIHPs. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.

3. Enrollment and Reconciliation

a. Member Enrollment and Reconciliation

i. Enrollment:

1. The PIHP shall accept an 834 eligibility file daily from the Department with new, modified, and terminated Member records.
2. The PIHP shall add, modify, or terminate Members daily based on 834 eligibility file within any defined SLA periods.

ii. Reconciliation:

1. The Department will provide to the PIHP a weekly 834 eligibility file, including all members who were added, modified, and terminated for the period.
2. The Department will collect on a monthly basis the full roster of Members for reconciliation purposes across all partners.
3. The PIHP at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
4. At the Department's request, the PIHP shall provide a full roster of Members currently enrolled in their PIHP in the Department's preferred format within seventy-two (72) hours.
5. The PIHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
6. The Department shall determine if corrections are needed to the enrollment data to address PIHP discrepancies identified during reconciliation.
7. The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the PIHP.

8. The PIHP shall add, modify, or terminate Members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
  9. The PIHP shall reconcile the monthly 820 payment file with the monthly 834 eligibility file.
  10. The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
  11. In addition to the reconciliation process defined above, the PIHP shall be able to identify duplicate Members and report those findings to the Department in a format defined by the Department.
- b. AMH+/CMA and Reconciliation
    - i. All AMH+/CMA assignments made by the Member at application will be transmitted to the PIHP by the Department via an 834 transaction.
    - ii. If no choice is made by the Member, the PIHP shall assign a PCP and transmit to the Department on a daily basis.
    - iii. The file format and layout will be defined by the Department. It is anticipated this will be a daily batch transaction.
    - iv. The PIHP shall reconcile AMH+/CMA data with the Department at least monthly using the monthly 834 file described above.
    - v. The PIHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
    - vi. The Department shall determine if corrections are needed to the AMH+/CMA data to address PIHP discrepancies identified during reconciliation.
  - c. Provider Enrollment and Credentialing
    - i. The Department or a designated vendor will provide to the PIHP a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment, affiliation, and credentialing information.
      1. During the Provider Credentialing Transition Period, the information will be provided daily, in a format and transmission protocol to be defined by the Department.
      2. After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the PIHP a notice of change to the frequency and format not less than one hundred twenty (120) Calendar Days prior to implementation.
        - i. The PIHP shall reconcile provider data with the Department, or designated vendor, daily.
        - ii. The PIHP is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
        - iii. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address PIHP discrepancies identified during reconciliation.
        - iv. The PIHP shall integrate the daily enrollment file sent by the department and apply any updates to their database.
        - v. The Department or designated vendor will provide the PIHP with a Response File after successfully receiving the PIHP's full network directory file daily.
        - vi. The PIHP shall accept the Response File from the Department or designation vendor daily, work to correct any errors within twenty four (24) hours, and provide notice to the Department of any discrepancy.
4. Provider Identification Numbers (NPIs, Atypical Providers)

- a. In accordance with requirements set forth in Sections 1932(d)(4) and 1173(b)(2) of the Social Security Act, the PIHP must use the registered NPI that the provider used to enroll with NC DHHS or the assigned Atypical number for those providers who do not qualify for an NPI and must require that providers use these identifiers when submitting data to the PIHP.
  - b. The Department produces a daily provider enrollment file that includes all active Medicaid providers, Medicaid providers terminated within the last year, and suspended Medicaid providers. PIHP is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.
5. Provider Directory
- a. NCTracks shall validate and integrate the provider directory information transmitted by the PIHP and supply the Enrollment Broker and NC Fast with a Consolidated Provider Directory to support PIHP choice counseling and selection.
    - i. The PIHP should use the National Provider Identifier (NPI) enrolled with the Department plus the assigned Service Location Code as the unique provider identifier. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by the Department's should be used.
    - ii. The PIHP shall ensure the Provider Directory aligns with the parameters laid out in *Section IV.A.3. Readiness Review Requirements*, if the PIHP delegates this activity to a Subcontractor.
    - iii. The PIHPs shall verify that all providers included in the Provider Directory are actively enrolled in NC Medicaid.
  - b. Consolidated Provider Directory Data Transmissions
    - i. The Department has designated a vendor to create a Consolidated Provider Directory which will include all North Carolina Medicaid and NC Health Choice enrolled providers.
    - ii. The PIHP will, at a frequency defined by the Department, create a full provider directory file including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The PIHP will deliver the file to the Department's designated vendor based on the Department's defined technical process.
    - iii. The final file format will be determined by the Department; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).
    - iv. The transport method will also be determined by the Department; however, it is also anticipated to be an industry standard method (SFTP, etc.).
    - v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration required.
    - vi. The PIHP will be provided with policies and process flows developed by the Department that defines the overall process.
6. Technology Documents
- a. The PIHP shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Execution. The Department may request additional information be made available or developed if the documentation is not satisfactory.
  - b. Security Documentation: The PIHP must comply with all State and NC DHHS security policy as outlined in the State and DHHS Security manuals. These manuals are available at the following link, accurate as of the date of execution of this Contract: [s.ncdhs and https://policies.ncdhhs.gov/departamental/policies-manuals/section-viii-privacy-and-security/manuals](https://policies.ncdhhs.gov/departamental/policies-manuals/section-viii-privacy-and-security/manuals). In compliance with this policy, the NC DHHS Privacy and Security Office and the Department of Information Technology require at a minimum three documents to be submitted by the PIHP. Two of the three documents as detailed below must be submitted using the State's templates. As long as the System Security Plan, Vendor Readiness Assessment Reports and SOC 2 Self-assessments clearly state that they apply to the PIHP, they may apply to other LME/ MCO operations, including, without limitation, the BH I/DD Tailored Plan contract.

- i. Vendor Readiness Assessment Report (VRAR) - The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the information system. The template for the VRAR can be accessed here: <https://it.nc.gov/documents/vendor-readiness-assessment-report>.
  - a. System Security Plan (SSP): The PIHP shall provide a plan that details how the PIHP will comply with the Department Confidentiality, Privacy and Security Protections requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above using the template provided by the Department. After approval by the Department, the System Security Plan shall be updated annually and resubmitted to the Department for review.
- ii. SOC 2 Type 2 Report – The PIHP must submit a completed Soc 2 Type 2 report on or before the end of Contract Year One. If the technology platform used to deliver the services under this contract has not been used in a production setting prior to the go live of the PIHP, a Self-Assessment must be performed on the technology platform and submitted in lieu of the Soc 2 Type 2. After a minimum of one hundred eighty (180) Calendar Days of production activity, a Soc 2 Type 2 assessment must be performed, and the resulting report submitted to the State. The Soc 2 Type 2 must be submitted within one year after PIHP go-live, then updated and submitted annually thereafter. If a Self-Assessment is required, it must be completed on the template provided by the NC DHHS Privacy and Security Office.
- c. Encounter Implementation Approach. The PIHP shall provide a plan that shows how the PIHP will implement its encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
  - i. Approach to meeting performance, accuracy, and timeliness requirements;
  - ii. Operating model including staffing and technology to process and submit encounters;
  - iii. Reference data management process including how the State’s reference data (if applicable) will be integrated into the encounter management process;
  - iv. Change management plan including how changes to the encounter submission infrastructure are tested and implemented; and
  - v. Quality assurance and process improvement processes including how errors detected by the State’s Encounter Processing System are addressed by the PIHP, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the PIHP’s processes.
- d. System Interface Design. The PIHP shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
  - i. Detailed design by interface showing the PIHP approach to meeting the requirements defined by the State;
  - ii. Approach to managing EDI transactions including technology;
  - iii. Technical integration architecture including the PIHP’s technical approach to integrating multiple internal systems with external partners;
  - iv. Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and

- v. Software and platform testing processes for new interfaces including the data management approach.
7. Testing
- a. System Test Plan. The PIHP shall develop and maintain a System Test Plan inclusive of the PIHP's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. The Test Plan shall be submitted to the Department annually at the end of each Contract Year by July 31 and otherwise upon request by the Department and shall include:
    - i. High level description of the scope of each testing phase;
    - ii. Applications or Systems that are part of the testing;
    - iii. Integrations that are part of the testing;
    - iv. Testing techniques or tools that will be used for testing;
    - v. Test Environment; and
    - vi. Test Metrics and Reporting of Defects.
  - b. The PIHP shall complete internal unit and integration testing and report status throughout the duration of the project.
  - c. The PIHP shall facilitate User Acceptance Testing with key state identified personnel as requested.
  - d. The PIHP will participate in all End-to-End testing with other Department partners as directed by the Department. This will include End-to-End testing prior to launch and may include periodic End-to-End testing as other technical processes and systems are modified or brought online.
  - e. The PIHP will maintain dedicated test environments adequate to support multiple testing workstreams concurrently, for example multiple concurrent cycles of internal testing and End to End Testing. In addition, for the End-to-End environment and testing specifically, the PIHP will maintain a test environment provisioned with the same security controls that are required by the Department's Privacy and Security Office for production environments. This may include but is not limited to encryption of data at rest, production like authentication and authorization processes (e.g., dedicated user IDs, password policies, etc.), and appropriate scanning and intrusion detection. As part of -End-to--End testing, this environment will need to support and secure production data including production volumes.
  - f. The PIHP will leverage the Department's test management platform (currently Microfocus ALM) as the test management system to document test procedures as part of End-to-End testing. This requirement does not preclude the PIHP from using their own test management platform in addition to the Department platform for all phases of testing.
8. PIHP Data Management and Health Information Systems
- a. The following Section contains high-level information on Health Information System and member data that will be established, maintained, analyzed, and reported by the PIHP. Specific details on the data, analysis, and reporting will be provided upon Contract Effective Date.
    - i. The PIHP shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for the PIHP's operations as well as satisfying the reporting requirements detailed in this Contract which may include but are not limited to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
    - ii. The PIHP shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

- iii. The PIHP shall collect and maintain data on Member and provider characteristics and interactions as specified by the Department and on all services furnished to members through a claims processing system or other methods as specified by the state.
- iv. All data, reports, and information submitted by the PIHP on behalf of the providers (including providers within or outside of its networks) shall be validated by the PIHP as accurate and complete prior to submission.
- v. The PIHP shall collect data from providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
- vi. The PIHP shall make all collected data available to the Department and upon request to CMS.
- b. North Carolina’s Health Information Exchange
  - i. The PIHP shall submit encounters and claims to North Carolina’s Health Information Exchange, known as NC HealthConnex, as required by Article 29B of Chapter 90 of the NC General Statutes, the Statewide Health Information Exchange Act.
  - ii. Pursuant to N.C. Gen. Stat. § 90-414.4(a1) (3), the PIHP may authorize the Department to submit the required data NC HealthConnex on behalf of the PIHP.
- c. Test Environments
  - i. The PIHP shall have at least two (2) dedicated testing environments – one (1) for Systems Integration Testing, and one (1) for -End-to--End testing. The environments shall use the appropriate data sets (production or synthetic) as defined by the Department.
  - ii. The PIHP shall ensure test environments are compliant with all security requirements defined by North Carolina State and the Department’s Privacy and Security Office to support testing with production data.
  - iii. The PIHP shall have test environments available and configured within one hundred twenty (120) Calendar Days of the Department’s written notice.
  - iv. The PIHP shall have the ability to refresh test environments from production data as needed for testing, as well as the ability and capacity to ingest production sized files with limited to no down time.

**M. Innovation Waiver Services**

- 1. The PIHP shall provide Innovation Waiver services for federally recognized tribal members and Indian Health Services (IHS) eligible beneficiaries enrolled in North Carolina’s 1915(c) Innovations Waiver. The PIHP shall provide Innovation Waiver services to eligible Members in accordance with this Section. The requirements of this Section shall only apply if the PIHP has a federally recognized tribal member and IHS eligible beneficiary enrolled in the Innovations Waiver who did not select to enrolled in the BH I/DD Tailored Plan.
  - a. Covered services:  
 PIHP shall cover Innovations Waiver services identified in *Section IV. M. Table 1: Innovation Waiver Services* contingent on CMS approval of 1915(c) Waiver renewals and authorization of funding by the General Assembly.

<b>Section IV. M Table 1: Innovations Waiver Services</b>	
• Assistive Technology Equipment and Supplies	• Natural Supports Education
• Community Living and Support	• Residential Supports
• Community Navigator	• Respite
• Community Networking	• Supported Employment
• Community Transition	• Specialized Consultation



<ul style="list-style-type: none"> <li>• Crisis Services</li> <li>• Day Supports</li> <li>• Financial Support Services</li> <li>• Home Modifications</li> <li>• Individual Goods and Services</li> </ul>	<ul style="list-style-type: none"> <li>• Supported Living</li> <li>• Supported Living - Periodic</li> <li>• Supported Living – Transition</li> <li>• Vehicle Adaptations</li> </ul>
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2. Utilization Management

- a. UM policy for Innovations Waiver members:
  - i. The PIHP shall use the NC Innovations level of care assessment tool to determine whether a Member meets the level of care required by the Innovations Waiver.
  - ii. The PIHP shall utilize a NC Medicaid-approved template to notify Members enrolled in the Innovations Waiver of the results of any new Supports Intensity Scale® (SIS®) evaluation and to inform Members in writing of the opportunity and process for:
    - a. Raising concerns regarding SIS® evaluations and results, and
    - b. Filing a Grievance regarding SIS® evaluations and results.
  - iii. The process for raising concerns shall include an opportunity to discuss the results of the SIS® evaluation with the PIHP and the potential for the results to be adjusted if it is determined, that the particular needs of the individual were not accurately captured.
  - iv. The failure to request a Grievance shall not waive the Innovations Waiver Member’s ability to argue that the results of the SIS® evaluation are incorrect in requesting of services, or during reconsideration review or the State Fair Hearing.
  - v. The PIHP shall ensure that the SIS® is used to guide the development of the ISP, and that the results of the SIS®, or any other similar evaluation, are not the sole basis for limiting the services requested or approved. The PIHP may use the SIS® in conjunction with other information to reduce or deny requested services.
    - i. The PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations Waiver Member and that such desires are reflected in the Innovations Waiver member’s ISP, including the desired type, amount, and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section IV.M.3. Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver* for additional details.
      - i. The member’s care manager based in a PIHP, AMH+ or CMA shall discuss with the Member the duration of the services expected by the Member and shall ensure that proposed ISP request authorization for each service at the duration requested by the member during the ISP plan year.
      - ii. The Member’s care manager shall assist the Member in developing an ISP and shall explain options regarding the services available to the member.
    - ii. The PIHP shall inform Innovations Waiver Members that they may make a new request for services at any time by requesting an updated ISP.
    - iii. Care Managers based in a PIHP, AMH+ or CMA may not exercise prior authorization authority over the ISP.
    - iv. The PIHP shall issue prior authorizations for all services covered under the Innovations Waiver according to the requirements set forth in the service definitions that will be established by the Department.
    - v. If the PIHP authorizes a requested service for a duration less than the duration requested in the ISP, the PIHP shall provide written notice with appeal rights and clinical reasons for the decision at the time of the limited authorization.

- vi. If the PIHP denies a request for authorization of services by a member, 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 a member must not prevent any authorized services from being provided pending the outcome of the Appeal.
    - ii. PIHP must not prevent the member from making a new request for services during a pending Appeal.
  - vii. The PIHP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all members 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 a member's right or decision to file or pursue a Grievance or request an Appeal.
  - viii. The PIHP shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver member and that such desires are reflected in the Innovations waiver member's ISP, including the desired type, amount, and duration of services.
  - ix. The PIHP shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to the Innovations waivers and other trainings relevant to due process procedures, whether related to the waiver or otherwise.
  - x. The PIHP may terminate a Member from participation in the Innovations Waiver based upon the following circumstances:
    - i. The Member's or Member's personal representative's fails to comply with the requirements set forth in the Innovations Waiver as approved by CMS;
    - ii. The member no longer meets the Level of Care criteria stipulated in the Innovations Waiver; or
    - iii. For other reasons explicitly authorized in the Innovations Waiver approved by CMS.
  - xi. Prior to the termination of a member from the Innovations Waiver, the PIHP must notify the Department of its decision. Termination of Innovations Waiver participation is considered an adverse benefit determination.
3. Tailored Care Management
- a. Eligibility for Tailored Care Management
    - i. All Members enrolled in the Innovations Waiver are eligible for Tailored Care Management, with the following exceptions for Members participating in services that are duplicative of Tailored Care Management:
      - i. Members receiving Assertive Community Treatment (ACT);
      - ii. Members participating in Care Management for At-Risk Children (CMARC);
      - iii. Members obtaining care management from the Department's PCCM vendor;
      - iv. Members participating in the High-Fidelity Wraparound program as described in *Section IV.G.7 Other Care Management Programs*; and
      - v. Tailored Care Management shall incorporate all Innovations Waiver care coordination activities, as required in the Innovations Waiver.
    - i. Enrollment in Tailored Care Management
      - a. The PIHP shall enroll and disenroll Innovation Waiver Members eligible for Tailored Care Management into Tailored Care Management as required in *Section IV.G.2. Tailored Care Management*.

- b. The PIHP shall auto-enroll new members who obtain an Innovations Waiver slot after PIHP launch into Tailored Care Management if they are not already enrolled in Tailored Care Management. The PIHP shall send new Waiver enrollees information about Tailored Care Management and the option to opt out with the materials informing them of their Waiver slot.
  - c. The PIHP must auto-enroll all current Innovations Waiver enrollees in Tailored Care Management.
    - 1. Innovations Waiver enrollees may opt out of Tailored Care Management.
    - 2. Innovations Waiver enrollees who have opted out of Tailored Care Management shall still receive care coordination as described in *Section IV.G.3. Care Coordination and Care Transitions for all Members* and Innovations Waiver care coordination as described in *Section IV.M. Innovation Waiver Services*
  - d. In cases where a member enrolled in the Innovations Waiver opts out of Tailored Care Management, the PIHP must provide the Innovations Waiver care coordination services as stipulated by the Innovations Waiver.
- ii. Tailored Care Management Assignment
- a. The PIHP shall ensure that all eligible Members enrolled in the Innovations Waiver have a choice of organization where they obtain Tailored Care Management.
  - b. The PIHP shall consider the following factors when assigning each Member enrolled in the Innovations Waiver to care management at an AMH+ practice or a CMA, or at the PIHP level:
    - 1. If the member enrolled in the Innovations Waiver has an existing relationship with an LME/MCO care coordinator who meets the Tailored Care Management qualifications and training requirements as described in *Section IV.B.3. Staff Training* and is employed by the member's PIHP or in the PIHP's network, the PIHP must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.
    - 2. The PIHP shall assign members enrolled in the Innovations Waiver to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) Waiver enrollees. 42 C.F.R. § 431.301(c)(1)(vi). The PIHP shall ensure that members do not obtain both 1915(c) Waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.
- iii. Development of Care Plan/Individual Support Plan (ISP for Members Engaged in Tailored Care Management)
- a. The PIHP shall ensure that each Care Plan/ISP for Innovations members meets the requirements of *Section IV.G.2 Tailored Care Management* incorporates results of SIS® screening and/or level of care determination tool, unless modified by the Department.
- iv. Additional Tailored Care Management Requirements for Members Enrolled in the Innovations Waiver
- a. For members who were enrolled in the Innovations Waiver prior to PIHP launch and engage in Tailored Care Management:
    - 1. If the member's ISP annual update is in the first six (6) months of Year 1 of PIHP launch, the PIHP shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment prior to completing the ISP.
    - 2. If the member's annual update is in the second half of Year 1 of PIHP launch, the PIHP shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment according to the timeframes described in *Section IV.G.2. Tailored Care Management*. The PIHP shall ensure that the organization providing Tailored Care Management completes the

- care management comprehensive assessment prior to the annual update, and in subsequent years, aligns the timing of the reassessment with the ISP annual update.
3. The ISP developed prior to PIHP launch will continue to serve as the ISP under Tailored Care Management in Year 1 of PIHP operation, until updated.
  4. The PIHP must ensure that the ISP is aligned with Tailored Care Management requirements at the member's next annual update (during the month before the individual's birth month), after a triggering event or at the member's request.
  5. Prior to the annual update, the member's care management comprehensive assessment results may be used to amend the ISP if appropriate, but a full update is not required.
- b. If the member is enrolled in the Innovations Waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall adhere to, whichever is higher in frequency and modality (e.g., number of in-person contacts):
    1. The contact requirements found in the 1915(c) Waiver, or
    2. The contacts noted in *Section IV.G.2. Tailored Care Management*.
  - c. For Innovations Waiver enrollees, the PIHP shall ensure that results of the SIS<sup>®</sup> are shared with the member's care manager in an electronic format to aid completion of the care management comprehensive assessment.
- v. **Additional Staffing and Training Requirements for Care Managers Delivering Tailored Care Management to Innovation Waiver members**
    - a. Current Innovations Waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.
  - vi. **Additional Oversight of Tailored Care Management for Innovation Waiver members**
    - a. For Innovations Waiver members engaged in Tailored Care Management, the PIHP must ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) Waiver as described further in *Section IV.G.2. Tailored Care Management*. 42 C.F.R. § 441.301(c)(1)(vi).
  - vii. **Additional Care Coordination Functions for Members Enrolled in the Innovations Waiver**
    - a. In cases where a member enrolled in the Innovations Waiver opts out of Tailored Care Management, the PIHP must provide the Innovations Waiver care coordination services as stipulated by the Innovations 1915(c) Waiver and in alignment with the requirements of 42 C.F.R. § 438.208(c).
      1. The PIHP shall ensure that Innovations Waiver care coordination services are performed by a care manager meeting the following qualifications:
        - i. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area;
        - ii. Two (2) years of experience working directly with individuals with I/DD; and
        - iii. Two (2) years of prior Long Term Service and Support (LTSS) and/or Home and Community-Based Services (HCBS) coordination, care delivery monitoring and care management experience.
    - b. The Department will not make a Tailored Care Management payment to the PIHP for members who opt out of Tailored Care Management, as described in *Section IV.H.4. Provider Payments*.
    - c. For all members enrolled in the Innovations Waiver, regardless of whether they engage in Tailored Care Management, the PIHP shall ensure that Waiver care coordination includes:
      1. Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:

- i. The PIHP shall ensure that the member's care manager convenes a person-centered planning meeting and completes the ISP. This is done after the member is administered the SIS® and the level of care determination for initial plans of care.
  - ii. If applicable, the PIHP shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the PIHP.
  - iii. The PIHP shall review ISP for Waiver compliance, medical necessity, and the member's health and safety needs.
  - iv. The PIHP shall approve or deny the ISP within standard service authorization periods except for in the case of initial plans which must be received within sixty (60) Calendar Days of level of care determination. In the case where services are needed more immediately, an interim plan of care may be completed so that services may be approved with the full ISP being completed afterwards and within the sixty (60) Calendar Days of level of care determination.
  - v. The PIHP shall ensure that Waiver services begin within forty-five (45) Calendar Days of ISP approval.
2. Monitoring and contact requirements found in the 1915(c) Waiver.
3. Explaining the individual budgeting tool, the service authorization process and the mechanisms available to the member/legally responsible person (LRP) to modify their budget.
4. Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the ISP, including providing a list of available providers and arranging provider interviews.
5. Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal.
6. Maintaining close contact with the member/LRP (if applicable), providers and other members of the ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
7. Informing the member/LRP of the option to participate in individual-directed/family-directed supports.
8. Assisting in the appointment of the representative for self-direction, as needed.
9. Assessing the employer of record, managing employer and representative, if applicable, to determine the areas of support needed to self-direct services.
10. Promoting the delivery of services and supports in the most clinically appropriate, integrated setting.
11. Completing annual reassessment of the member's level of care.
12. Ensuring that the member/LRP completes the Freedom of Choice statement annually.
13. Completing the NC Innovations Risk/Support Needs Assessment / or other approved assessment, prior to the development of the ISP and updating at least annually or as significant changes occur with the member.
14. Providing timely notification to PIHP utilization management of updates to the level of care determination and timely processing of updates to the ISP.
15. Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan.
16. Monitoring of service delivery to verify that:

- i. At least one (1) service is utilized monthly, per Innovations Waiver requirements, with the exception of children under the age of twenty-one (21) with a diagnosis of autism spectrum disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD.
        - ii. Services are furnished in accordance with the ISP.
        - iii. Member is offered a choice of Waiver service providers.
        - iv. Member has access to services and services meet the member's needs.
        - v. Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/exploitation, backup staffing) and non-Waiver service needs (medical care) are addressed and documented as appropriate.
        - vi. Services utilized do not exceed authorization.
        - vii. Member is satisfied with the services being rendered.
        - viii. Services are compliant with HCBS final rule as applicable.
      - d. The PIHP shall notify the member's provider and AMH+ practice or CMA (if applicable) of authorization decisions.
  - viii. In-Reach and Transition from Institutional Settings
    - a. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
  - ix. In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State
    - a. The PIHP shall be responsible for providing transition services for Members residing in ICF-IIDs not operated by the state. Transition activities for Members residing in ICF-IIDs not operated by the state must include, at a minimum:
      - 1. For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
  - x. Care Management and Care Coordination Policy
    - a. The PIHP shall submit its policies and procedures for Innovation Waiver members part of its Care Management and Care Coordination Policy (*Section IV.G.9. Care Management and Care Coordination Policy*). As long as the Care Management and Care Coordination Policy clearly states that it apply to the PIHP, the Care Management and Care Coordination Policy may apply to other PIHP operations, including without limitation the BH I/DD Tailored Plan Contract.
- b. Innovation Waiver Services
- i. The PIHP shall ensure that Innovations providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and requirements set forth by the Department.
  - ii. Provider agencies shall comply with the applicable provider specifications for services set forth in the Innovations Waiver.
  - iii. For Beneficiaries enrolled in the Tribal Option for primary care case management who also receive services through the Innovations Waiver, Innovations Waiver services shall be provided by the PIHP operating in the Tribal Option service area. The PIHP shall coordinate with the Tribal Option to ensure the receipt and coordination of appropriate services.
  - iv. National accreditation is required of most providers of Innovations Waiver services per the NC Innovations Waiver. Upon contracting with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the Waiver. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
- c. Engagement with Innovations Waiver Members

- i. The PIHP shall develop stakeholder group(s) consisting of Innovations Waiver members, families, advocates, and providers to provide recommendations regarding implementation and operation of Innovations Waiver services and policies. Stakeholder group(s) may be shared across and inclusive of both this product and the Behavioral Health I/DD Tailored Plan.
- ii. The PIHP shall meet with this stakeholder group(s) at least on a quarterly basis. Meetings may be virtual, in-person, or hybrid.
- iii. The PIHP shall keep meeting minutes and attendance records for each of these stakeholder meetings. PIHP shall make these records available for review by Department and shall report on these efforts during the regular sessions between the PIHP and the Department. These records should be submitted on a regular basis as defined by the Department, with a quarterly minimum
- iv. The PIHP shall ensure that this stakeholder group(s) has representation from federally recognized tribal members.
- v. Stakeholder group(s) may be shared across and inclusive of both this product and the Behavioral Health I/DD Tailored Plan.

## V. Contract Performance

### A. Contract Compliance and Performance

1. The PIHP shall comply with all terms, conditions, requirements, performance standards as set forth in the Contract and any amendments thereto, including any rules, policies, or procedures explicitly incorporated into the Contract, as well as all applicable laws, rules, and regulations.
2. The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity including but not limited to, remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the PIHP has violated any provision of the Contract, or if the PIHP does not comply with any other applicable North Carolina or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract, which shall include, but may not be limited to the following (42 C.F.R. § 438.702(b)):
  - a. Fails substantially to provide medically necessary covered services;
  - b. Imposes on Members premiums or cost share that are in excess of the premiums or cost share permitted by the Department;
  - c. Acts to discriminate among members on the basis of their health status or need for health care services;<sup>4</sup> this includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3);
  - d. Misrepresents or falsifies information that it furnishes to CMS or to the State;
  - e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or provider;
  - f. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information; and

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<sup>4</sup> This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3).

- g. Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.
3. Risk Level Assignment
- a. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or of applicable law (each considered a "Violation"), the Department shall assign the Violation into one of four risk levels:
    - i. Level 1: Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care or services; and/or jeopardize the integrity of Medicaid or NC Health Choice Services.
    - ii. Level 2: Action(s) or inaction(s) that jeopardize the integrity of Medicaid or NC Health Choice Services but does not necessarily jeopardize Members' health, safety, and welfare or reduces access to care.
    - iii. Level 3: Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid or NC Health Choice Services.
    - iv. Level 4: Action(s) or inaction(s) that inhibit the efficient operation of Medicaid or NC Health Choice Services.
  - b. The Department's decision to impose specific remedial action(s), intermediate sanction(s) and/or liquidated damages against the PIHP will include consideration of some or all of the following factors:
    - i. Risk Level assignment;
    - ii. The nature, severity, and duration of the violation;
    - iii. The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, Program Integrity);
    - iv. Whether the Violation resulted from negligent or willful conduct;
    - v. Whether the violation (or one that is substantially similar) has previously occurred;
    - vi. The timeliness in which the PIHP self-reports a violation;
    - vii. The PIHP's history of compliance;
    - viii. The good faith exercised by the PIHP in attempting to stay in compliance (including self-reporting by the PIHP); or
    - ix. Any other factor the Department deems relevant based on the nature of the violation.
    - x. The Department may impose additional remedial actions, intermediate sanctions, or liquidated damages if the same noncompliant behavior continues, or if the PIHP fails to comply with the originally imposed action.
    - xi. The Department also may elevate the violation to a higher Risk Level if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.
  - c. Additional detail on risk level assignment is included in *Section VI. Attachment J. Risk Level Matrix*.

## **B. Notice of Deficiency**

1. Except for the appointment of temporary management imposed pursuant to the Contract, the Department shall provide the PIHP with written notice of any remedial action, intermediate sanction, or liquidated damages against the PIHP or termination of the Contract for cause, detailing the nature of the Violation or noncompliance, the risk level assigned to the Violation, any actions the Department seeks to impose against the PIHP, and, if applicable, the method and timeframes by which the PIHP may dispute the claim of the Violation or noncompliance and the imposed actions.
2. Within three (3) Business Days of full remediation of the identified Violation(s) in the Notice of Deficiency, or within another timeframe as requested by the Department, the PIHP shall provide the



Department with written notice confirming the date that the Violation or noncompliance was resolved and the actions the PIHP took to remediate the Violation or noncompliance.

## C. Remedial Actions

1. **Remedial Actions:** Prior to the imposition of intermediate sanctions or liquidated damages or contemporaneously with, if the Department, in its sole discretion, determines that the PIHP is in violation of the Contract or any other applicable law, the Department may require the PIHP to take or to engage in the following remedial actions to address identified violation(s) or other noncompliance:
  - a. Immediate remediation of the Violation or non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the Violation or noncompliance;
  - b. Submission and implementation of a Corrective Action Plan; or
  - c. Participation in additional education or training.
2. **Corrective Action Plans (CAPs):** PIHP shall accept and implement a Department defined CAP or develop a CAP for Department approval as required in this Section.
  - a. Following notification of the original Violation giving rise to the CAP, the PIHP shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the Violation until an approved CAP is implemented.
  - b. Any CAP required to be submitted by the PIHP shall, at a minimum, identify the following:
    - i. The Violation or finding resulting in a request for corrective action by the Department;
    - ii. A description of how the Violation or finding resulting in a request for corrective action will be remediated;
    - iii. The timeline for the implementation and completion of each corrective action(s) included in the CAP; and
    - iv. The name of the responsible person(s) who will lead each of the corrective action activities and the person responsible for the overall implementation of the CAP.
  - c. Any CAP submitted by the PIHP shall be subject to approval by the Department.
  - d. The PIHP shall submit the CAP within fifteen (15) Calendar Days, or another timeframe as determined by the Department depending on the nature of the Violation, from the date of the Notice of Deficiency requiring the CAP.
  - e. Upon receipt, the Department may accept the CAP as submitted, accept the CAP with specified modifications, or reject the CAP.
  - f. If the Department requests modifications or rejects the CAP, the PIHP shall revise or submit a new CAP within ten (10) Calendar Days, or, depending on the nature of the violation, within a timeframe determined by the Department that addresses the concerns identified.
  - g. The PIHP shall complete the corrective action(s) contained in the CAP within the time period approved by the Department.
  - h. The PIHP shall provide updates to the Department on the implementation of the CAP and the remediation of the findings resulting in the CAP at the interval requested by the Department.
3. **Effective Date of Remedial Actions**
  - a. The effective date for any required remedial action is the date of the written Notice of Deficiency. Any time frames regarding Contractor action will be calculated from the date of the Notice of Deficiency.
  - b. A remedial action is not contestable under the dispute resolution process described in this Section, and the PIHP shall be required to complete the remedial action within the timeframe provided in the Notice of Deficiency, except for a requirement to submit and implement a CAP that shall be completed in accordance with Contract requirements.

## D. Intermediate Sanctions

1. **Imposition:** If the Department, in its sole discretion, determines that the PIHP is in violation of the Contract or any other applicable law, the Department may impose the following intermediate sanctions against the Contractor:
  - a. Suspension, recoupment, or withholding of payment;
  - b. Suspension of all or part of marketing activities;
  - c. Suspension of part of the Contract;
  - d. Exclusion from participation in Medicaid;
  - e. Any other additional sanctions allowed under North Carolina or federal law or regulation;
  - f. Civil Monetary Penalties (CMP) in accordance with 42 C.F.R. § 438.704;
  - g. Appointment of temporary management of the Contractor in accordance with 42 C.F.R. § 438.706(a) and 122C-125;<sup>5</sup>
  - h. Notification to members of their right to terminate their enrollment with the Contractor without cause; or
  - i. Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction.
2. **Effective Date of Intermediate Sanctions**
  - a. If the PIHP elects not to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next Calendar Day following the expiration of the period to dispute or such other date determined by the Department and included in the written Notice of Deficiency.
  - b. If the PIHP elects to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next Calendar Day of the date on the written final decision issued by the Department.
  - c. The Department shall not be required to delay the appointment of temporary management to provide the PIHP the opportunity to dispute the imposition of the sanction before imposing temporary management. The Department shall not terminate temporary management until it determines that the PIHP can ensure that the noncompliant behavior resulting in the temporary management will not reoccur.

## E. Liquidated Damages

1. If the PIHP is determined by the Department, in its sole discretion, to be in violation with the terms, conditions, requirements, and/or performance standards of the Contract, it is presumed by the PIHP that the Department will be harmed, and the Department shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.
2. The actual damage sustained by the Department as a result of the PIHP's failure to meet the requirements of this Contract will be extremely difficult or impossible to ascertain with precise accuracy. Therefore, the Department and the PIHP agree that if the PIHP is in violation of the terms, conditions, requirements and/or performance standards of the Contract, the Department may assess liquidated damages against the PIHP in accordance with the Contract, up to a maximum of the total capitation payment received for that Contract Year.

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<sup>5</sup> If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. Part 438, the Department will notify affected members of their right to terminate enrollment in the Contractor without cause.

3. Following receipt of a Notice of Deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract until such time as the Department, in its sole discretion, determines the Violation(s) has been cured.
4. The Department, in its sole discretion, reserves the right to assess a general liquidated damage in an amount commensurate with the Violation, as applicable, for any violation not specifically listed in *Section VI. Attachment N. Performance Metrics, Service Level Agreements and Liquidated Damages*.
5. Liquidated damages assessed by the Department do not affect the Contractor's rights or obligations with respect to any third-party including beneficiaries or providers.

## **F. Payment of Liquidated Damages and other Monetary Sanctions**

1. If the PIHP elects not to dispute the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within fifteen (15) Calendar Days of the date of the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.
2. If the PIHP elects to dispute the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages or other monetary sanctions shall be due and payable within ten (10) Calendar Days of the date on the written notice of the final decision issued by the Department upholding its original decision to impose the liquidated damages or other monetary sanctions (including a final decision modifying the amount owed).
3. If the PIHP fails to pay liquidated damages or other monetary sanctions by the applicable due date, the PIHP shall be subject to interest and a late payment penalty in accordance with N.C. Gen. Stat. § 147-86.23 and N.C. Gen. Stat. § 105.241.21 until the past due amount is paid.
4. The Department shall reserve the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount (including interest and late payment penalties) from future payments owed to the PIHP. The Department shall provide written notice to the PIHP at least 10 days prior to withholding a portion of the payment for assessed liquidated damages or other monetary sanctions. Actions taken by the Department to withhold a portion of a capitation payment for assessed liquidated damages or other monetary sanctions shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a).

## **G. Dispute Resolution for Contract Performance**

1. The PIHP shall exhaust the dispute resolution process described in this Section to dispute the imposition of intermediate sanctions, the assessment of liquidated damages, CMPs, and/or for cause termination of the Contract whether pursuant to 42 C.F.R. § 438.708 or otherwise by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the PIHP under North Carolina or federal law or regulation.
2. The PIHP shall have the right to dispute certain contract performance actions by the Department, including the imposition of CAPs, intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the PIHP shall not have the right to dispute the Department's decision to require the PIHP to perform a remedial action.
3. **Dispute Resolution Procedures**
  - a. To initiate a dispute, the PIHP shall submit a written request for a dispute resolution within fifteen (15) Calendar Days of the date of the Notice of Deficiency imposing the Department's intended action. The Department may extend the PIHP's deadline to request dispute resolution for good cause if the PIHP requests an extension within ten (10) Calendar Days of the date on the written notice.

- b. The PIHP shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
  - c. The PIHP waives any dispute not raised within thirty (30) Calendar Days of the date of the Notice of Deficiency unless the Department grants an extension.
  - d. The PIHP also waives any arguments, materials, data, and information it fails to raise in writing within fifteen (15) Calendar Days (unless the Department grants an extension) of the date of the Notice of Deficiency for dispute resolution and in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
  - e. The Department shall review the dispute resolution request and any evidence and information submitted and issue a written final decision within sixty-five (65) Calendar Days of the PIHP's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the PIHP of any extension and the reason for such extension.
  - f. The final decision issued by the Department following dispute resolution shall not be subject to further review or appeal within the Department.
4. **Hearing Prior to Termination of Contract with Cause**
- a. The PIHP shall be entitled to a hearing only in the event that the Department seeks to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the Termination for Cause Section of the Contract.
  - b. At least fifteen (15) Calendar Days prior to the hearing, the PIHP shall receive written notice of the hearing that includes the date, time, place, nature of the hearing, and whether the hearing shall be held in-person or by telephone.
  - c. The hearing may be conducted even if the PIHP fails to appear at the hearing after receiving proper notice.
  - d. At the hearing, the burden shall be on the PIHP to demonstrate that the Department's decision to terminate the Contract with cause pursuant to 42 C.F.R. § 438.708 should be reversed.
  - e. Following the hearing, the PIHP shall receive a written final decision within sixty-five (65) Calendar Days of the date of the scheduled hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, the Contractor shall be notified of the extension and the reason for such extension.
  - f. In a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to the PIHP and give the Contractor's members notice of the termination and information, consistent with 42 C.F.R. § 438.10, of their options for receiving Medicaid after the Contract is terminated.
5. **Legal Representative:** The Department and the PIHP may be represented by legal counsel throughout the dispute resolution process.

## H. Notice to External Agencies

1. The Department shall provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) Calendar Days after the Department imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.
2. The Department shall provide notice as required by law to any other state or federal agency for Violations of the terms, conditions, or requirements of this Contract or applicable laws or regulations by the PIHP.

## **I. Publication of Contract Compliance Issues**

1. The Department may publish on its website on a quarterly basis a list of Contractors subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the risk level assigned to Violation(s), the type of actions imposed on the Contractor, and the basis for the actions taken by the Department.
2. The Department shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by the Department.

## **J. Right to Waive or Modify**

The Department, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor for any good cause as determined by the Department, which includes the right of the Department to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve the underlying Violation that resulted in the action taken by the Department.

## **K. Performance Standards and Service Level Agreements**

1. The Department has established performance standards for the measures listed in Tables 3-5 of *Section VI. Attachment N: Performance Metrics, Services Level Agreements and Liquidated Damages* and corresponding liquidated damages for any performance standard that is not met.
2. The PIHP shall meet the requirements of the Contract, including the performance standards and service level agreements specified in *Section VI. Attachment N: Performance Metrics, Service Level Agreements and Liquidated Damages*.
3. If the PIHP fails to meet any performance standard, the Department may assess liquidated damages as provided in *Section V. Contract Performance*, and impose any other remedial action or intermediate sanction, in accordance with *Section V. Contract Performance* for the period in which the deficiency occurs and until the Department, in its sole discretion, determines the deficiency has been cured.

## **L. Withholds**

1. The PIHP shall participate in the Department's withhold program.
2. The withhold program will conform to 42 C.F.R. § 438.6.
3. The withhold program applicable to PIHP will be effective at a date determined by the Department.

## Contract Execution

By signing below, the Parties execute this Contract in their official capacities and agree to all terms, conditions, provisions, and requirements of the Contract.

**XXX (PIHP NAME)**

\_\_\_\_\_  
**XXX (NAME AND TITLE)**

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Dave Richard, Deputy Secretary

\_\_\_\_\_  
Date

## VI. Contract Attachments A-W

### Attachment A. PIHP Organization Roles and Positions

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

Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1. Supervising Care Managers	<p>These individuals are responsible for overseeing assigned care managers delivering Tailored Care Management and care coordination.</p> <p>These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs.</p> <p>These individuals are responsible for ensuring fidelity to the Tailored Care Management model.</p>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• If serving Members with BH conditions, must:               <ul style="list-style-type: none"> <li>○ Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT) or licensure as a Registered Nurse (RN)</li> <li>○ Have three (3) years of experience providing care management, case management, or care coordination to the population being served</li> </ul> </li> <li>• If serving Members with an I/DD or TBI, must have one (1) of the following:               <ul style="list-style-type: none"> <li>○ A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area or licensure as an RN; and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD; OR</li> <li>○ A Master's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area or licensure as an RN; and three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI</li> </ul> </li> </ul>

**Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions**

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
2. Care Managers	<p>These individuals shall be responsible for providing:</p> <ul style="list-style-type: none"> <li>• Integrated whole-person care management under the Tailored Care Management model, including coordinating across BH, I/DD, TBI, LTSS, and Unmet Health-Related Resource Needs;</li> <li>• Care coordination for Members with a behavioral health transitional care need; and</li> <li>• Care coordination for all Members.</li> </ul>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor’s degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as an RN.</li> <li>• If serving Members with BH needs, must have two (2) years of experience working directly with individuals with BH conditions.</li> <li>• If serving Members with an I/DD, must have two (2) years of experience working directly with individuals with I/DD or TBI</li> <li>• If serving members with LTSS needs, the care manager must have the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, as described above</li> </ul>
3. Full-Time Care Management Housing Specialist(s)	<p>This individual or these individuals act as expert(s) on affordable and supportive housing programs for Members and care managers. This individual or these individuals coordinate with relevant staff at the Department or PIHP (e.g., Transition Coordinators and DSOHF staff).</p>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> </ul>
4. Full-Time Transition Supervisor(s)	<p>This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.</p>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must meet the care manager supervisor qualifications described above and outlined in in <i>Section IV.G. Care Management</i>. PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff</li> </ul>



**Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions**

<b>Role</b>	<b>Duties and Responsibilities of the Role</b>	<b>Minimum Certifications and/or Credentials Requested by the Department</b>
<p>5. Full-Time Transition Coordinator(s)</p>	<p>This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for:</p> <ul style="list-style-type: none"> <li>• Individuals who are moving from a state psychiatric hospital to supportive housing; and</li> <li>• individuals moving from a state developmental center or an ACH to a community setting.</li> </ul>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> </ul> <p>Transition Coordinators serving individuals with SMI:</p> <ul style="list-style-type: none"> <li>• Must hold a Master’s degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or</li> <li>• Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI.</li> </ul> <p>Transition Coordinators serving individuals with I/DD or TBI:</p> <ul style="list-style-type: none"> <li>• Must hold a Master’s degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD; or</li> <li>• Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI.</li> <li>• PIHP may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff</li> </ul>
<p>6. Full-Time Peer Support Specialist(s)</p>	<p>This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members with BH diagnoses residing in a state psychiatric hospital or an ACH.</p>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must have NC Certified Peer Support Specialist Program Certification</li> </ul>
<p>7. Full-Time In-Reach Specialist(s)</p>	<p>This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.</p>	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold a Bachelor’s degree in a human services field</li> <li>• Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.</li> <li>• PIHP may submit to the Department for approval alternate minimum</li> </ul>

**Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions**

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		qualifications for In-Reach and Transition staff
8. System of Care Family Partner(s)	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to the PIHP's System of Care functions.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold high school diploma or GED</li> <li>• Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid services</li> </ul>
9. System of Care Coordinator(s)	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to the PIHP's System of Care functions.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold:                             <ul style="list-style-type: none"> <li>○ a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or</li> <li>○ a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems</li> </ul> </li> </ul>
10. DSOHF Admission Through Discharge Manager	These individuals are responsible for: <ul style="list-style-type: none"> <li>• Coordinating and/or performing transition functions and activities described in Section IV.G. <i>Care Management</i> for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals.</li> </ul> Coordinating and/or performing discharge planning functions for PIHP members who are not receiving transition functions and activities described in Section IV.G. <i>Care Management</i> <p>DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as the PIHP's liaison to ADATCs in the PIHP's region.</p>	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: <ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI.</li> </ul> DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: <ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Must hold:                             <ul style="list-style-type: none"> <li>○ a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or</li> <li>○ a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or</li> <li>○ hold a Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.</li> </ul> </li> </ul>

**Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions**

<b>Role</b>	<b>Duties and Responsibilities of the Role</b>	<b>Minimum Certifications and/or Credentials Requested by the Department</b>
11. Member Appeal Coordinator	This individual manages and coordinates member appeals in a timely manner.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
12. Member Grievance Coordinator	This individual manages and attempts to resolve Member grievances in a timely manner.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
13. Full-Time Member Grievance Staff	These individuals work to resolve Member grievances in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> <li>For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing grievances</li> </ul>
14. Full-Time Peer Review and/or Member Appeals Staff	These individuals work to resolve Member appeals in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> <li>Peer reviewers must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals</li> </ul>
15. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
16. Provider Relations and Service Line Staff	These individuals coordinate communications between the PIHP and providers.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
17. Provider Network Relations Staff	These individuals support the Provider Network Director in network development and management.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
18. Provider Grievance Coordinator	This individual manages and resolves provider grievances in a timely manner.	<ul style="list-style-type: none"> <li>Must have North Carolina Residency</li> </ul>
19. Provider Appeal Coordinator	This individual coordinates and manages provider appeals in a timely manner.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>
20. Full-Time BH/SUD Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	<ul style="list-style-type: none"> <li>Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing</li> </ul>
21. Full-Time I/DD Utilization Management Staff	These individuals conduct I/DD UM activities, including but not limited to prior authorization, concurrent review, and retrospective review.	<ul style="list-style-type: none"> <li>Must be a Qualified Intellectual Disability Professional, or Qualified Professional, in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3</li> </ul>
22. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	<ul style="list-style-type: none"> <li>Must reside in North Carolina</li> </ul>

**Section VI. Attachment A. Table 1: PIHP Organization Roles and Positions**

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
23. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> </ul>
24. Special Investigations Unit (SIU) Lead	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	<ul style="list-style-type: none"> <li>• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, criminal justice, or pre-law, or have at least five (5) years of relevant experience</li> <li>• Must complete CLEAR training or provide a timeframe as to when it will be complete</li> </ul>
25. Special Investigations Unit (SIU) Staff	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	<ul style="list-style-type: none"> <li>• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, <del>or</del> pre-law or criminal justice, or have at least three (3) years of relevant experience</li> </ul>
26. Liaison to the Division of Social Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinated through local DSS offices, and serves as a primary contact to triage and escalate member specific or PIHP questions.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> </ul>
27. Waiver Contract Manager	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1915(i) waiver and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	<ul style="list-style-type: none"> <li>• Must reside in North Carolina</li> <li>• Minimum of seven (7) years of management experience, preferably in human services</li> </ul>

## Attachment B. Approved Behavioral Health In Lieu of Services for Medicaid

The *Section VI. Attachment B. Table 1: Department-Approved Behavioral Health In Lieu of Services* for Medicaid. Below is a list of all BH In Lieu of Services (ILOS) that have been approved by the Department as described in *Section IV.F. Benefits*. PIHP must submit the standardized ILOS Service Request Form to the Department for approval if they wish to offer any of these ILOS. Per this Contract, PIHP may use the BH ILOS services or settings that are a medically appropriate, cost-effective alternative to a State Plan covered service. Nothing herein prohibits the PIHP from submitting ILOS for other services for approval by the Department.

<b>Section VI. Attachment B. Table 1: Department-Approved Behavioral Health In Lieu of Services for Medicaid</b>
<ul style="list-style-type: none"><li>• Behavioral Health Urgent Care/ Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)</li><li>• Institution for Mental Disease for acute psychiatric care</li><li>• Rapid Care Services</li><li>• Family Centered Treatment</li><li>• Long Term Community Support</li></ul>

## Attachment C. Contractual Deliverable Schedule

The following represents the current *anticipated dates* for Contractual Deliverables. The Department may make adjustments after Contract Execution but in no event will Contractual Deliverables be due earlier than provided for below. For any deliverable which is indicated below as leveraged from the BH I/DD Tailored Plan contract, the PIHP will still be required to submit through the standard process. This column indicates a reduced administrative burden on the PIHP and the Contractual Deliverable may closely mirror the submission for the BH I/DD Tailored Plan.

- If the *Leverage Tailored Plan Deliverable* column of the table below is marked “No”, then the PIHP will be required to submit a completely new deliverable specific to the requirements of the PIHP contract.
- If the *Leverage Tailored Plan Deliverable* column of the table below is marked “Yes”, then the PIHP may use the same deliverable submitted for the BH/IDD Tailored Plan deliverable submission as the baseline document, provided that modifications are made to incorporate any variations in PIHP program requirements (where applicable).

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule					
Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
1.	Additional Special Terms with IHCP	Tailored Plan	The date the PIHP shall submit the additional special terms with Indian Health Care Providers.	Yes	Contract Execution + one hundred eighty (180) days
2.	Behavioral Health Crisis Line Script	Benefits	The date all service line scripts, including Member Service Line and Behavioral Health Crisis Line scripts, shall be made available to the Department.	Yes	Contract Execution + one hundred eighty (180) days
3.	Business Continuity Plan	Compliance	The date PIHP Business Continuity Plan shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
4.	Call Center Services Line Policy	Call Center	The date the Call Center and Service Line Policy shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
5.	Claims Payment, Review, and Program Integrity Process	Compliance	The date that a PIHP shall develop, maintain, and operate a claims payment, review and program integrity process which minimizes incorrect claim payments and inappropriate claim denials by.	Yes	Contract Execution + one hundred eighty (180) days
6.	Compliance Plan	Compliance	The PIHP shall submit a compliance plan to the department.	Yes	Contract Execution + one hundred eighty (180) days
7.	Compliance Program Report	Compliance	The date for the annual report monitoring and auditing work plan(s) for the upcoming year to be submitted.	Yes	Contract Execution + one hundred eighty (180) days
8.	Conflict of Interest Policy	Compliance	The date the PIHP will adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices.	Yes	Contract Execution + one hundred eighty (180) days
9.	Deficit Reduction Act Policies and Procedures	Compliance	The date the Deficit Reduction Act (DRA) Reporting for Medicaid shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
10.	Disclosure of Conflict of Interest	Tailored Plan	The PIHP shall disclose any known conflicts of interest, or perceived conflicts of interest, at the time they arise.	Yes	Ad-Hoc
11.	Disclosure of Ownership Interest	Tailored Plan	The date the PIHP shall disclose the information on individuals or corporations with an ownership or control interest.	Yes	Upon Effective date of the Contract

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
12.	Encounter Implementation Approach	Finance	The date the PIHP shall provide the Encounter Implementation Approach to the Department.	Yes	Contract Execution + thirty (30) days
13.	EPSDT Policy	Benefits	The date the PIHP shall submit an EPSDT Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
14.	Establishment of PIHP Call Center(s) in NC	Tailored Plan	The date the PIHP shall begin implementing call center(s) and staff in North Carolina if not already in place and submit to the Department.	Yes	Contract Execution + ninety (90) days
15.	Establishment of PIHP Office in NC	Tailored Plan	The date the PIHP shall begin implementing Medicaid Direct staff in North Carolina if not already in place and submit to the Department.	Yes	Contract Execution + ninety (90) days
16.	Fraud Prevention Plan	Compliance	The date the PIHP shall submit their Fraud Prevention Plan to the Department.	Yes	Contract Execution + one hundred eighty (180) days
17.	Good Faith Provider Contracting Policy	Tailored Plan	The date the PIHP shall develop and submit the Good Faith Provider Contracting Policy that includes a description of how the PIHP will conclude that a "good faith" contracting effort has been made and/or refused.	Yes	Contract Execution + one hundred eighty (180) days
18.	Identification of Additional Resources for	Tailored Plan	The date the PIHP's must identify any additional resources	Yes	Contract Execution+ thirty (30) days



Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
	Implementation Team		needed to support the implementation activities		
19.	Implementation Plan	Tailored Plan	The date PIHP's Implementation Plan Draft must be submitted to the Department	Yes	Contract Execution + fourteen (14) days
20.	In Lieu of Services Request Form	Benefits	The date the PIHP shall submit the ILOS form to the Department.	No	Contract Execution + one hundred eighty (180) days
21.	In-Reach and Transition Policy	Quality & Pop Health	The date the PIHP submits the In-Reach and Transition Policy to the Department.	Yes	Contract Execution + ninety (90) days
22.	Key Personnel Matrix	Tailored Plan	The date the PIHP shall submit the Key Personnel Matrix to the Department.	Yes	Contract Execution + one hundred eighty (180) days
23.	Key Personnel Resume and Qualifications	Tailored Plan	The date the PIHP shall submit the Key Personnel resumes and qualifications to the Department.	Yes	Contract Execution + one hundred eighty (180) days
24.	Local Area Crisis Plans	Quality & Pop Health	The date the PIHP shall submit the Local Area Crisis Plans to the Department.	Yes	Contract Execution + one hundred eighty (180) days
25.	Local Community Collaboratives and Engagement Strategy	Communications and Stakeholder Engagement	The date the PIHP shall submit the Local Community Collaboratives Strategy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
26.	Locum Tenens Policy	Tailored Plan	The date the PIHP shall submit the Locum Tenens Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
27.	Marketing Materials	Communications and Stakeholder Engagement	The date the PIHP shall submit marketing materials to the Department for review.	Yes	One hundred sixty nine (169) days prior to launch

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
28.	Marketing Plan	Communications and Stakeholder Engagement	The date the PIHP shall submit their Marketing Plan to the Department.	Yes	Contract Execution + One hundred sixty nine (169) days prior to launch
29.	Member Educational Approach	Member	The date the PIHP submits its planned member education efforts to the Department.	Yes	Contract Execution + sixty (60) days
30.	Member Educational Materials	Member	The date all written communications, call center scripts, websites or other communications directed to Members or potential Members, shall be sent to the Department for approval.	Yes	Contract Execution + one hundred eighty (180) days
31.	Member Engagement and Marketing Plan for Historically Marginalized Populations	Communications and Stakeholder Engagement	The date the PIHP submits the Member Engagement and Marketing Plan for Historically Marginalized Populations to the Department.	Yes	Contract Execution + one hundred twenty (120) days
32.	Member Enrollment and Disenrollment Policy	Member	The date the PIHP shall submit the Member Enrollment and Disenrollment Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
33.	Member Grievances and Appeals Policies	Member	The date the PIHP shall submit the PIHP Member Grievances and Appeals Policies to the Department.	Yes	Contract Execution + one hundred eighty (180) days
34.	Member Handbook	Member	The date the PIHP will submit the Member Handbook to the Department.	No	Contract Execution + ninety (90) days
35.	Member Incentive Program	Quality & Pop Health	The date the Member Incentive Program shall be	Yes	Contract Execution + one hundred eighty (180) days

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
			submitted to the Department.		
36.	Member Mailing Policy	Member	The date the Member Mailing Policy shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
37.	Member Rights and Responsibilities Policy	Member	The date the PIHP shall submit the Member Rights and Responsibilities Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
38.	Member Service Line Script	Member	The date the listing of topics which scripts will address to the Department for approval.	Yes	Contract Execution + one hundred eighty (180) days
39.	Member Welcome Packet	Member	The date the PIHP submits the Member Welcome Packet to the Department.	No	Contract Execution + ninety (90) days
40.	Network Access Plan	Tailored Plan	The date the PIHP shall provide the Network Access Plan to the Department.	Yes	Contract Execution + thirty (30) days
41.	Non-Discrimination Policy	Compliance	The date the PIHP will submit the Non-Discrimination Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
42.	Operating Plan	Tailored Plan	The date the PIHP's Operating Plan shall be submitted to the Department	Yes	June 30th Every Year
43.	Performance Improvement Projects	Quality & Pop Health	The date the PIHP shall submit the PIPs to the Department.	Yes	Contract Execution + Sixty (60) days
44.	Plan for Protection Against Insolvency	Finance	The date the PIHP shall submit a plan for protection against insolvency to the Department.	Yes	Contract Execution + one hundred eighty (180) days
45.	Provider Contract Templates	Tailored Plan	The date the PIHP shall provide Provider Contract	No	Contract Execution + thirty (30) days

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
			Templates to the Department.		
46.	Provider Directory	Provider	The PIHP shall submit the Provider Directory to the Department.	Yes	Contract Execution + one hundred eighty (180) days
47.	Provider Grievances and Appeals Policies	Provider	The date the PIHP shall submit the PIHP Provider Grievances and Appeals Policies.	Yes	Contract Execution + Sixty (60) days
48.	Provider Manual	Provider	The date the PIHP shall provide the Provider Manual to the Department.	Yes	Contract Execution + ninety (90) days
49.	Provider Payment Monitoring and Audit Policy	Compliance	The PIHP shall submit policies and procedures to perform monitoring and auditing of provider payments to the Department.	Yes	Contract + one hundred eighty (180) days
50.	Provider Recruitment Materials	Provider	The PIHP shall submit recruitment materials to the Department for review at least thirty (30) Calendar Days before the proposed use of the material.	Yes	Ad-Hoc
51.	Provider Support Service Line Script	Provider	The date the PIHP will submit to the Department, for approval, a listing of topics which scripts will address.	Yes	Contract Execution + one hundred eighty (180) days
52.	Provider Training Materials	Provider	The PIHP shall provide education, specific to PIHP requirements, policies, including the Department's Medicaid Direct BH/I/DD Billing Guide, and procedures, training and technical assistance on all	Yes	Contract Execution + one hundred eighty (180) days

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
			PIHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.		
53.	Provider Training Plan	Provider	The date the PIHP shall provide the Provider Training Plan to the Department.	Yes	Contract Execution + thirty (30) days
54.	Provider Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Provider Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
55.	Provider Welcome Packet	Provider	The date the PIHP shall submit a Provider Welcome Packet to the Department.	Yes	Contract Execution + one hundred eighty (180) days
56.	Quality Assessment and Performance Improvement	Quality & Pop Health	The date the PIHP shall submit a Quality Management and Improvement Program to the Department.	Yes	Contract Execution + Sixty (60) days
57.	Security Compliance Plan	Technology	The date the PIHP shall provide the Security Compliance Plan to the Department.	Yes	Contract Execution + thirty (30) days
58.	System Interface Design	Technology	The date the PIHP shall provide the System Interface Design to the Department.	Yes	Contract Execution + thirty (30) days
59.	System Test Plan	Technology	The date the PIHP shall provide the System Test Plan to the Department.	Yes	Contract Execution + thirty (30) days
60.					

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
61.	Reimbursement Policy	Finance	The PIHP shall submit the Reimbursement Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
62.	Reinsurance Arrangement	Finance	The PIHP shall submit their Service Line Phone Numbers to the Department.	Yes	Contract Execution + one hundred eighty (180) days
63.	Service Line Phone Numbers	Call Center	The date the PIHP must have its service line phone number acquired and operationalized	Yes	Contract Execution + one hundred eighty (180) days
64.	Staff Training and Evaluation Program	Staff Training	The PIHP shall submit their training and evaluation program to the Department.	Yes	Contract Execution + one hundred eighty (180) days
65.	System of Care Policy	Quality & Pop Health	The date the PIHP shall submit their System of Care Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
66.	Telehealth Policy	Benefits	The date the PIHP shall submit their Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
67.	Third Party Administrator License (as applicable)	Tailored Plan	The date the PIHP shall submit their Third-Party Administrator's license if applicable.	Yes	Contract Execution + one hundred eighty (180) days
68.	Third-Party Liability Policy	Finance	The date the PIHP shall submit their Third-Party Liability Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
69.	Transition of Care Policy	Quality & Pop Health	The date the PIHP shall submit the Medicaid Transition of Care Policy to the Department.	Yes	Contract Execution + one hundred fifty (150) days

Section VI. Attachment C. Table 1: Contractual Deliverable Schedule

Ref. #	Contractual Deliverable	Business Unit	Description	Leverage Tailored Plan Deliverable	Due Date
70.	Tribal Engagement Strategy (as applicable)	Member	The date the PIHP's Tribal Engagement Strategy Medicaid shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
71.	Utilization Management Policy	Benefits	The date the PIHP shall submit their UM Policy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
72.	Value-Added Services Request Form	Benefits	The PIHP shall submit to the Department the Value-Added Services Request form for approval.	No	Contract Execution + one hundred eighty (180) days
73.	VBP Assessment	Finance	The date the PIHP's first retrospective VBP Assessment shall be submitted to the Department.	Yes	Contract Execution + one hundred eighty (180) days
74.	VBP Strategy	Finance	The date the PIHP shall submit the prospective VBP Strategy to the Department.	Yes	Contract Execution + one hundred eighty (180) days
75.	Vendor Readiness Assessment Report	Technology	The date the PIHP shall provide the VRAR to the Department.	Yes	Contract Execution + thirty (30) days
76.	Whistleblower Policy	Compliance	The date the PIHP shall submit the Whistleblower Policy related to whistleblower protections to the Department.	Yes	Contract Execution + one hundred eighty (180) days

## Attachment D. PIHP Quality Metrics

The PIHP will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be provided no later than six (6) months prior to PIHP launch. The PIHP will also be required to report the Innovations waiver measures listed, which can be included in reporting for the BH/IDD Tailored Plan. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with PIHPs around these performance measures.

Section VI. Attachment D. Table 1: Survey Measures and General Measures: Pediatric					
Ref #	NQF #	Measure Name	Steward	Measurement Period	Submission
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA	Annually Calendar Year	June 1
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1
9.	2801	Use of Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1
10	N/A	Total Eligible Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS	Annually Calendar Year	June 1

Section VI. Attachment D. Table 2: Survey Measures and General Measures: Adult					
Ref #	NQF #	Measure Name	Steward	Frequency	Submission
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA	Annually Calendar Year	June 1
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC	Annually Calendar Year	June 1
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	Annually Calendar Year	June 1
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA	Annually Calendar Year	June 1



**Section VI. Attachment D. Table 2: Survey Measures and General Measures: Adult**

Ref #	NQF #	Measure Name	Steward	Frequency	Submission
16.	NA	Rate of Screening for Unmet Resource Needs	NC DHHS	Annually Calendar Year	June 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
14.	Percentage of beneficiaries reporting that their ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of individuals whose annual ISP was revised or updated	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
18.	Proportion of individuals for whom an annual ISP took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
19.	Number and percentage of waiver participants whose ISPs were revised, as applicable, by the Care Coordinator to address their changing needs	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 3 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
25.	Number and percentage of Innovations waiver beneficiary deaths where required PIHP follow-up interventions were completed as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27.	Percentage of Innovations waiver beneficiaries who received appropriate medication	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
30.	Percentage of PIHP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Number and percentage of level 2 or 3 incidents where required PIHP follow-up interventions were completed as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
33.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
37.	The proportion of claims paid by the PIHP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
38.	The consistency of NC Innovations capitated rates (The proportion of the PIHP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM)	NC DHHS	Annually Fiscal Year	November 1

**Section VI. Attachment D. Table 3: Innovations Waiver Performance Measures**

Ref #	Measure Name	Steward	Measurement Period	Submission
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
40.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
41.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
42.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

## Attachment E. PIHP Network Adequacy Standards

At a minimum, the PIHP network shall consist of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, TBI and I/DD providers, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section IV.H.1. Provider Network*.

For the purposes of this attachment and the PIHP Network Adequacy Standards, “urban” is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as “regional cities or suburban counties” or “urban counties which will be covered by the applicable PIHP.” “Rural” is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

More background information is available at the following link, accurate as of the date of execution of this Contract: [http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural\\_Center\\_Impacts\\_Report.pdf4-6-16.pdf](http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf). The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

*In order to ensure that all Members have timely access to all covered health care services, PIHP shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually.* For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a Member who is 18 years of age, or older and pediatric/adolescent (child/children) services are those provided to a Member who is less than 18 years of age.

The PIHP is required to use the definitions of service categories for BH time/distance standards found in Distance Standards for BH service types in this attachment.

Section VI. Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
1	Outpatient BH Services	<ul style="list-style-type: none"> <li>≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members</li> <li><i>Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i></li> </ul>	<ul style="list-style-type: none"> <li>≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members</li> <li><i>Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i></li> </ul>
2	Location-Based Services	<ul style="list-style-type: none"> <li><i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members</li> </ul>	<ul style="list-style-type: none"> <li><i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members</li> </ul>



Section VI. Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
		<ul style="list-style-type: none"> <li>• <i>Child and Adolescent Day Treatment Services</i>: Not subject to standard</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Child and Adolescent Day Treatment Services</i>: Not subject to standard</li> </ul>
3	Crisis Services	<ul style="list-style-type: none"> <li>• <i>Professional treatment services in facility-based crisis program</i>: The greater of:               <ul style="list-style-type: none"> <li>○ 2+ facilities within each PIHP Region, OR</li> <li>○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates).</li> </ul> </li> <li>• <i>Facility-based crisis services for children and adolescents</i>: ≥ 1 provider within each PIHP Region</li> <li>• <i>Non-Hospital Medical Detoxification</i>: ≥ 2 provider within each PIHP Region</li> <li>• <i>Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal</i>: ≥ 1 provider of each crisis service within each PIHP Region</li> <li>• <i>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)</i>: Not subject to standard</li> </ul>	
4	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each PIHP region	
5	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
6	Community/Mobile Services	≥ 2 providers of community/mobile services within each PIHP Region. Each county in PIHP Region must have access to ≥ 1 provider that is accepting new patients.	
7	1915(i) HCBS	<i>Community Living &amp; Support, Individual and Transitional Support, Respite, and Supported Employment (for IDD and MH/SUD)</i> : ≥ 2 providers of each (i) Option service within each PIHP Region	
8	Residential Treatment Services	<ul style="list-style-type: none"> <li>• <i>Residential Treatment Facility Services</i>: Access to ≥ 1 licensed provider per PIHP Region</li> <li>• <i>Substance Abuse Medically Monitored Residential Treatment</i>: Access to ≥ 1 licensed provider per PIHP Region (refer to 10A NCAC 27G.3400)</li> <li>• <i>Substance Abuse Non-Medical Community Residential Treatment</i>:               <ul style="list-style-type: none"> <li>○ <i>Adult</i>: Access to ≥ 1 licensed provider per PIHP Region (refer to licensure requirements to be determined by the Department)</li> <li>○ <i>Adolescent</i>: Contract with all designated CASPs within the PIHPs Region</li> <li>○ <i>Women &amp; Children</i>: Contract with all designated CASPs within the PIHP's Region</li> </ul> </li> <li>• <i>Substance Abuse Halfway House</i>:               <ul style="list-style-type: none"> <li>○ <i>Adult</i>: Access to ≥1 male and ≥1 female program per PIHP Region (Refer to 10A NCAC 27G .5600)<sup>6</sup></li> <li>○ <i>Adolescent</i>: Access to ≥1 program per PIHP Region (refer to 10A NCAC 27G.5600)</li> </ul> </li> </ul>	

<sup>6</sup> PIHPs must also ensure that gender non-conforming Members have access to substance abuse halfway house services.

Section VI. Attachment E. Table 1: PIHP Time/Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
		<ul style="list-style-type: none"> <li>Psychiatric Residential Treatment Facilities (PRTFs) &amp; Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard</li> </ul>	
9	1915(c) HCBS Waiver Services: NC Innovations	<ul style="list-style-type: none"> <li>Community Living &amp; Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each PIHP Region.</li> <li>Crisis Intervention &amp; Stabilization Supports, Day Supports, Financial Support Services: ≥ 1 provider of each Innovations waiver service within each PIHP Region.</li> <li>Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification: Not subject to standard</li> </ul>	

Section VI. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	Service Type	Definition
1.	Outpatient BH Services	<ul style="list-style-type: none"> <li>Outpatient BH services provided by direct-enrolled providers (adults and children)</li> <li>Research-based Behavioral Health treatment for Autism Spectrum Disorder (ASD)</li> </ul>
2.	Location-Based Services (BH I/DD)	<ul style="list-style-type: none"> <li>Psychosocial Rehabilitation</li> <li>Substance Abuse Comprehensive Outpatient Treatment</li> <li>Substance Abuse Intensive Outpatient Program</li> <li>Outpatient Opioid treatment (OTP) (adult)</li> <li>Child and adolescent day treatment services</li> </ul>
3.	Crisis Services	<ul style="list-style-type: none"> <li>Facility-based crisis services for children and adolescents</li> <li>Professional treatment services in facility-based crisis program (adult)</li> <li>Ambulatory detoxification</li> <li>Non-hospital medical detoxification (adult)</li> <li>Ambulatory withdrawal management with extended on-site monitoring</li> <li>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)</li> </ul>
4.	Inpatient BH Services	<p><i>Inpatient Hospital – Adult</i></p> <ul style="list-style-type: none"> <li>Acute care hospitals with adult inpatient psychiatric beds</li> <li>Other hospitals with adult inpatient psychiatric beds</li> <li>Acute care hospitals with adult inpatient substance use beds</li> <li>Other hospitals with adult inpatient substance use beds</li> </ul>

Section VI. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	Service Type	Definition
		<p><i>Inpatient Hospital – Adolescent / Children</i></p> <ul style="list-style-type: none"> <li>• Acute care hospitals with adolescent inpatient psychiatric beds</li> <li>• Other hospitals with adolescent inpatient psychiatric beds</li> <li>• Acute care hospitals with adolescent inpatient substance use beds</li> <li>• Other hospitals with adolescent inpatient substance use beds</li> <li>• Acute care hospitals with child inpatient psychiatric beds</li> <li>• Other hospitals with child inpatient psychiatric beds</li> </ul>
5.	Partial Hospitalization	<ul style="list-style-type: none"> <li>• Partial Hospitalization (adults and children)</li> </ul>
6.	Residential Treatment Services	<ul style="list-style-type: none"> <li>• Residential treatment facility services</li> <li>• Substance abuse non-medical community residential treatment</li> <li>• Substance abuse medically monitored residential treatment</li> <li>• Psychiatric Residential Treatment Facilities (PRTFs)</li> <li>• Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)</li> </ul>
7.	Community/Mobile Services	<ul style="list-style-type: none"> <li>• Assertive Community Treatment (ACT)</li> <li>• Community Support Team (CST)</li> <li>• Intensive In-Home (IIH) services</li> <li>• Multi-systemic Therapy (MST) services</li> <li>• Peer Supports</li> <li>• Diagnostic Assessment</li> </ul>
8.	1915(i) HCBS	<ul style="list-style-type: none"> <li>• Supported Employment</li> <li>• Individual Support</li> <li>• Respite</li> <li>• Community Living and Support</li> <li>• Community Transition</li> </ul>
9.	1915(c) HCBS Waiver Services: NC Innovations	<ul style="list-style-type: none"> <li>• Assistive Technology Equipment and Supplies</li> <li>• Community Living and Support</li> <li>• Community Networking</li> <li>• Community Transition</li> <li>• Crisis Services: Crisis Intervention &amp; Stabilization Supports</li> <li>• Day Supports</li> <li>• Financial Support Services</li> <li>• Home Modifications</li> <li>• Individual Directed Goods and Services</li> <li>• Natural Supports Education</li> <li>• Residential Supports</li> <li>• Respite</li> </ul>

Section VI. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	Service Type	Definition
		<ul style="list-style-type: none"> <li>• Specialized Consultation</li> <li>• Supported Employment</li> <li>• Supported Living</li> <li>• Vehicle Modifications</li> </ul>

The PIHP is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service.

Section VI. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
Behavioral Health and I/DD Services			
1	Mobile Crisis Management Services	Refer to <i>Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to <i>Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Emergency Services for Mental Health	Refer to <i>Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
4	Emergency Services for SUD	Refer to <i>Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
5	Urgent Care Services for Mental Health	Refer to <i>Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	Within twenty-four (24) hours
6	Urgent Care Services for SUD	Refer to <i>Section VI. Attachment M.4. BH Service</i>	Within twenty-four (24) hours

Section VI. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
		<i>Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards</i>	
7	Routine Services for Mental Health	Refer to Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards	Within fourteen (14) calendar days
8	Routine Services for SUDs	Refer to Section VI. Attachment M.4. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards	Within forty-eight (48) hours

## Attachment F. Required Standard Provisions for PIHP and Provider Contracts

### Required Standard Provisions for PIHP and Provider Contracts

The PIHP shall develop and implement contracts with providers to meet the requirements of the Contract or have the option to amend BH I/DD Tailored Plan contracts with providers to add Medicaid Direct requirements as an Addendum or Attachment. The PIHP provider contracts shall, at a minimum, comply with the terms of the Contract, state and federal law, and include required standard contracts clauses.

**a. Contracts between the PIHP and providers, must at a minimum, include provisions addressing the following:**

- i. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
- ii. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.

In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PIHP utilizes the definition as found in Section II.A. of the PIHP Contract or include the definition verbatim from that section.
- iii. Contract Term: The contract term shall not exceed the term of the PIHP Contract with the State, but may include the option to extend the contract's term if the PIHP Contract with the state includes an extension option.
- iv. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PIHP shall specifically include a provision permitting the PIHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the PIHP or the Division, or upon termination of the PIHP contract by the State. PIHP also shall specifically include a provision permitting the PIHP to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the PIHP or the Division. The contract must also require the provider to notify the PIHP of members with scheduled appointments upon termination. The contract may include a no-cause termination clause.
- v. Survival: The contract must identify those obligations that continue after termination of the provider contract and
  1. In the case of the PIHP's insolvency, the contract must address:
    1. Transition of administrative duties and records; and
    2. Continuation of care when inpatient care is on-going in accordance with the requirements of the Contract. If the PIHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- vi. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PIHP's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the PIHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

1. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
  2. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
    - a. During the provider credentialing transition period, no less frequently than every five (5) years.
    - b. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- vii. **Liability Insurance:** The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PIHP, and at the provider's sole cost, and to notify the PIHP of subsequent changes in status of professional liability insurance on a timely basis.
- viii. **Member Billing:** The contract must address the following:
1. That the provider shall not bill any member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the PIHP may not cover or continue to cover specific services and the member requests to receive the service; and
  2. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- ix. **Provider Accessibility:** The contract must address provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PIHP's standards for provider accessibility. The contract must address how the provider will:
1. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
  2. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
  3. Have a "no-reject policy" for referrals within capacity and 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 the PIHP and the provider.
- x. **Eligibility Verification:** The contract must address the PIHP's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the PIHP, before rendering health care services.
- xi. **Medical Records:** The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
1. Maintain confidentiality of member medical records and personal information and other health records as required by law;
  2. Maintain adequate medical and other health records according to industry and PIHP standards; and
  3. Make copies of such records available to the PIHP and the Department in conjunction with its regulation of the PIHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

- xii. Member Appeals and Grievances: The contract must address the provider's obligation to cooperate with the member in regard to member appeals and grievance procedures.
- xiii. Provider Network: The PIHP shall require network providers of services provided under Outpatient Commitment to a member to notify the PIHP of the Outpatient Commitment order upon receipt.
- xiv. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
- xv. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the PIHP's web-based billing process.
- xvi. Data to the Provider: The contract must address the PIHP's obligations to provide data and information to the provider, such as:
  - 1. Performance feedback reports or information to the provider if compensation is related to efficiency criteria.
  - 2. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
  - 3. Notification of changes in these requirements shall also be provided by the PIHP, allowing providers time to comply with such changes.
- xvii. Utilization Management (UM): The contract must address the provider's obligations to comply with the PIHP's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- xviii. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.
- xix. Provider Directory: The provider's authorization and the PIHP's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
- xx. Dispute Resolution: Any process to be followed to resolve contractual differences between the PIHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section IV.H.4. Provider Grievances and Appeals*.
- xxi. Assignment: Provisions on assignment of the contract must include that:
  - 1. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PIHP.
  - 2. The PIHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.
- xxii. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- xxiii. Interpreting and Translation Services: The contract must have provisions that indicate:
  - 1. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.



2. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
  3. The provider shall report to the PIHP, in a format and frequency to be determined by the PIHP, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- xxiv. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- xxv. Miscellaneous Provisions - The contract shall include provisions which address the following:
1. If the PIHP determines that services, supplies, or other items are covered and Medically Necessary, the PIHP shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.
  2. When the PIHP offers to contract with a provider, the PIHP shall make available its schedule of fees, if any associated with the top 30 services or procedures most commonly billed by the class of provider, with the exception of Value-Based Fees, which would not be included until Contract Year 2.
  3. The contract shall include the following definitions:
    - a. "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order or by the PHIP Contract is not an amendment.
    - b. "Contract" – A written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.
    - c. "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
  4. Notice contact provisions - The contract shall address the following:
    - a. All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.
    - b. Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five (5) business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice

is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider.

5. Contract Amendments - The contract shall address the following:

- a. PIHP shall send any proposed contract amendment to the notice contact of a health care provider. The proposed amendment shall be dated, labeled "Amendment," signed by the PIHP, and include an effective date for the proposed amendment.
- b. A health care provider receiving a proposed amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within sixty (60) days.
- c. If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the PIHP shall be entitled to terminate the contract upon sixty (60) days written notice to the health care provider.
- d. A health care provider and the PIHP may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

6. Policies and Procedures: The contract shall address the following:

- a. PIHP's policies and procedures applicable to contracted health care providers shall be incorporated into the PIHP's Provider Manual or posted to the PIHP's website.
- b. The policies and procedures of the PIHP shall not conflict with or override any term of a contract, including contract fee schedules.

xxvi. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

xxvii. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in *Section IV.H.4 Provider Payments* of the PIHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PIHP shall reimburse providers no less than one hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Section VII. Attachment G. Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the PIHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PIHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

xxviii. Clinical Records Requests for Claims Processing: The contract shall indicate that the PIHP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.

xxix. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PIHP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medically Necessary Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes

arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

- xxx. Physician Advisor Use in Claims Dispute: The contract must indicate that the PIHP shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as provider's approved representative for a claim or prior authorization in review or dispute.

**b. All contracts between PIHP and providers that are created or amended, must include the following provisions verbatim, except PIHP may insert appropriate term(s), including pronouns, to refer to the PIHP, the provider, the PIHP/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:**

i. Compliance with state and federal laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the PIHP's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [PIHP's] contract with NC DHHS could result in liability for money damages, including civil or criminal penalties and sanctions under state and/or federal law.

ii. Hold Member Harmless

The [Provider] agrees to hold the member harmless for charges for any covered service. The [Provider] agrees not to bill a member for medically necessary services covered by the PIHP so long as the member is eligible for coverage.

iii. Liability

The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [PIHP], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [PIHP] or any judgment rendered against the [PIHP].

iv. Non-discrimination

Equitable Treatment of Members

The [Provider] agrees to render Provider Services to members with the same degree of care and skills as customarily provided to the [Provider's] patients who are not members, according to generally accepted standards of medical practice. The [Provider] and [PIHP] agree that members and non-members should be treated equitably. The [Provider] agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.

v. Department authority related to the Medicaid program

The [Provider] agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

vi. Access to Provider Records

The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [PIHP and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [PIHP and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;
3. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee
4. The Office of Inspector General
5. North Carolina Department of Justice Medicaid Investigations Division
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
7. The North Carolina Office of State Auditor, or its designee
8. A state or federal law enforcement agency.
9. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC Department of Health and Human Services.

Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

vii. Prompt Claim Payments.

PIHP shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims to the [PIHP] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

1. The [PIHP] shall within eighteen (18) Calendar Days of receiving a Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.

2. The [PIHP] shall pay or deny a Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Claim or the first scheduled provider reimbursement cycle following adjudication.
3. A medical pended Claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
4. If the requested additional information on a Claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [PIHP] shall deny the claim.
5. The [PIHP] shall reprocess claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
6. If the [PIHP] fails to pay a clean claim Clean Claim in full pursuant to this provision, the [PIHP] shall pay the [Provider] interest and penalties. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the Claim should have been paid or was underpaid.
7. Failure to pay a Clean Claim within thirty (30) days of receipt will result in the [PIHP] paying the [Provider] penalties equal to one (1) percent of the total amount of the Claim per day beginning on the date following the day on which the Claim should have been paid or was underpaid.
8. The [PIHP] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to request the interest or the liquidated damages.

*viii.* Contract Effective Date.

The contract shall at a minimum include the following in relation to the effective date of the contract.

The effective date of any [Provider] added under this [Agreement] shall be the later of the effective date of this [AGREEMENT] or the date by which the [Provider's] enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).

*ix.* Tobacco-free Policy.

The contract with a provider shall at a minimum include the following in relation to the implementation of a tobacco-free policy unless the provider is a residential facility provider described below.

[Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting [Provider] from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients [Provider] serves.

Contracts with facilities that are owned or controlled by the provider, and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services

(HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required:

[Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

(1) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].

(2) For outdoor areas of campus, [PROVIDER] shall:

- i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
- ii. Prohibit staff/employees from using tobacco products anywhere on campus.

## Attachment G. Addendum for Indian Health Care Providers

The PIHP shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

### 1. Purpose of Addendum; Supersession.

The purpose of this PIHP Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between \_\_\_\_\_ (herein "PIHP") and \_\_\_\_\_ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the PIHP's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.<sup>7</sup>

### 2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

- a. "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
  - b. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
  - c. Is an Eskimo or Aleut or other Alaska Native;
  - d. Is considered by the Secretary of the Interior to be an Indian for any purpose;
  - e. Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

- f. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- g. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid Managed Care contract.

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<sup>7</sup> Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

- h. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.
- i. "Indian tribe" has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).
- j. "Tribal health program" has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).
- k. "Tribal organization" has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).
- l. "Urban Indian organization" has the meaning given in the IHCA Section 4(29), 25 U.S.C. § 1603(29).

### 3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

- a. IHS.
- b. An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §5301 et seq.
- c. A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 5301 et seq.
- d. A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
- e. An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCA.

### 4. Cost Sharing Exemption for Indians; No Reduction in Payments.

The PIHP shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. §447.53 and §457.535.

### 5. Agreement to Pay IHCP.

- a. The PIHP shall pay the IHCP for covered services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and §457.1209.
- b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the PIHP pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the PIHP is less than the amount they would have received under FFS or the applicable encounter rate.



**6. Persons Eligible for Items and Services from IHCP.**

- a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.
- b. No term or condition of the PIHP's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The PIHP acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

**7. Applicability of Federal Laws not Generally Applicable to other Providers.**

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving PIHP members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

**8. Non-Taxable Entity.**

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a PIHP to collect or remit any federal, state, or local tax.

**9. Insurance and Indemnification.**

- a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the PIHP network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.
- b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 5301, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the PIHP will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 5301, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the PIHP network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.
- c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the PIHP will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the PIHP network provider agreement or any addendum thereto shall

be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

**10. Licensure and Accreditation.**

Pursuant to 25 U.S.C. §§ 1621t and §1647a, the PIHP shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the PIHP shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

**11. Dispute Resolution.**

In the event of any dispute arising under the PIHP's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the PIHP's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

**12. Governing Law.**

The PIHP's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the PIHP's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

**13. Medical Quality Assurance Requirements.**

To the extent the PIHP imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCA, 25 U.S.C. § 1675.

**14. Claims Format.**

The PIHP shall process claims from the IHCP in accordance with Section 206(h) of the IHCA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

**15. Payment of Claims.**

The PIHP shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c) and §457.1209 and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

**16. Hours and Days of Service.**

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the PIHP as to its hours and days of service. At the request of the PIHP, such IHCP shall provide written notification of its hours and days of service.

**17. Coordination of Care/Referral Requirements.**

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the PIHP.

**18. Sovereign Immunity.**

Nothing in the PIHP’s network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

**19. Endorsement.**

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the PIHP.

**APPROVALS**

**For the PIHP:**

**For the IHCP:**

*Date:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

**Applicable Federal Laws Referenced in Section 8 of this Addendum**

**( ) The IHS as an IHCP:**

- Anti-Deficiency Act, 31 U.S.C. § 1341;
- ISDEAA, 25 U.S.C. § 5301 et seq.;
- Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
- Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- IHCIA, 25 U.S.C. § 1601 et seq.

**(a) An Indian tribe or a Tribal organization that is an IHCP:**

- ISDEAA, 25 U.S.C. § 5301 et seq.;
- IHCIA, 25 U.S.C. § 1601 et seq.;
- FTCA, 28 U.S.C. §§ 2671-2680;
- Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

**(b) An urban Indian organization that is an IHCP:**

- IHCIA, 25 U.S.C. § 1601 et seq.
- Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- HIPAA, 45 C.F.R. Parts 160 and 164.

## Attachment H. Provider Appeals

The following items outlined in Table 1 are the reasons for which the PIHP must allow a provider to appeal a decision adverse to the provider made by the PIHP, which is separate from an Adverse Benefit Determination issued to a Member, which may only be appealed with written permission of the Member/LRP. The PIHP shall provide an appeals process to providers in accordance with *Section IV.H.5. Provider Grievances and Appeals*.

Section VI. Attachment H. Table 1: Provider Appeals	
Reference Number	Appeal Criteria
For Participating Providers	
1	A Participating Provider has the right to appeal certain actions taken by the PIHP. Provider appeals to the PIHP shall be available for the following reasons: <ul style="list-style-type: none"> <li>a) Finding of or recovery of an overpayment by the PIHP;</li> <li>b) Withhold or suspension of a payment related to waste or abuse concerns;</li> <li>c) Contract termination for cause or finding of contract violation</li> <li>d) Corrective action by the PIHP</li> <li>e) Determination to de-certify an AMH+ or CMA</li> </ul>
For Non-Participating Providers	
2	A Non-Participating Provider may appeal certain actions taken by the PIHP. Appeals to the PIHP shall be available to a Non-Participating Provider for the following reasons: <ul style="list-style-type: none"> <li>a) Disputes regarding an out-of-network payment arrangement, such as a single-case agreement</li> <li>b) Finding of waste or abuse by the PIHP; and</li> <li>c) Finding of or recovery of an overpayment by the PIHP</li> </ul>

## Attachment I. Reporting Requirements

The following tables detail the reports that the PIHP must submit to the Department. The Department will provide additional details on report format, fields, and frequency after Contract Award.

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

The Department will provide additional details and on report format, fields and frequency after Contract Award.

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

Section VI. Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	PIHP Report Description	Frequency
<b>A. Administration and Management</b>		
1. PIHP Operating Report	Annual report of each entity identified under the PIHP Operating Report, providing evidence of PIHP oversight activities and entity performance (i.e., metrics, CAPs, sanctions).	Annually
<b>B. Members</b>		
1. Member Services Quality Assurance Report	Quarterly report of survey results which measures Member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member Appeals and Grievances Report	Monthly report on the appeals and grievances received and processed by the PIHP including the total number of appeal and grievance requests filed with the PIHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Monthly
3. PIHP Enrollment Summary Report	Monthly summary report highlighting key member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid or NC Health Choice eligibility category, number of Member welcome packets and ID cards sent, and time to distribute Member welcome packets. and ID cards.	Monthly

<b>Section VI. Attachment I. Table 1: PIHP Reporting Requirements</b>		
<b>PIHP Report Name</b>	<b>PIHP Report Description</b>	<b>Frequency</b>
4. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
5. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
<b>C. Benefits</b>		
1. Institution for Mental Disease (IMD) Report	Weekly summary of Members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Weekly
2. EPSDT Reports	Quarterly report listing volume of approvals and denials, types of services required, and total paid claims.	Quarterly
3. PASRR Report	Monthly report of Specialized Services provided to Members admitted to nursing facilities who have been identified by the PASRR process	Monthly
4. Annual Prevention and Population Health Report	Annual report of all members outreached, utilization and key program metrics.	Annually
5. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
6. Ongoing Status Reports on Transitions of Care	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the PIHP on an ongoing basis.	Monthly
7. Quarterly Admission & Readmission Report	Quarterly summary report of admission and readmission.	Quarterly
8. Innovations Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver reserved capacity, and list of Members on the Registry of Unmet Needs (waiting list). Report can be included with TP Innovations Waiver Slot and Waiting List Report.	Monthly
9. Monthly TCLI and CWCN Report	Monthly report containing the names and Member Medicaid ID numbers of the Transitions to Community Living Initiative and Children with Complex Needs in the PIHP's Region.	Monthly
<b>C. Care Management and Care Coordination</b>		
1. Care Needs Screening Report	Quarterly report of Member screening results, including Healthy Opportunity & Care Needs Screening of Members.	Monthly
2. High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly

Section VI. Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	PIHP Report Description	Frequency
3. Monthly report of Members receiving care coordination for a BH transitional care need, including the outcomes of the transition at 3 month, 6 month, 9 month, and 12 month increments	Monthly report of Members receiving care coordination for a BH transitional care need, including the outcomes of the transition at 3 month, 6 month, 9 month, and 12 month of a member's receipt of such service	Monthly
4. Monthly report of Members referred to the PCCM vendor	Monthly report of Members referred to the PCCM vendor for care management for a complex physical health need	Monthly
5. Monthly report of participation in case conferences facilitated by different entities	Monthly report of PIHP participation in case conferences facilitated by other entities providing care management, care coordination, or case management to PIHP members (e.g., PCCM vendor, CAP/C or CAP/DA case management entity, DSS, etc.)	Monthly
<b>D. In-Reach and Transitions</b>		
1. In-Reach Activity Report	Number and percentage of Members eligible for in-reach activities who are engaged for in-reach activities; number and percentage of Members who began transition planning following in-reach. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
2. Diversion Activity Report	Number and percentage of Members eligible for diversion activities who are engaged for diversion activities; number and percentage of Members who remain in the community after engaging in diversion activities. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED).	Quarterly
3. Transition Activity Report for Members age 18 and above	Number and percentage of Members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting where Member was discharged (e.g., ICF-IID, State Developmental Center, state psychiatric hospital, ACH).	Quarterly
4. Transition Activity for PRTF Residents, Members Under Age 18 in a State Psychiatric Facility, and Members Receiving Residential	<ul style="list-style-type: none"> <li>Average length of stay</li> <li>Total number of Members in a PRTF, Members under age 18 in a state psychiatric facility, and Members receiving Residential Treatment Levels II/Program Type, III, and IV; and Percentage of members under age 18 in a PRTF, Residential Treatment Levels II/Program Type, III, and IV, or state psychiatric facility.</li> </ul>	Quarterly

<b>Section VI. Attachment I. Table 1: PIHP Reporting Requirements</b>		
<b>PIHP Report Name</b>	<b>PIHP Report Description</b>	<b>Frequency</b>
Treatment Levels II/Program Type, III, and IV		
<b>E. Providers</b>		
1. Quarterly Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members' needs are being met, the PIHP work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.	Quarterly
2. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
3. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
5. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and corresponding statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
6. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
7. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
8. Capitation Reconciliation Report	Monthly report to inform the State of any capitation-related payment discrepancies observed. PIHPs will include records of members where no payment was received from the State or payment received differed from the amount expected. PIHPs will only include member records with discrepancies on this report to the State. The PIHP Capitation Reconciliation Report will be submitted on a monthly cadence. PIHPs will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
<b>F. Quality and Value</b>		
1. QAPI Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
2. PIP Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly



<b>Section VI. Attachment I. Table 1: PIHP Reporting Requirements</b>		
<b>PIHP Report Name</b>	<b>PIHP Report Description</b>	<b>Frequency</b>
3. Quality Measures Report	Annual PIHP performance on quality measures.	Annually
4. Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Quarterly
5. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
<b>G. Stakeholder Engagement</b>		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PIHP to collaborate with county organizations to address issues by county/Region.	Monthly
2. Tribal Engagement Report (as indicated)	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
3. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.	Quarterly
<b>H. Program Administration</b>		
1. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
2. Service Line Issue Summary Report	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
<b>I. Compliance</b>		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the PIHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential fraud, and actual waste and abuse by Participating Providers, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly

<b>Section VI. Attachment I. Table 1: PIHP Reporting Requirements</b>		
<b>PIHP Report Name</b>	<b>PIHP Report Description</b>	<b>Frequency</b>
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential fraud, and actual waste and abuse by Members, including date of alleged non-compliant activity, description of allegation/complaint, key findings, recoupments, and coordination with the Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member and Recipient complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
6. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Health Insurance Premium Payment (HIPP) program	Monthly report of Members whose claims should have been presented to a member's employer-sponsored insurer before submission to the PIHP.	Monthly
<b>J. Financial Requirements</b>		
1. Monthly Financial Schedule	Monthly financial report providing the Department with details on PIHP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, and expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to encounter submissions to identify discrepancies.	Monthly
2. Quarterly Financial Schedule	Quarterly financial report providing the Department with details on PIHP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, utilization statistics, payments made under alternative payment models, recoupments, and timely provider payment statistics and other items.	Quarterly
3. Final Year End Financial Schedule	Annual culminative report providing the Department with details on PIHP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, utilization statistics, payments made under alternative payment models, recoupments, and timely provider payment statistics and other items.	Annually
4. Monthly Claim Lag Report	As required to include the historical claims liability information as outlined that are associated with the specific claim type for which the lag report is being completed.	Monthly
5. Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.	Annually

Section VI. Attachment I. Table 1: PIHP Reporting Requirements		
PIHP Report Name	PIHP Report Description	Frequency
6. Audited Financial Statements	Annual submission of the audited financial statements. 42 C.F.R. § 438.3(m).	Annually
7. Annual PIHP Medical Loss Ratio (MLR) Report	Annual Medical Loss Ratio report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).	Annually
8. NAIC Filings	Regulatory filings will be provided upon request by the Department. Ad hoc report, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe	Ad hoc
9. Claim payment summary by category of service and provider (NPI)	This report will include claims payment history by category of service for certain providers (NPI) as requested by the Department.	Annually

Section VI. Attachment I. Table 2: PIHP Data Extracts		
PIHP Report Name	PIHP Report Description	Frequency
<b>A. Members</b>		
1. PIHP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Weekly
2. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of Adverse Benefit Determination issued by the PIHP to a Member and each grievance received by PIHP from Members.	Daily
<b>B. Benefits and Care Management</b>		
1. Medical Prior Authorization Extract	Monthly extract providing information on medical prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
<b>C. Providers</b>		
1. Network Data Details Extract	Quarterly report containing demographic information on network providers. <i>Note: Ad-hoc upon request.</i> Report can be included with TP Innovations Waiver Slot and Waiting List Report.	Quarterly

## Attachment J. Risk Level Matrix

The PIHP agrees and acknowledges that the Risk Level Matrix is intended to be an illustrative, non-exhaustive list of the types of acts, failures to act, behaviors, and/or practices that may be assigned to a specific level by the Department upon consideration of some or all of the factors described in the Contract.

If the PIHP is found to be noncompliant with the terms, conditions, or requirements of the Contract or of any other violation by the Department, the PIHP agrees and acknowledges that the Risk Level Matrix, as provided in the Contract, is for demonstrative purposes only, and the Department retains the sole discretion to assign an appropriate level to each type of noncompliance or violation by the PIHP based on the nature of the noncompliance or violation as described in the Contract.

The PIHP further agrees and acknowledges that the content included in the examples of noncompliant behavior and/or practices in the Risk Level Matrix are not the full scope of violations subject to a Risk Level assignment by the Department and that if a specific example of non-compliant behavior or practice identified in the Matrix occurs, the Department is not obligated to assign the non-compliant behavior or practice in accordance with the level provided in this Matrix.

Section VI. Attachment J. Table 1: Risk Level Matrix	
Level	Examples of Noncompliant Behavior and/or Practices
<p><b>LEVEL 1</b> Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or the integrity of the program</p>	<p>Failure to substantially and materially provide medically necessary covered services covered under this contract</p> <p>Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract</p> <p>Failure to substantially and materially meet minimum care management and care coordination requirements</p> <p>Failure to substantially and materially meet minimum Transition of Care Policy requirements</p> <p>Failure to substantially and repeatedly meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception)</p> <p>Denying coverage for out-of-network care when no reasonable access to an in-network provider is available</p> <p>Systemic or repeated failure to resolve Member and provider appeals and grievances within specified timeframes</p> <p>Systemic or repeated failure to timely submit accurate and/or complete encounter data in the required file format</p> <p>Misrepresenting or falsifying information that it furnishes to CMS or to the Department</p>

**Section VI. Attachment J. Table 1: Risk Level Matrix**

Level	Examples of Noncompliant Behavior and/or Practices
	<p>Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation</p> <p>Failure to substantially and materially comply with the claims processing requirements and standards</p> <p>Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation</p> <p>More than one Level 2 violations within a contract year</p>
<p><b>LEVEL 2</b> Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize Member(s) health, safety, and welfare or access to care</p>	<p>Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract</p> <p>Failure to comply with established rate floors and fee schedules as required under the Contract</p> <p>Failure to make provider contracting decisions within required timeframes</p> <p>Failure to comply with member services requirements (including hours of operation, call center, and online portal)</p> <p>Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PHI</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation</p> <p>Two or more Level 3 violations within a contract year</p>
<p><b>LEVEL 3</b> Action(s) or inaction(s) that diminish the effective oversight and administration of the program</p>	<p>Systemic or repeated failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval</p> <p>Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)</p> <p>Systemic or repeated failure to notify the Department and Members of terminated network providers within required timeframes</p>

**Section VI. Attachment J. Table 1: Risk Level Matrix**

Level	Examples of Noncompliant Behavior and/or Practices
	<p>Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested</p> <p>Failure to implement and maintain required policies, plans, and programs (e.g., fraud prevention plan, clinical practice guidelines)</p> <p>Using unapproved Member notices, educational materials, and handbooks and marketing materials</p> <p>Engaging in prohibited marketing activities and practices</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation</p> <p>Three or more Level 4 violations within a contract year</p>
<p><b>LEVEL 4</b> Action(s) or inaction(s) that inhibit the efficient operation of the managed care program</p>	<p>Systemic or repeated submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports)</p> <p>Failure to comply with time frames for distributing (or providing access to) Member Handbooks, identification cards, provider directories, and educational materials to Members (or potential members)</p> <p>Failure to meet minimum requirements requiring coordination and cooperation with external entities</p> <p>EQRO or other program audit reports with non-substantial findings</p> <p>Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements)</p> <p>Failure to timely furnish a policy, handbook, directory, or manual upon request by a Member or potential Member as required under the Contract</p>

## Attachment K. Managed Care Terminology Provided to the PIHP for Use with Members Pursuant to 42 C.F.R. § 438.10

Key terms below are defined as they are intended to be used with Members and do not conflict with the definitions in *Section II. Definitions and Abbreviations* of this contract.

1. **Appeal:** If NC Medicaid Direct makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an appeal when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask NC Medicaid Direct for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." Appeals and grievances are different.
2. **Copayment (Copay):** An amount you pay when you get certain health care services or a prescription.
3. **Durable Medical Equipment (DME):** Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.
4. **Emergency Medical Condition:** A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.
5. **Emergency Medical Transportation:** Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
6. **Emergency Department Care (or Emergency Room Care):** Care you receive in a hospital if you are experiencing an emergency medical condition.
7. **Emergency Services:** Services you receive to treat your emergency medical condition.
8. **Excluded Services:** Services that are not covered by NC Medicaid Direct.
9. **Grievance:** A complaint about your provider, care or services. Contact NC Medicaid Direct and tell them you have a "grievance" about your services. Grievances and appeals are different.
10. **Habilitation Services and Devices:** Health care services that help you keep, learn or improve skills and functioning for daily living.
11. **Health Insurance:** A type of insurance coverage that helps pay for your health and medical costs. Your Medicaid coverage is a type of health insurance.
12. **Home Health Care:** Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.
13. **Hospice Services:** Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social and spiritual services that support terminally ill individuals and their families or caregivers.
14. **Hospitalization:** Admission to a hospital for treatment that lasts more than 24 hours.
15. **Hospital Outpatient Care:** Services you receive from a hospital or other medical setting that do not require hospitalization.
16. **Medically Necessary:** Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
17. **Network (or Provider Network):** A group of doctors, hospitals, pharmacies and other health professionals who have a contract with NC Medicaid Direct to provide health care services for members.

18. **Out-of-Network Provider (or Non-participating Provider):** A provider that is not in NC Medicaid Direct's provider network.
19. **Network Provider (or Participating Provider):** A provider that is in NC Medicaid Direct's provider network.
20. **Physician Services:** Health care services you receive from a physician, nurse practitioner or physician assistant.
21. **Health Plan (or Plan):** Organization providing you with health insurance.
22. **Prior Authorization (or Preauthorization):** Approval you must have from NC Medicaid Direct before you can get or continue getting certain health care services or medicines.
23. **Premium:** The amount you pay for your health insurance every month. Most Medicaid and NC Health Choice beneficiaries do not have a premium.
24. **Prescription Drug Coverage:** Refers to how NC Medicaid Direct helps pay for its members' prescription drugs and medications.
25. **Prescription Drugs:** A drug that, by law, requires a provider to order it before a beneficiary can receive it.
26. **Primary Care Provider (or Primary Care Physician):** The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes.) Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.
27. **Provider:** A health care professional or a facility that delivers health care services, like a doctor, clinician, hospital or pharmacy.
28. **Rehabilitation Services and Devices:** Health care services and equipment that help you recover from an illness, accident, injury or surgery. These services can include physical or speech therapy.
29. **Skilled Nursing Care:** Health care services that require the skill of a licensed nurse.
30. **Specialist:** A provider who is trained and practices in a specific area of medicine.
31. **Urgent Care:** Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury.



## Attachment L. Policies

### 1. Medicaid Direct Prepaid Inpatient Health Plan Enrollment Policy

#### a. Scope

- i. The North Carolina Medicaid Direct Prepaid Inpatient Health Plan (PIHP) Enrollment Policy outlines the expectations of the Department and the PIHP in the enrollment of beneficiaries into PIHPs.

#### b. Identification of Beneficiaries Eligible for a PIHP

- i. In accordance with N.C. Gen. Stat. § 108D-40(a)(13) and 108D-60(b) as amended by S.L. 2021-642, s. 3.4A, the Department will identify beneficiaries who are members of the following eligibility groups who are excluded or delayed from Medicaid Managed Care and are eligible for the PIHP upon its launch.
  1. Beneficiaries who reside in a nursing facility and have so resided for a period of 90 days or longer.
  2. Beneficiaries who are in one of the following categories will be enrolled in the PIHP until the launch of the Foster Care Plan:
    3. Enrolled in the foster care system;
    4. Receiving Title IV-E adoption assistance; or
    5. Under the age of twenty-six (26) and formerly were in the foster care system.
  6. Beneficiaries who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing except for beneficiaries enrolled in the Innovations waiver.
  7. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations waiver excluding federally recognized tribal members
  8. Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the TBI waiver excluding federally recognized tribal members;
  9. Presumptively eligible beneficiaries, during the period of presumptive eligibility, excluding presumptive eligibility for pregnant women.
  10. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations and TBI waivers.
  11. Beneficiaries being served through CAP/C.
  12. Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice).
- ii. In accordance with N.C. Gen. Stat. § 108D-40(a)(5) beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are eligible for the PIHP.
  1. These beneficiaries will default to the Tribal Option for care management if they reside in a county where the Tribal Option is offered and will default to the PIHP for BH I/DD and TBI services and NC Medicaid Direct for physical health services, pharmacy, and State Plan LTSS.
  2. These beneficiaries will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible).
  3. More details of these options can be found in Section *IV.H.1 Tribal Member Services and Indian Health Care Providers* (42 C.F.R. § 438.14).
- iii. The Department shall auto-assign beneficiaries who are part of a group that is delayed or excluded from Medicaid Managed Care as described in Section V.B.E. (ii) to the PIHP that is responsible for their county of Medicaid eligibility through an 834 eligibility file.

- iv. The PIHP shall accept Member Enrollment and effectuate coverage on the first day of the month in which Medicaid eligibility is determined.
- c. Medicaid Eligibility Redeterminations**
- i. At a Member's annual Medicaid renewal, if a Member is redetermined eligible for Medicaid and continues to be eligible for a PIHP, the Department will auto-assign the Member into the same PIHP from the prior eligibility year, provided that the Member's Medicaid county of eligibility remains in the same PIHP Region.
    - 1. If the Member's eligibility has moved to a county that is part of a different PIHP Region, the Department will auto-assign the Member into the PIHP in the Member's new county of eligibility on the first day of the month following the change in the Member's county of eligibility.
  - ii. If a Member is determined based on data reviews to no longer be part of a group that is delayed or excluded from managed care, the Department will refer the Member to the Enrollment Broker for enrollment in a Standard Plan or BH I/DD Tailored Plan.
  - iii. If a Member is determined to no longer be eligible for Medicaid, the Member will be notified and disenrolled from the PIHP by the Department.
- d. Special Enrollment Cases**
- i. Exempt populations
    - 1. Exempt populations as defined in *Section II.A* that are PIHP Medicaid Direct eligible will be able to enroll in PIHPs.
    - 2. The Enrollment Broker will provide choice counseling to exempt populations and support NC Medicaid Direct, PIHP, and EBCI Tribal Option (as applicable).
    - 3. If a beneficiary in an exempt population selects NC Medicaid Direct, the Enrollment Broker will transmit the PIHP selection to the Department. The Department will transmit PIHP selection to the PIHP through an 834 eligibility file.
    - 4. If a beneficiary in an exempt population elects to move from NC Medicaid Direct and a PIHP to a Standard Plan, BH I/DD Tailored Plan or other delivery system (such as the EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan, BH I/DD Tailored Plan, or other delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan, BH I/DD Tailored Plan, or delivery system.<sup>1</sup>
    - 5. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system at redetermination and at any point during the year.
  - ii. Disenrollment from PIHPs required by the Department
    - 1. The Department may disenroll a Member from the PIHP for any of the following reasons:
      - a. Loss of eligibility
        - i. If the Department determines that a member is no longer eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the PIHP. The disenrollment effective date will be the last date of the Member's Medicaid eligibility.

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<sup>1</sup> There may be instances (e.g., an urgent medical need), as determined by the Department and based on the beneficiary's needs, in which enrollment in the new PHP or the new delivery system may become effective sooner, including mid-month.

- ii. If a Member is disenrolled from a PIHP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the PIHP upon reenrollment in Medicaid.<sup>2</sup>
- b. Change in Medicaid eligibility category
  - i. If the Department determines that a Member is no longer eligible for the PIHP because they are no longer part of an Exempt, excluded or delayed population as described defined in Section II.A, the Member will be notified by the Department and the Department will disenroll the Member from the PIHP. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.
- c. Change in county of Medicaid Administration
  - i. If the Department determines that the Member's county of Medicaid Administration has changed to a county outside the PIHP's catchment area, the Member will be notified by the Department and the Department will disenroll the Member from the PIHP and auto-enroll the member into the PIHP that is responsible for the new county of residence. The disenrollment date will be the first of the month following the change in the Member's county of residence.
- iii. In accordance with 42 C.F.R. § 438.56(f), Members, or an authorized representative, may appeal disenrollment determinations made by the Department through an appeals process defined by the Department.

**e. PIHP Enrollment Policy Changes**

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes.

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<sup>2</sup> 42 C.F.R. § 438.56(g).

## 2. AMH+ Practice and CMA Certification Policy

### Background

- i. Prior to PIHP launch, the Department will implement a direct process to certify provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs as described below and in the BH I/DD Tailored Plan Provider Manual for Tailored Care Management <https://medicaid.ncdhhs.gov/tailored-care-management> his certification process will require providers to apply to the Department and be assessed against the criteria in this policy.
  1. AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI. “Active” patients are those with at least two encounters with the AMH+ applicant’s practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department’s vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.
  2. CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization’s primary purpose at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. The “CMA” designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.
- ii. Beginning at BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan will assume responsibility for certifying provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs. The BH I/DD Tailored Plan must assess providers applying to become an AMH+ practice or CMA against the criteria in this policy. The Department will release additional guidance prior to BH I/DD Tailored Plan launch to describe the parameters for certification by BH I/DD Tailored Plans.

### a. Eligibility

To become certified as an AMH+ practice or CMA, an organization must meet the requirements for an AMH+ practice or CMA, given at *Section IV.G Care Management and Care Coordination*.

**b. Organizational Standing and Experience Criteria**

- i. The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the BH I/DD Tailored Plan population, specifically the subpopulation(s) for which it proposes to become a certified Tailored Care Management provider.
- ii. All organizations entering the certification process, including prospective AMH+ practices, will be required to indicate one or more of the following specialty designation type(s):
  1. Mental health and SUD
    - a. Adult
    - b. Child/adolescent
  2. I/DD (not enrolled in the Innovations Waiver)
  3. TBI (not enrolled in the TBI Waiver)
  4. Innovations Waiver
  5. Co-occurring I/DD and behavioral health
    - a. Adult
    - b. Child/adolescent
- iii. Organizations that specialize in BH must demonstrate their capacity to serve populations with both mental health and SUD needs. The organization must offer an array of services that is aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization will be able to show at least a two (2) year history of providing services to the BH I/DD Tailored Plan population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management.
- iv. The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.
- v. The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.
- vi. Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.
- vii. The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.
- viii. The Department (prior to PIHP launch) or PIHP (beginning at PIHP launch) will look for evidence of a strong governance structure.

Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

**c. Staffing Criteria**

- i. AMH+ practices and CMAs must meet the same care management staffing requirements as the BH I/DD Tailored Plan. See *Section IV.B.3 Staffing and Facilities*.
- ii. The evaluation of each provider organization's application for AMH+ or CMA certification will include gaining an understanding of the role of any CIN or other partners in supporting or facilitating Tailored Care Management.

1. Where the AMH+ practice or CMA proposes to rely on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look to ensure that care management is sufficiently integrated with the organization’s practice team, as Tailored Care Management requires.
2. Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to:
  - a. Approve hiring/placement of a care manager and
  - b. Require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.
- iii. CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support the Tailored Care Management model.
  1. Arrangements with CINs or Other Partners must include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.
  2. Any subsidiaries of PIHPs, BH I/DD Tailored Plans or other health plans may not be considered CINs or Other Partners for the purposes of Tailored Care Management with the following exception:
    - i. That AMH+ practice or CMA may decide to enter into arrangements with a BH I/DD Tailored Plan as an “Other Partner” for use of its IT products or platforms for care management, in order to meet the care management data system requirements.
  3. AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section IV.G.2 Tailored Care Management*

**d. Population Health and HIT Criteria**

- i. The AMH+ or CMA must have implemented an EHR or a clinical system of record that is in use by the AMH+ practice or CMA’s providers that may electronically record, store, and transmit their assigned Members’ clinical information, including medication adherence.
- ii. The AMH+ or CMA must use a single care management data system, whether or not integrated within the same system as the EHR or clinical system of record, which allows care managers to perform the following care management functions, at minimum:
  1. Maintain up-to-date documentation of Tailored Care Management Member lists and assignments of individual Members to care managers;
  2. Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
  3. Electronically document and store the Care Plan or ISP;
  4. Incorporate claims and encounter data;
  5. Provide role-based access to and electronically share, if requested the Member’s records with the Member’s care team to support and coordinate care management, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
  6. Track referrals; and
  7. Allow care managers to:
    - a. Identify risk factors for individual Members;
    - b. Develop actionable Care Plans and ISPs;
    - c. Monitor and quickly respond to changes in a Member’s health status;
    - d. Track a Member’s referrals and provide alerts where care gaps occur;
    - e. Monitor a Member’s medication adherence;

- f. Transmit and share reports and summary of care records with care team members; and
    - g. Support data analytics and performance and send quality measures (where applicable).
  - iii. The AMH+ practice or CMA must receive and use enrollment data from the PIHP to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner on its behalf) must be able to:
    - 1. Receive, in machine-readable format, and maintain up-to-date records of acuity tiers by Member, as determined and shared by the BH I/DD Tailored Plan;
    - 2. Receive, in machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the BH I/DD Tailored Plan; and
    - 3. Electronically reconcile the Tailored Care Management assignment lists received from the BH I/DD Tailored Plan with its list of Members for whom it provides Tailored Care Management.
  - iv. The same requirements for use of ADT information apply at the PIHP level and AMH+ or CMA level. See *Section IV.G.2 Tailored Care Management*.
  - v. The same requirements for use of “NCCARE360” apply at the PIHP level and AMH+ or CMA level. See *Section IV.G Care Management and Care Coordination*.
  - vi. The Department expects that during the first two contract years, PIHP, AMH+ practices, and CMAs will rely on the standardized acuity tiering methodology described above *Section IV.G.2 Tailored Care Management* as the primary method for segmenting and managing their populations.
  - vii. As described in *IV.G.2 Tailored Care Management*, the PIHP will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs.
  - viii. By Contract Year 3, as the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approach, refining the data and risk stratification scores they receive from the PIHP to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs’ use of Member registries to track Members by condition type/cohort is encouraged, but not required.
  - ix. Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of Members and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.
- e. Quality Measurement Criteria**
- i. After the launch of the PIHP, AMH+ practices and CMAs will be required to gather, process, and share data with the PIHP for the purpose of quality measurement and reporting.
  - ii. The Department will publish quality measure requirements each year. Elements of the list may be modified on a quarterly basis, but new measures will be added only during annual updates.
  - iii. AMH+ practices and CMAs may need to perform tasks including:
    - 1. Abstracting data from Member charts;
    - 2. Performing quality assurance to validate the accuracy of data in Member charts that is used for quality measurement purposes;
    - 3. Using additional codes to fully document Member status and needs in order to improve the accuracy of quality measurement; and
    - 4. Explaining to Members the purpose of certain state-sponsored surveys, how the state and PIHP will use survey results, and how their information will be kept confidential.
  - iv. As covered in *Section IV.G Care Management and Care Coordination*, BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

**f. Other Tailored Care Management Criteria**

- i. AMH+ practices and CMAs must develop policies for communicating and sharing information with Members, their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.
- ii. AMH+ practices and CMAs must meet the same contact requirements as the BH I/DD Tailored Plan. *See Section IV.G Care Management and Care Coordination.*
- iii. AMH+ practices and CMAs must meet the same requirements for Care Management Comprehensive Assessment that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
- iv. AMH+ practices and CMAs must meet the same requirements for Care Plans and ISPs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
- v. AMH+ practices and CMAs must meet the same requirements for the composition of a care team that apply at the BH I/DD Tailored Plan level.
- vi. By PIHP launch, the AMH+ practice or CMA must demonstrate the ability to electronically and securely transmit the Care Plan or ISP to each member of the multidisciplinary care team. *See Section IV.G Care Management and Care Coordination.*
- vii. AMH+ practices and CMAs must meet the same requirements for ongoing care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
- viii. AMH+ practices and CMAs must meet the same requirements related to addressing Unmet Health-Related Resource Needs that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
- ix. AMH+ practices and CMAs must meet the same requirements for transitional care management that apply at the BH I/DD Tailored Plan level. *See Section IV.G Care Management and Care Coordination.*
- x. Care managers based at AMH+s and CMAs, as well as any supporting CINs or Other Partners, will be required to undergo the same training requirements as care managers based at BH I/DD Tailored Plans. *See Section IV.G Care Management and Care Coordination.*



### 3. Uniform Credentialing and Re-credentialing Policy for Medicaid and NC Health Choice Providers

#### a. Background

This Uniform Credentialing and Re-credentialing Policy for Medicaid and NC Health Choice Providers outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a PIHP in determining whether to allow a provider to be included in the PIHP's Network. This is based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider. The PIHP shall also have the authority to select which providers may enroll in the PIHP Closed Network consistent with the PIHP selection and retention criteria. Enrollment in the NC Medicaid Direct Program is distinct from Enrollment in the PIHP Closed Network. The PIHP has the authority to maintain a closed network for all services as set forth in N.C.G.S. § 108D-1(6). The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the PIHP in selection and retention of network providers for Medicaid BH and I/DD services.

#### Scope

This Policy applies to the PIHP and covers credentialing and re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to, mental health, SUD, and HCBS [42 C.F.R. 438.12(a)(2); 42 C.F.R. § 438.214(b)(1)].

#### Policy Statement

The PIHP shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Re-credentialing Policy.

#### Centralized Provider Enrollment and Credentialing

- i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:
  1. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid Direct for BH and I/DD Services.
    - a. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
    - b. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.
  2. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
  3. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan accrediting organization. The applicable data and processing standards shall be consistent

- with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.
4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid Enrolled provider, with the application serving for enrollment as PIHP providers.
    - a. The Department shall not mandate PIHP providers enrolled with the State to provide State-funded services.
  5. Providers will be reverified and recredentialed as permitted, by the Department in the Contract.
  6. A PIHP shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the PIHP will routinely evaluate its Provider Network to confirm a provider's continue active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
  7. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The PIHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

#### **Provider Credentialing and Re-credentialing Policy**

- i. The PIHP shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:
  1. Meet the requirements specified in 42 C.F.R. § 438.214;
  2. Meet the requirements specified in this Contract;
  3. Follow this Policy and any applicable requirements from the Contract, and address acute, mental health, substance use disorders, and long-term services and supports providers;
  4. Establish that the PIHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.
  5. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider and therefore eligible for contracting;
  6. Prohibit PIHP from discriminating against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
  7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
  8. Prohibit PIHP to 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;
  9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and
  10. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH and I/DD services. At a minimum, these standards shall assess a provider's ability to deliver care.
  11. Describe the information that providers will be requested to submit as part of the contracting process.
  12. Describe the process by which the PIHP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).

13. If PIHP requires a provider to submit additional information as part of its contracting process, the PIHP's policy shall include a description of all such information.
  14. PIHP shall re-credential providers as follows:
    - a. The PIHP shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
    - b. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
  15. Include all previous versions, be published on the PIHP's website and include the Policy effective dates.
- ii. PIHP shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.
  - iii. PIHP shall have discretion to make network contracting decisions consistent with the Policy.

#### **4. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards**

##### **A. Background**

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

##### **B. Behavioral Health Services**

- i. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.
- ii. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.
- iii. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.
- iv. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of network adequacy standards.
- v. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
- vi. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
- vii. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- viii. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- ix. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- x. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- xi. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- xii. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- xiii. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- xiv. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- xv. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- xvi. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- xvii. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.
- xviii. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

- xix. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.
- xx. Urgent Care for Mental Health:
1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
  2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.
- xxi. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.
- xxii. Emergency Services for SUDs: Services to treat 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 use; includes crisis intervention for the purpose of BH appointment wait-time standards.
- xxiii. Urgent care for SUD:
3. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
  4. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.
- xxiv. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.
- xxv. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

## 5. Tribal Payment Policy

### 1) Background

This Tribal Payment Policy outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by a PIHP.

Indian Health Care Provider (IHCP) refers to a “health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by state recognized tribes are not considered IHCPs.

In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a “Tribal Provider Attestation.” This “Tribal Provider Attestation” letter from the EBCI Chief’s office shall be submitted to NC DHHS as part of the NC DHHS centralized credentialing process. The information about tribal providers will be shared with PIHPs through DHB’s existing process

### 1) Scope

This Policy applies to PIHPs and covers payment for covered services provided by IHCPs and other Tribal providers. This Policy shall apply to all IHCPs/Tribal providers regardless of the provider’s contracting status.

### 3) Policy Statement

The PIHP shall implement:

#### a) Claim Submission

- i) Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.
- ii) Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NC Tracks in fee for service.

#### b) Payment

- i) PIHP shall comply with PIHP Contract Section V.D.4.h., *Indian Health Care Provider (IHCP) Payments*
  - (1) In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PIHP shall reimburse IHCPs as follows:
    - (a) Those that are not enrolled as an FQHC, regardless of whether they participate in the PIHP’s network:
      - (i) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
      - (ii) The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.
    - (2) The PIHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
  - ii) PIHP shall comply with PIHP Contract *Section IV.D.1., Engagement with Tribes* with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.
    - (1) The PIHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

#### c) Prompt Pay

- i) PIHP shall comply with PIHP Contract *Section IV.J.1 Claims*.
  - (1) The PIHP shall promptly pay Clean Claims, regardless of provider contracting status. The PIHP shall reimburse medical providers in a timely and accurate manner when a clean medical claim is received.

- (a) Claims
    - (i) The PIHP shall, within eighteen (18) calendar days of receiving a Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.
    - (ii) The PIHP shall pay or deny a Clean Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
    - (iii) A Pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.
  - (2) The PIHP shall reprocess claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
  - (3) The PIHP may require that claims be submitted within one hundred eighty (180) calendar days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) calendar days after the date of the Member's discharge from the facility. However, the PIHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by the PIHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.
  - (4) Interest and Penalties
    - (a) The PIHP shall pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.
    - (b) In addition to the interest on late payments required by this Section, the PIHP shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.
    - (c) The PIHP shall not be subject to interest or penalty payments if its failure to comply is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the PIHP's reasonable control, including an act of God, insurrection, strike, fire, or power outages. Also, the PIHP is not subject to interest or penalty payments if the PIHP has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.
  - (5) The PIHP shall maintain written or electronic records of its activities under the prompt pay standards, including records of when each claim was received, paid, denied, or pended, and the PIHP's review and handling of each claim under this section, sufficient to demonstrate compliance with the prompt pay standards.
  - (6) For purposes of actions which must be taken by a PIHP as found in PIHP Contract *Section IV.J.1 Claims*, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.
- d) Other Payment Sources**
- i) Due to the change in payer hierarchy, the PIHP will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.
  - ii) Tribal self-funded insurance is not a billable source for the Eastern Band of Cherokee Indians (EBCI), and therefore, PIHP shall not attempt to coordinate benefits with that plan.
- e) Sovereignty**
- i) No contractual relationship shall deny or alter tribal sovereignty.

# Attachment M. Addendum for Division of State Operated Healthcare Facilities

## 1. Background

The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.<sup>10</sup> DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The PIHP shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

## 2. Scope

The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, grievances and appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the PIHP and DSOHF facilities.

## 3. Admissions

When admitting a member to a DSOHF facility, the PIHP must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:

- a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):
  - i. The PIHP or PIHP designated community provider (e.g., BH community provider or hospital/emergency department) shall complete and submit a Regional Referral Form available on the Department's website<sup>11</sup> or initiate referral via the North Carolina BH Crisis Referral System ("BH-CRSys") as defined in *Section II.A. Definitions* to the DSOHF facility.
  - ii. The PIHP must review the admission based on review of the information provided in the Regional Referral Form or BH-CRSys.
  - iii. In cases where the Member presents directly to a psychiatric hospital or ADATC for admission, the PIHP shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.
  - iv. The PIHP shall ensure that a PIHP-employed utilization management staff member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;
  - v. For members subject to involuntary commitment proceedings, the PIHP must provide information or a representative who can assist the district court in determining if the member requires continued services. If the PIHP elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the PIHP.
  - vi. Prior to referral or authorization of any member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the PIHP must verify that the referral is in accordance with the requirements of N.C.G.S. 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a State psychiatric hospital.
  - vii. For members who have multiple disorders and medical fragility or have multiple disorders and deafness, the PIHP shall be designated by the Department to determine whether members have a

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<sup>10</sup> DSOHF also serves individuals with neuro-medical needs in specialized treatment centers that are carved out of Medicaid Managed Care and therefore not included in the PIHP contract.

<sup>11</sup> The Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC is available at <https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf>.  
<https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf>.



high level of disability which indicates that alternative care is inappropriate, consistent with N.C.G.S. § 122C-261(e)(4).

- viii. In determining whether members with known or reasonably believed I/DD are eligible for referral and/or authorization for admission to a State psychiatric hospital, the PIHP must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose to determine that any less restrictive and less costly options in the community have been exhausted.
- b. State Developmental Centers:
  - i. The PIHP must exhaust all options for community care and supports before it refers a Member to a State Developmental Center.
  - ii. When a PIHP refers a Member to a State Developmental Center, the PIHP must submit an application packet, inclusive of a letter of endorsement, to the State Developmental Center Admission/Discharge Coordinator;
  - iii. The PIHP must comply with the DSOHF admission criteria and protocols; and
  - iv. The PIHP must ensure timely execution of the Memorandum of Agreement (MOA)<sup>12</sup> with the Member's guardian regarding the Member's discharge plan.

#### 4. Authorization

The PIHP must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid clinical coverage policies as detailed in *Section IV.F.1 Behavioral Health and I/DD Benefits Package*, respectively, as well as the specific requirements listed below.

##### a. General Requirements for State Psychiatric Hospitals and ADATCs:

###### i. Emergency Services:

- A. The PIHP must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.
- B. The PIHP cannot refuse to cover emergency services based upon the DSOHF facility failing to notify the member's PIHP of the individual's screening and treatment following presentation for emergency services.
- C. For members who present directly to the psychiatric hospital or ADATC as an emergency commitment or as a self-referral, the DSOHF facility shall submit a completed Electronic Authorization Request (EAR) to the PIHP the next business day following an admission to request admission authorization.
- D. Upon receipt of the EAR, the PIHP must authorize and cover ongoing emergency medical services in accordance with applicable clinical coverage policies and consistent with the prudent layperson standard, as defined in EMTALA (Section 1867(a) of the Social Security Act).

###### ii. Inpatient Services:

- A. The PIHP must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services, provided that the deadline may be extended for one additional business day if: (i) the individual or DSOHF facility requests the extension; and (ii) the PIHP justifies to the DSOHF facility a need for additional information and how the extension is in the Member's interest.
- B. The PIHP must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.
- C. Following initial admission authorization, the PIHP must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.
- D. To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the PIHP prior to the expiration of the prior

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<sup>12</sup> The MOA is a formal agreement made between the State Developmental Center, legally responsible person/guardian, and the PIHP identifying the responsibilities of all parties in supporting the individual to return to their home or community setting within the identified length of admission as specified in the MOA.

authorization no later than the last covered day of the existing authorization, or the previous business day if the last covered day occurs on a weekend or holiday.

- E. The PIHP must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.
- b. Requirements for Assessment and Stabilization
  - i. The PIHP shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of members who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).
  - ii. The PIHP must identify an appropriate discharge plan for all such members beginning at admission.
- c. Requirements for State Developmental Centers:
  - i. Initial authorization:
    - A. Prior to admission to a State Developmental Center, the PIHP shall complete the ICF-IID level of care determination form (Level of Care Form) including obtaining the physician signature and send a copy to the facility's reimbursement office to complete the authorization to bill Medicaid.
    - B. If authorization is not received from the PIHP by the time of admission to a State Developmental Center, the PIHP shall promptly provide retrospective authorization after:
      - 1. The State Developmental Center sends the EAR to the PIHP; and
      - 2. The State Developmental Center receives the Level of Care Form from the PIHP, completes it and submits it to the PIHP
  - ii. Re-authorization:
    - A. To reauthorize services in a State Developmental Center, the facility must send a completed Level of Care Form, Person Centered Plan (PCP) if it has been updated since the previous authorization, and psychological evaluation to the PIHP prior to the expiration of the initial authorization.
    - B. Upon receipt of the required documentation, the PIHP must approve or deny the request in accordance with the standard timeframes for service authorization requests. Authorization shall be for at least 180 days from the date of the physician signature on the Level of Care Form. The PIHP must review the Utilization Review Level of Care form every six months even if the authorization is in excess of 180 days.
    - C. Facility-based respite services for members enrolled in the Innovations Waiver:
      - 1. The PIHP shall issue prior authorization for Respite Facility Based services provided at a State Developmental Center prior to a member's admission.

## **5. Member Grievances**

- a. The DSOHF facility and the Department will manage and resolve all member clinical concerns, or grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with grievance procedures established by the Department.
- b. The PIHP must agree that DSOHF facilities shall refer any unresolved patient grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the PIHP Hotline number for reporting any grievances.)

## **6. Event Reporting and Abuse/Neglect/Exploitation.**

- a. The PIHP must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to members receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.
- b. The PIHP must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.

- c. The DSOHF facility will cooperate with the PIHP's written request for information regarding any individual safety events/allegations involving members to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the PIHP with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the PIHP's request.
- d. The PIHP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The PIHP shall provide the DSOHF a written summary of its finding within thirty (30) days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

# Attachment N. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

**Table 1: Liquidated Damages for Compliance Issues**

Section VI. Attachment N: Table 1: Liquidated Damages		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
<b>Administration and Management</b>		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	\$1,250 per calendar day
2.	Failure to comply with conflict of interest requirements described in <i>Section III.B.15. Disclosure of Conflicts of Interests</i> and <i>Section IV.A.6. Staffing and Facilities</i> .	\$2,500 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by <i>Section III.B.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition</i> .	\$250 per calendar day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in <i>Section III.B.17. Disclosure of Ownership Interest</i> .	\$625 per contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in <i>Section III.B.46 Subcontractors</i> .	Up to \$12,500 per occurrence
<b>Members</b>		
6.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in <i>Section IV.E.4. Marketing</i>	\$1,250 per occurrence
7.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in <i>Section IV.E.1 Eligibility and Enrollment for PIHPs</i>	\$125 per occurrence per member
8.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in <i>Section IV.E.3 Member Engagement</i> .	\$125 per occurrence per member
9.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in <i>Section IV.E.3 Member Engagement</i> .	Up to \$12,500 per occurrence

**Section VI. Attachment N: Table 1: Liquidated Damages**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
10.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in <i>Section IV.E.6. Member Grievances and Appeals</i> .	\$125 per occurrence
11.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	\$1,250 per occurrence
12.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in <i>Section IV.E.6. Member Grievances and Appeals</i> .	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department.  AND  \$125 per calendar day for each day the PIHP fails to provide continuation or restoration as required by the Department.
13.	Failure to attend mediations and hearings as scheduled as specified in <i>Section IV.E.6. Member Grievances and Appeals</i> .	\$250 for each mediation or hearing that the PIHP fails to attend as required
14.	Failure to comply with Transition of Care requirements as specified <i>Section IV.G.3. Care Coordination and Care Transitions for all Members</i> .	\$25 per calendar day, per Member  AND  The value of the services the PIHP failed to cover during the applicable transition of care period, as determined by the Department.
<b>Benefits</b>		
15.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	\$1,250 per occurrence per member
16.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified <i>Section IV.F.1. Behavioral Health and I/DD Benefits Package</i> .	\$1,250 per standard authorization request \$1,875 per expedited authorization request
17.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified <i>Section IV.H.1. Provider Network</i> .	\$250 per occurrence
18.	Failure to follow Department required Clinical Coverage Policies as specified <i>Section IV.F.1. Behavioral Health and I/DD Benefits Package</i> .	\$625 per occurrence

**Section VI. Attachment N: Table 1: Liquidated Damages**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
<b>Care Management</b>		
19.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by <i>Section IV.G.2. Tailored Care Management.</i>	\$62.50 per calendar day
20.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in the <i>Section IV.G.2. Tailored Care Management</i> (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	\$125 per deficient/missing care management comprehensive assessment or plan
21.	Failure to adhere to the quarterly minimum contact requirements for a Member’s acuity tier as described in <i>Section IV.G. Care Management and Care Coordination.</i>	\$62.50 per contact not provided per Member (i.e., failure to have two of the required contacts for a Member would result in a \$125 payment)
22.	Failure to comply with minimum Transitional Care Management requirements for members engaged in Tailored Care Management as described in <i>Section IV.G.2. Tailored Care Management.</i>	\$62.50 per occurrence per Member
23.	Failure to comply with minimum care coordination requirements for members with a BH transitional care need as described in <i>Section IV.G. Care Management and Care Coordination</i>	\$62.50 per occurrence per Member
24.	Failure to comply with federal conflict-free case management requirements for Members enrolled in the Innovations Waiver	\$125 per occurrence per Member
25.	Failure to complete outreach to all Members in foster care/adoption assistance and former foster youth within twenty-one (21) days of PIHP launch, as described in <i>Section IV.G. Care Management and Care Coordination.</i>	\$500 per occurrence
26.	Failure to schedule and attend meetings with County Child Welfare Workers for Members involved in the child welfare system, as described in <i>Section IV.G Care Management and Care Coordination</i>	\$500 per occurrence
<b>Providers</b>		
27.	Failure to update online and printed provider directory with accurate provider information as required by <i>Section IV.H.2. Provider Network Management.</i>	\$250 per confirmed incident

**Section VI. Attachment N: Table 1: Liquidated Damages**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
28.	Failure to report notice of provider termination from participation in the PIHP’s provider network (includes terminations initiated by the provider or by the PIHP) to the Department or to the affected Members within the timeframes required by <i>Section IV.H.2. Provider Network Management</i>	\$25 per calendar day per Member for failure to timely notify the affected member or Department
29.	Failure to notify a provider of the network contracting decision with five (5) Business Days of verification of the provider’s status as a Medicaid Enrolled provider.	\$12.50 per calendar day per provider
30.	Failure to submit timely initial and updated, compliant Network Access Plan as described in <i>Section IV.H.1. Provider Network</i> .	\$1,250 per calendar day
31.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in <i>Section IV.H.1. Provider Network</i> (excludes Department approved exceptions to the network adequacy standards).	\$625per month for failure to meet any of the listed standards, either individually or in combination
32.	Failure to timely submit a PIHP Network Data File that meets the Department’s specifications	\$62.50 per calendar day
33.	Failure to maintain accurate provider directory information as required by <i>Section IV.H.2. Provider Network Management</i> .	\$25 per calendar day per provider
<b>Quality and Value</b>		
34.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in <i>Section IV.I.1. Quality Management and Quality Improvement</i> .	\$1,250 per calendar day
35.	Failure to timely submit appropriate PIPs to the Department as described in <i>Section IV.I.1. Quality Management and Quality Improvement</i> .	\$250 per calendar day
36.	Failure to timely submit QAPI to the Department as described in <i>Section IV.I.1. Quality Management and Quality Improvement</i> .	\$250 per calendar day
<b>Claims and Encounter Management</b>		
37.	Failure to timely submit monthly encounter data set certification.	\$250 per calendar day

**Section VI. Attachment N: Table 1: Liquidated Damages**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
<b>Financial Requirements</b>		
38.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Section VI. Attachment I. Reporting Requirements.</i>	\$500 per calendar day
39.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in <i>Section VI. Attachment I. Reporting Requirements.</i>	\$250 per calendar day
40.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in <i>Section IV.K.2. Medical Loss Ratio</i> and <i>Section VI. Attachment I. Reporting Requirements.</i>	\$500per calendar day
41.	Failure to timely and accurately submit financial reports in accordance with <i>Section VI. Attachment I. Reporting Requirements</i> or comply with any other ad-hoc request for financial reporting as directed by the Department.	\$250 per calendar day
<b>Compliance</b>		
42.	Failure to establish and maintain a Special Investigative Unit as described in <i>Section IV.C. Compliance.</i>	\$1,250 per calendar day that the Department determines the PIHP is not in compliance
43.	Failure to timely submit on an annual basis the Compliance Program report as described in <i>Section IV.C. Compliance and Section VI. Attachment I. Reporting Requirements.</i>	\$250 per calendar day
44.	Failure to timely submit the Recoveries from Third Party Resources Report described in <i>Section IV.C.4. Third Party Liability (TPL)</i> and <i>Section VI. Attachment I. Reporting Requirements.</i>	\$62.50 per calendar day
45.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$625 per incident for failure to fully cooperate during an investigation
46.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PIHP's own conduct, a provider, or a member.	\$62.50 per calendar day
47.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in <i>Section IV.C. Compliance and Section VI. Attachment I. Reporting Requirements.</i>	\$500 per calendar day



**Section VI. Attachment N: Table 1: Liquidated Damages**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
<b>Technical Specifications</b>		
48.	Failure by the PIHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	\$125 per Member per occurrence
49.	Failure by the PIHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	\$125 per occurrence
50.	Failure by the PIHP to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	\$125 per Member per occurrence, not to exceed \$2,500,000
<b>Directives and Deliverables</b>		
51.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	\$125 per calendar day
52.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	\$250 per occurrence per committee
53.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	\$125 per calendar day the unapproved agreement or materials are in use
54.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g., prevention and population health management programs, drug utilization review program).	\$ 5,000 per occurrence per plan or program
55.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	\$125 per calendar day for each day the CAP is late, or for each day the PIHP fails to comply with an approved CAP

**Table 2: Metrics, SLAs and Liquidated Damages**

Section VI. Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
<b>Enrollment and Disenrollment</b>					
1.	Member Enrollment Processing	The PIHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PIHP to its system to trigger enrollment and disenrollment processes.	Daily	\$250 per twenty-four (24) hour period  Note: Effective one month prior to PIHP.
<b>Member Grievances and Appeals</b>					
2.	Member Appeals Resolution - Standard	The PIHP shall resolve at least ninety-eight percent (98%) of PIHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	\$2,500 per month
3.	Member Appeals Resolution - Expedited	The PIHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PIHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	\$2,500 per month
4.	Member Grievance Resolution	The PIHP shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PIHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	\$1,250 per month
<b>Care Management</b>					

**Section VI. Attachment N: Table 2 Performance Metrics, Service Level Agreements and Liquidated Damages**

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
5.	Contracting with AMH+ and CMAs	The PIHP shall contract with 100 percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in the contract ( <i>Section IV.G.2 Tailored Care Management.</i> )	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the PIHP divided by the total number of certified AMH+ practices and CMAs.	Monthly	\$12,500 per month
<b>Encounters</b>					
6.	Encounter Data Timeliness/ Completeness	The PIHP shall submit ninety-eight percent (98%) of encounters within thirty (30) calendar days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	\$12.50 per claim per calendar day
7.	Encounter Data Accuracy	The PIHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	\$6,250 per month
8.	Encounter Data Reconciliation	The encounters submitted by the PIHP shall reconcile to at least ninety-eight percent (98%) of paid medical claims amounts reported on financial reports.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PIHP.	Monthly	\$2,500 per month

## Attachment O. Subcontractor Identification Form

The Contractor must complete a *Subcontractor Identification Form* for each known Subcontractor, as defined in Contract Section II. Definitions and Abbreviations, A Definitions, who will be used to meet the Contract requirement or otherwise perform any services pursuant to the Contract (i.e., there should be one form for each Subcontractor).

By executing the Contract, or submitting this Attachment after Contract Execution in accordance with the **Subcontractor** clause of the Contract, the Contractor:

1. Certifies that the information provided in this Attachment is true to the best of its information and belief; and
2. Acknowledges the requirements set forth in the Terms and Conditions related to Subcontractors and the resulting obligations, including requiring Department approval of any Subcontractors used in the performance of the Contract; and
3. Agrees to notify the Department of any material changes to the information provided in this Attachment that arise prior to execution or during the term of the Contract.

A: Subcontractor Identification	
<b>1. Business Information.</b> Provide the requested Information in the space provided:	
Legal Name of Subcontractor	Click or tap here to enter text.
Name Used for Business if Different	Click or tap here to enter text.
FEIN/Taxpayer ID	Click or tap here to enter text.
Address	Click or tap here to enter text.
Contract Executed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Term of Contract	Click or tap here to enter text.
Name of Contact Person	Click or tap here to enter text.
Title	
Phone Number	
Email Address	
<b>2. Scope of Subcontracted Services.</b> Identify the scope of services and activities that will be provided by the Subcontractor; cite specific Sections of the Contract as applicable:	
Click or tap here to enter text.	
<b>3. Is Subcontractor a government entity?</b> If no, complete Section B: Historically Underutilized Businesses below.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

**B: Historically Underutilized Businesses (HUB)**

1. Is proposed non-government entity Subcontractor **owned** by a HUB?

- Yes** (if yes, complete Question 2)
- No** (if no, skip to Question 3)
- Unknown** (if unknown, skip to Question 3)

**Owned** means at least fifty-one percent (51%) of the business is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in question b. below, or in the case of a corporation, at least fifty-one percent (51%) of the stock is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in Question 2. below.

2. Identify the Type of minority business group(s). Check all that apply.

- Black** A person having origins in any of the black racial groups of Africa.
- Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- American Indian** A person having origins in any of the original Indian peoples of North America.
- Female**
- Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

3. Is the proposed non-government Subcontractor **operated** by a HUB?

- Yes** (if yes, complete Question 4)
- No** (if no, skip to Question 5)
- Unknown** (if unknown, skip to Question 5)

**Operated** means the management and daily business operations are controlled by one or more owners of the business who are citizens or lawful permanent residents of the United States of at least one of the groups listed in Question 4. below

4. Identify the type of minority business group(s). Check all that apply.

- Black** A person having origins in any of the black racial groups of Africa.
- Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- American Indian** A person having origins in any of the original Indian peoples of North America.
- Female**
- Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

5. Is the proposed non-government Subcontractor Certified with North Carolina as a HUB?

- Yes
- No
- Unknown

## Attachment P. PIHP Capitation Rates

[Placeholder]

## Attachment Q. PIHP Catchment Areas

The Department has defined six (6) PIHP Catchment Areas within North Carolina. See **Table 1: List of Counties by PIHP Catchment Area** for the counties included in each of the six (6) PIHP Catchment Areas.

**Table 1: List of Counties by PIHP Catchment Area**

PHIP	Counties in Catchment Area
Alliance	Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake.
Eastpointe	Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, and Wilson.
Partners	Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, and Yadkin.
Sandhills	Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham
Trillium	Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington.
Vaya	Alexander, Alamance, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey.

# Attachment R. Business Associate Agreement

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

*This Business Associate Agreement (“Agreement”) is made effective upon the later of the execution dates of this Agreement (“Effective Date”) by and between North Carolina Department of Health and Human Services, Division of Health Benefits (“Covered Entity”) and [Click or tap here to enter text.](#) (“Business Associate”) (collectively the “Parties”).*

## 1. BACKGROUND

- a. Covered Entity and Business Associate are Parties to a contract entitled: (Placeholder for Contract Title) (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 Agreement 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. Except as provided in this Agreement, all applicable terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- b. 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.
- c. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

**IN WITNESS WHEREOF**, the Parties, through their authorized representatives, execute this Agreement as of the Effective Date.

**BUSINESS ASSOCIATE**

\_\_\_\_\_  
Full Name  
Title

\_\_\_\_\_  
Date

**COVERED ENTITY**

\_\_\_\_\_  
Dave Richard  
Deputy Secretary

\_\_\_\_\_  
Date

# Attachment S. State Certifications

## State Certifications Contractor Certifications Required by North Carolina Law

**Instructions:** The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order 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](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf)
- G.S. 133-32: <http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32>
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): <https://digital.ncdcr.gov/digital/collection/p16062coll5/id/11940>
- G.S. 105-164.8(b): [http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter\\_105/GS\\_105-164.8.pdf](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](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](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](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf)
- G.S. 143-133.3: [http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_143/GS\\_143-133.3.html](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html)
- G.S. 143B-139.6C: [http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter\\_143B/GS\\_143B-139.6C.pdf](http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf)

### Certifications

- (1) Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009), the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.
- (2) Pursuant to G.S. 143-48.5 and G.S. 143-133.3, 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](http://www.uscis.gov)
- (3) 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.
- (4) 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.
- (5) Pursuant to G.S. 143B-139.6C, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C. and that a violation of that statute shall void the Agreement.
- (6) The undersigned hereby certifies further that:
- (a) He or she is a duly authorized representative of the Contractor named below;
  - (b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
  - (c) 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:

[Click or tap here to enter text.](#)

Contractor's Authorized Agent:

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name: [Click or tap here to enter text.](#)

Title: [Click or tap here to enter text.](#)

## Attachment T. Federal Certifications and Disclosures

### The undersigned states that:

1. He or she is the duly authorized representative of the Contractor named below;
2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, 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;
3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
4. [Check the applicable statement]
  - He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **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 Contractor **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.
5. The Contractor shall require its subcontractors to whom such certifications and disclosures apply, if any, to make the same certifications and disclosure.

\_\_\_\_\_  
Signature

[Click or tap here to enter text.](#)

\_\_\_\_\_  
Title

[Click or tap here to enter text.](#)

\_\_\_\_\_  
Contractor Name

\_\_\_\_\_  
Date

**[This Certification Must be Signed by the Same Individual Who Signed the Proposal Execution Page]**

### I. Certification Regarding Nondiscrimination

**The Contractor 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 Contractor 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 Contractor'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:
    - i. The dangers of drug abuse in the workplace;
    - ii. The Contractor's policy of maintaining a drug-free workplace;
    - iii. Any available drug counseling, rehabilitation, and employee assistance programs; and
    - iv. 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:
    - i. Abide by the terms of the statement; and
    - ii. 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)(ii) 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)(ii), with respect to any employee who is so convicted:
    - i. Taking appropriate personnel action against such an employee, up to and including termination; or
    - ii. 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 pages if necessary):

**Address:**

Street:	Click or tap here to enter text.
City, State, Zip Code:	Click or tap here to enter text.

**Address:**

Street:	Click or tap here to enter text.
City, State, Zip Code:	Click or tap here to enter text.

3. Contractor 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 Contractor certifies** that it will comply with the requirements of the Act. The Contractor 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 Contractor.]

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, 22 CFR 513.100. 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 Contractor 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 subrecipients 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. Subawards 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, 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

**Disclosure of Lobbying Activities**

**(Approved by OMB 0344-0046)**

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

<b>1. Type of Federal Action</b> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b> <input type="checkbox"/> a. Bid/offer/application <input type="checkbox"/> b. Initial Award <input type="checkbox"/> c. Post-Award	<b>3. Report Type</b> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year:          Enter Year      Quarter:      Enter Qtr Date of Last Report:          Enter a date.													
<b>4. Name and Address of Reporting Entity:</b>  <input type="checkbox"/> Prime  <input type="checkbox"/> Subawardee Tier (if known):          Enter Text Congressional District (if known):      Enter Text		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Name:</td> <td>Click or tap here to enter text.</td> </tr> <tr> <td>Street Address:</td> <td>Click or tap here to enter text.</td> </tr> <tr> <td>City, State, Zip:</td> <td>Click or tap here to enter text.</td> </tr> <tr> <td>Congressional District (if known):</td> <td>Click or tap here to enter text.</td> </tr> </table>		Name:	Click or tap here to enter text.	Street Address:	Click or tap here to enter text.	City, State, Zip:	Click or tap here to enter text.	Congressional District (if known):	Click or tap here to enter text.				
Name:	Click or tap here to enter text.														
Street Address:	Click or tap here to enter text.														
City, State, Zip:	Click or tap here to enter text.														
Congressional District (if known):	Click or tap here to enter text.														
<b>6. Federal Department/Agency:</b> Click or tap here to enter text.		<b>7. Federal Program Name/Description:</b> Click or tap here to enter text.  <b>CFDA Number (if applicable):</b> Click here to enter text.													
<b>8. Federal Action Number (if known):</b> Click or tap here to enter text.	<b>9. Award Amount (if known)</b> \$Click here to enter text.														
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI)</i>  Click or tap here to enter text.		<b>b. Individuals Performing Services</b> <i>(last name, first name, MI)</i> <i>(including address if different from No.10a.)</i>  Click or tap here to enter text.													
<i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i>															
<b>11. Amount of Payment</b> <i>(check all that apply):</i>	\$Click or tap here to enter text.		<b>13. Type of Payment</b> <i>(check all that apply):</i>												
<input type="checkbox"/> Actual <input type="checkbox"/> Planned  <input type="checkbox"/> a. cash <input type="checkbox"/> b. In-kind (specify below):		<input type="checkbox"/> a. retainer <input type="checkbox"/> b. one-time fee <input type="checkbox"/> c. commission <input type="checkbox"/> d. contingent fee <input type="checkbox"/> e. deferred <input type="checkbox"/> f. other; specify:          Click or tap here to enter text.													
<b>12. Form of Payment</b> <i>(check all that apply):</i>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Nature:</td> <td colspan="2">Click to enter text.</td> </tr> <tr> <td>Value:</td> <td colspan="2">\$Click to enter text.</td> </tr> </table>			Nature:	Click to enter text.		Value:	\$Click to enter text.							
Nature:	Click to enter text.														
Value:	\$Click to enter text.														
<b>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</b> <i>(attach Continuation Sheet(s) SF-LLL-A, if necessary):</i>  Click or tap here to enter text.															
<b>15. Continuation Sheet(s) SF-LLL-A attached:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No													
<b>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.</b>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Signature:</td> <td colspan="2"></td> </tr> <tr> <td>Print Name:</td> <td colspan="2">Click or tap here to enter text.</td> </tr> <tr> <td>Title:</td> <td colspan="2">Click or tap here to enter text.</td> </tr> <tr> <td>Telephone No.</td> <td>Enter text.</td> <td>Date:</td> </tr> </table>		Signature:			Print Name:	Click or tap here to enter text.		Title:	Click or tap here to enter text.		Telephone No.	Enter text.	Date:
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<b>Federal Use Only</b>		Authorized for Local Reproduction Standard Form - LLL													

## Attachment U. Historically Underutilized Businesses

Historically Underutilized Businesses (HUBs) consist of minority, women and disabled business firms that are at least fifty-one percent (51%) owned and operated by an individual(s) of the categories. Also included in this category are disabled business enterprises and non-profit work centers for the blind and severely disabled.

Pursuant to G.S. 143B-1361(a), 143-48 and 143-128.4, the State invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled. This includes utilizing subcontractors to perform the services and required functions in this Contract. Information pertaining to the HUB Status of subcontractors shall be provided in *Attachment O: Subcontractor Identification*. Any questions concerning NC HUB certification, contact the **North Carolina Office of Historically Underutilized Businesses** office at (919) 807-2330.

The Contractor shall respond to the questions below.

A. Is Contractor a government entity?

**Yes** HUB *does not* apply.

**No** Proceed to Question B.

B. If Contractor checked No in Question A above, Contractor shall complete the Historically Underutilized questionnaire below.

### Historically Underutilized Businesses (HUB) Questionnaire

1. Is proposed non-government entity Contractor owned by a HUB?

**Yes** (if yes, complete Question 2)

**No** (if no, skip to Question 3)

**Unknown** (if unknown, skip to Question 3)

Owned means at least fifty-one percent (51%) of the business is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in question b. below, or in the case of a corporation, at least fifty-one percent (51%) of the stock is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in Question 2. below.

2. Identify the Type of minority business group(s). Check all that apply.

- Black** A person having origins in any of the black racial groups of Africa.
- Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- American Indian** A person having origins in any of the original Indian peoples of North America.
- Female**
- Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

3. Is the proposed non-government Contractor operated by a HUB?

- Yes** (if yes, complete Question 4)
- No** (if no, skip to Question 5)
- Unknown** (if unknown, skip to Question 5)

**Operated** means the management and daily business operations are controlled by one or more owners of the business who are citizens or lawful permanent residents of the United States of at least one of the groups listed in Question 4. below

4. Identify the type of minority business group(s). Check all that apply.

- Black** A person having origins in any of the black racial groups of Africa.
- Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- American Indian** A person having origins in any of the original Indian peoples of North America.
- Female**
- Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

5. Is the proposed non-government Contractor Certified with North Carolina as a HUB?

- Yes**       **No**       **Unknown**

## Attachment V. Contractor's Contract Administrators

*Contract Administrator for all contractual issues listed herein:*

Name & Title	Click or tap here to enter text.
Address 1 Physical Address	Click or tap here to enter text.
Address 2 Mailing Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

*Contract Administrator regarding day to day activities herein:*

Name & Title	Click or tap here to enter text.
Address 1 Physical Address	Click or tap here to enter text.
Address 2 Mailing Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

*HIPAA or Compliance Officer for all privacy matters herein:*

Name & Title	Click or tap here to enter text.
Address 1 Physical Address	Click or tap here to enter text.
Address 2 Mailing Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

# Attachment W. National Correct Coding Initiative Confidentiality Agreement

## NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL CORRECT CODING INITIATIVE EDITS CONFIDENTIALITY AGREEMENT

This Agreement is made effective upon the date of execution of Contract #30-2022-007-DHB-X, by and between the North Carolina Department of Health and Human Services, Division of Health Benefits (“Department”) and XXX (“Contractor”). The Department and Contractor may be collectively referred to as the “Parties.”

### I. BACKGROUND

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and is intended to reduce improper coding that may result in inappropriate payments of Medicare Part B claims and Medicaid claims. In 2010, Section 6507 of the Patient Protection and Affordable Care Act amended Section 1903(r) of the Social Security Act and required CMS to notify state Medicaid agencies of the NCCI Methodologies used in the Medicare Part B program that were compatible with Medicaid. As of October 2010, state Medicaid agencies have been required to incorporate the Compatible Medicaid NCCI Methodologies in their systems for processing applicable Medicaid Fee-for-Service (FFS) claims which are submitted with, and reimbursed on the basis of, Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes from the following types of providers: (1) practitioners and ambulatory surgical centers; (2) services provided to outpatients in hospitals (including services rendered in emergency rooms, observation units, laboratories, and radiology departments, and other diagnostic and therapeutic services); and (3) providers of durable and home medical equipment.

The implementation of the NCCI Edits is mandatory for all Medicaid FFS programs, but the application of the Compatible Medicaid NCCI Methodologies to FFS claims processed by managed care organizations within states’ Medicaid managed care programs is optional. In accordance with federal law, the Department has implemented the Compatible Medicaid NCCI Methodologies into its FFS program, NC Medicaid Direct, and has opted to use the Compatible Medicaid NCCI Methodologies its Medicaid Managed Care program and share the Non-public State Medicaid NCCI Edit Files, provided by CMS to the Department, with the Prepaid Health Plans (PHPs) for processing claims that are paid by the PHPs on a FFS basis.

### II. PURPOSE

This Agreement sets forth the terms and conditions under which the Department will share with Contractor the Non-public State Medicaid NCCI Edit Files posted by CMS on a quarterly basis to the secure Regional Information Sharing Systems (RISSNET) portal that is only accessible to state Medicaid agencies. The Agreement further specifies Contractor’s obligations for use and disclosure of the Non-public State Medicaid NCCI Edit Files once provided to Contractor by the Department.

### III. DEFINITIONS

1. **Compatible Medicaid NCCI Methodologies.** The six NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology with medically unlikely edits for durable medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.

2. **Contracted Parties.** Any contractor or subcontractor (including Commercial Off-the-Shelf (COTS) software vendors) which assist Contractor with implementation of claims processing or encounter data, and who must use the Non-public Medicaid NCCI Edit Files for processing purposes.
3. **National Correct Coding Initiative (NCCI).** The CMS-developed coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
4. **NCCI Edits.** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) MUEs, or units-of service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
5. **NCCI Methodologies.** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
6. **Non-public Medicaid NCCI Edit Files.** The quarterly Medicaid NCCI edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure RISSNET portal.

#### IV. **AGREEMENT**

The Parties agree to the following provisions of this Agreement:

##### 1. **USE AND DISCLOSURE**

- a. The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with Contractor when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
- b. Contractor is required to incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the Contractor pays on an FFS basis. The NCCI editing should occur prior to current procedure code review and any other editing by the Contractor's claims payment systems.
- c. Contractor agrees to use any non-public information from the Non-public Medicaid NCCI Edit Files only for business purposes directly related to the implementation of the Compatible Medicaid NCCI Methodologies in the State of North Carolina.
- d. Except as otherwise permitted in this Agreement, after the start of the calendar quarter, Contractor may disclose only nonconfidential information that is also available to the general public about the Non-public Medicaid NCCI Edit Files found on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
- e. Contractor may share the Non-public Medicaid NCCI Edit Files with a Contracted Party assisting with the implementation of the State's Medicaid NCCI program in the processing of claims or encounter data, only after execution of the appropriate confidentiality agreements that include the same restrictions on use and disclosure as contained herein. Such agreements with any Contracted Party shall be provided to the Department upon request.

##### 2. **RESTRICTIONS ON USE AND DISCLOSURE**

- a. Except as permitted by this Agreement, Contractor shall not disclose, publish, or share with any party, not involved in the implementation of the Compatible Medicaid NCCI Methodologies covered by this Agreement, the Non-public Medicaid NCCI Edit Files.

- b. Contractor shall not publish or otherwise share new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edits Files with individuals, medical societies, or any other entities, unless it is a Contracted Party, prior to the posting of the Medicaid NCCI Edits on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
  - c. Contractor shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
  - d. Contractor shall not release to the public any non-public information contained in the Non-public Medicaid NCCI Edit Files, at any time. Only the Department shall have the discretion to release additional information for selected individual edits or limited ranges of edits from the files posted on the secure RISSNET portal.
  - e. Contractor shall not use the Non-public Medicaid NCCI Edit Files for any non-Medicaid purpose, at any time.
- 3. REPORTING.** Contractor shall report in writing to the Department any unauthorized access, uses, or disclosures of the Non-public Medicaid NCCI Edit Files by Contractor, or by its Contracted Party, within twenty-four (24) hours after it becomes aware of the unauthorized access, use, or disclosure. Notice shall be provided to the Department Contract Administrators in accordance with the terms and conditions of *Section III.B.11. Contract Administrators* of the Contract which are incorporated herein by reference. In addition, Contractor shall reasonably cooperate with the Department to mitigate the damage or harm of any such incidents of unauthorized access, use, or disclosure of the Non-public Medicaid NCCI Edit Files.
- 4. 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. The Department may impose remedial actions, intermediate sanctions, liquidated damages and/or terminate the Contract in accordance with the terms and conditions of *Section III.B.45. Termination* and *Section V. Contract Performance* of the Contract, which are incorporated herein by reference, for violations of this Agreement.
- 5. TERM AND TERMINATION:**
- a. **Term.** This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract expires or terminates, whichever occurs first.
  - b. **Termination Without Cause.** The Department may terminate this Agreement without cause by providing thirty (30) Calendar Days written notice of the termination to Contractor.
  - c. **Termination for Cause.** Any use of the Non-public Medicaid NCCI Edit Files, except as contemplated under this Agreement or approved in writing by the Department, shall be a violation of the Agreement and any such violation shall be considered a material breach of the Agreement. A material breach of this Agreement by Contractor shall be considered sufficient basis for the Department to terminate this Agreement for cause. Upon the Department's knowledge of a material breach by Contractor, the Department may, at its discretion:
    - i. Provide an opportunity for Contractor to cure the breach or end the violation, and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department; or
    - ii. Immediately terminate this Agreement and/or the Contract as specified in *Section VI.4. GENERAL TERMS AND CONDITIONS* of this Agreement.



- d. **Effect of Termination.** Upon termination of this Agreement, for any reason, all the following shall occur:
  - i. The Department shall cease sharing the Non-public Medicaid NCCI Edit Files covered by this Agreement with Contractor; and
  - ii. Contractor shall only be allowed to continue using any Non-public Medicaid NCCI Edit Files shared by the Department prior to the termination of this Agreement for the remainder of the calendar quarter in which the edits are effective.
- e. **Survival.** All terms and conditions regarding the restrictions on use and disclosure of the Non-public Medicaid NCCI Edit Files set forth in this Agreement shall survive the termination of this Agreement and shall remain fully enforceable by Department against Contractor.

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XXX(Name and Title)

Date

PIHP

## **VII. Medicaid PIHP Rate Book**

The Medicaid PIHP Rate Book will be provided by the Department via an amendment to this agreement. The Medicaid PIHP Rate Book applies to the services provided under this Contract. The Medicaid Tailored Plan Rate Book, which applies to the services provided under, Contract #30-2020-052-DHB, is located at Contract #30-2020-052-DHB, Section IX. Medicaid Tailored Plan Rate Book.