2018 PIHP CONTRACT BETWEEN
THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND
ALLIANCE BEHAVIORAL HEALTHCARE

Contract # DMA-MCO-2018-1

This 2018 PIHP Contract is hereby entered into by and between the North Carolina Department of Health and Human Services (the Department"), Division of Medical Assistance ("DMA"), and Alliance Behavioral Healthcare, (herein referred to as, "Contractor" or "PIHP"), a public Medicaid managed care entity, operating as a Prepaid Inpatient Health Plan pursuant to 42 CFR Part 438, with its principal place of business in Durham, North Carolina (referred to collectively as the "Parties").

1. **Contract Documents:** This Contract consists of this master document and the following Attachments, all of which are incorporated herein by reference:
   - General Terms and Conditions (Attachment A)
   - Scope of Work (SOW) (Attachment B)
   - N.C. DHHS Business Associate Addendum (Attachment C)
   - Data Protection (Attachment D)
   - Consolidated Federal Certifications and Disclosures (Attachment E)
   - Contractor Certifications Required by North Carolina Law, Including the Certification of Eligibility Under the Iran Divestment Act (Attachment F)
   - Vendor Certification of Compliance with N.C.G.S. § 133-32 and Executive Order 24 (Attachment G)
   - Definitions (Attachment H)
   - Eligibility Categories (Attachment I)
   - Schedule of Benefits (Attachment J)
   - Statistical Reporting Measures and Late Submission Sanctions (Attachment K)
   - Requirements for Performance Improvement Projects (Attachment L)
   - Enrollee Grievance and Appeal Procedures (Attachment M)
   - Network Provider Enrollment and Re-Enrollment (Attachment N)
   - Credentialing and Re-Credentialing (Attachment O)
   - Capitation Rates and Rate Setting Methodology (Attachment P)
   - Business Transactions (Attachment Q)
   - Clinical Coverage Policies, Bulletins and Manuals (Attachment R)
   - Access and Availability Standards (Attachment S)
   - Mixed Services Payment Protocol (Attachment T)
   - Financial Reporting Requirements (Attachment U)
   - Reserved (Attachment V)
   - Contract Compliance (Attachment W)
   - Criminal Convictions Disclosures (Attachment X)
   - Audits, Self-Audits, Investigations (Attachment Y)
   - Terminations, Provider Enrollment Denials, Non-renewals, Other Actions (Attachment Z)
   - Reserved (Attachment AA)
   - In Lieu of Services (Attachment BB)
   - ICD-10 Codes (Attachment CC)
   - Traumatic Brain Injury (TBI) Waiver Program (Attachment DD)
   - Medicaid Payment Amounts (Appendix Y)

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

2. **Effective Period:** This Contract shall be effective July 1, 2017 and shall terminate on June 30, 2018 with the option to extend for an additional one (1) year period.

3. **Contractor's Duties:** PIHP shall provide the services as described in Attachment B, Scope of Work.

4. **Division's Duties:** DMA shall pay PIHP in the manner and in the amounts specified in Attachment B, Scope of Work, and Attachment P, Capitation Rates and Rate Setting Methodology. The total amount paid by DMA to PIHP under this Contract shall not exceed the capitated amount without a written amendment approved by the Parties. DMA will regularly monitor the cost-effectiveness of the Innovations Waiver program and determine whether the number of slots should be modified. If necessary, DMA will submit a waiver amendment to CMS for approval prior to the addition of any slots. Slot additions are subject to increase in Innovations (c) Waiver funding allocations from the North Carolina General Assembly.

5. **Conflict of Interest Policy:** Contractor is not a nonprofit entity; therefore, a conflict of interest policy is not required.

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

7. **Payment Provisions:** Payment shall be made as described in the Scope of Work, Attachment B, and in Capitation Rates and Rate Setting Methodology, Attachment P. The total not-to-exceed amount of this Contract is $403,855,800.

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

See next page for Contract Administrators' contact information.

DMA's Contract Administrator for Program Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Deb Goda, Behavioral Health Unit Manager Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699	Deb Goda, Behavioral Health Unit Manager Division of Medical Assistance 1985 Umstead Drive, Kirby Building Raleigh, NC 27603 Telephone: 919-855-4297 Email: Deborah.goda@dhhs.nc.gov

DMA's Contract Administrator for Contract Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Lynn Fowler, Contract Specialist Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699	Lynn Fowler, Contract Specialist Division of Medical Assistance 801 Ruggles Drive, Hoey Building Raleigh, NC 27603 Telephone: 919-855-4208 Email: lynn.fowler@dhhs.nc.gov

Contract Administrator for Program Issues for Alliance Behavioral Healthcare:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Alliance Behavioral Healthcare Mr. Ken Marsh, Medicaid Program Director Office of Legal Affairs 4600 Emperor Blvd., Suite 200 Durham, NC 27703	Alliance Behavioral Healthcare Mr. Ken Marsh, Medicaid Program Director Office of Legal Affairs 4600 Emperor Blvd., Suite 200 Durham, NC 27703 Telephone: 919-651-8552 Email: KMarsh@AllianceBHC.org

Contract Administrator for Contract Issues for Alliance Behavioral Healthcare:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Alliance Behavioral Healthcare Carol Wolff Hammett, General Counsel Office of Legal Affairs 4600 Emperor Blvd., Suite 200 Durham, NC 27703	Alliance Behavioral Healthcare Carol Wolff Hammett, General Counsel Office of Legal Affairs 4600 Emperor Blvd., Suite 200 Durham, NC 27703 Telephone: 919-651-8433 Email: chammett@AllianceBHC.org

9. **Outsourcing:**

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

10. **Signature Warranty:**

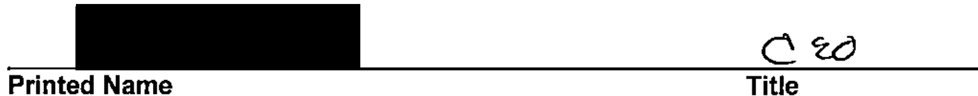
The undersigned represent and warrant that they are authorized to bind their principals to the terms of this agreement.

In Witness Whereof, PIHP and DMA have executed this 2018 PIHP Contract in duplicate originals, with one original being retained by PIHP and one being retained by DMA.

For Alliance Behavioral Healthcare

6-27-17

Signature **Date**



CEO

Printed Name **Title**

ATTEST

6-27-17

Signature **Date**

Carol Hammett General Counsel

Printed Name **Title**

[SEAL]

For North Carolina Department of Health and Human Services

Divisi

6/29/2017

Signature **Date**

Dave Richard, Deputy Secretary for Medical Assistance

Printed Name **Title**

ATTACHMENT A

GENERAL TERMS AND CONDITIONS

Relationships of the Parties

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

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

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

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

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

Indemnification

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

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

Default

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

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

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

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

Compliance with Applicable Laws

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

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

Confidentiality

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

Oversight

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

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

Miscellaneous

Choice of Law and Forum Selection: The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, are governed by the laws of North Carolina. The place of this Contract and all transactions and agreements relating to it, and their sites and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

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

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

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

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

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

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

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

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

ATTACHMENT B

SCOPE OF WORK (SOW)

SUMMARY TABLE OF CONTENTS:

SECTION 1 GENERAL PROVISIONS
- 1.1 Definitions and Construction
- 1.2 Non-Discrimination
- 1.3 Financial Status and Viability
- 1.4 Departmental Monitoring Team
- 1.5 Scope of Monitoring Activities
- 1.6 Monitoring Review
- 1.7 Conflict of Interest
- 1.8 Restricted Risk Reserve Account
- 1.9 Financial Reporting and Viability Measures
- 1.10 Disputes
- 1.11 Disclosure of Information on Ownership and Control
- 1.12 Disclosure of Information on Business Transactions
- 1.13 Disclosure of Criminal Convictions
- 1.14 Excluded Providers
- 1.15 Prohibited Affiliations with Individuals Debarred by Federal Agencies
- 1.16 PIHP Accreditation

SECTION 2 CONTRACTOR DESIGNATED AS A SINGLE PREPAID INPATIENT HEALTH PLAN
- 2.1 Law and Waiver
- 2.2 1915(b)/(c) Waiver Expansion Goals
- 2.3 PIHP Authorization

SECTION 3 ELIGIBILITY
- 3.1 Persons Eligible for Enrollment
- 3.2 Persons Ineligible for Enrollment

SECTION 4 ENROLLMENT
- 4.1 Plan Enrollment
- 4.2 Change of Household Composition
- 4.3 Children
- 4.4 Effective Date of Enrollment
- 4.5 Retroactive Disability Determination
- 4.6 Automatic Dis-enrollment
- 4.7 Involuntary Dis-enrollment and Termination from Waiver
- 4.8 Dis-enrollment Date

SECTION 5 MARKETING

SECTION 6 DUTIES AND RESPONSIBILITIES OF PIHP
- 6.1 Duties of PIHP
- 6.2 Covered Services
- 6.3 Emergency Medical Services
- 6.4 Access and Availability of Services
- 6.5 Customer Services
- 6.6 Choice of Health Professional
- 6.7 Facilities and Resources
- 6.8 Information for New Enrollees
- 6.9 Enrollee Written Materials
- 6.10 Enrollee Notice of Provider Termination
- 6.11 Coordination of Care
- 6.12 Education and Training for Enrollees
- 6.13 Enrollee Rights
- 6.14 Anti-Gag Clause
- 6.15 Support Services
- 6.16 Payment to Out-of-Network Providers
- 6.17 Advance Directives
- 6.18 Payments from Enrollees
- 6.19 Inpatient Hospital Services

6.20 Confidentiality
6.21 Indian Health Services
6.22 Innovations Services

SECTION 7 QUALITY ASSURANCE and QUALITY IMPROVEMENT
7.1 Internal Quality Assurance, Performance Improvement Program
7.2 Annual External Quality Reviews
7.3 Inspection and Monitoring
7.4 Utilization Management
7.5 Grievances and Appeals
7.6 Network Provider Qualification
7.7 Credentialing
7.8 Written Agreements
7.9 Site Visits
7.10 Termination of Providers
7.11 Provider Manual
7.12 Provider Reimbursement
7.13 Provider-Preventable Conditions

SECTION 8 HEALTH INFORMATION AND RECORDS
8.1 Health Information Systems
8.2 Clinical Records
8.3 Financial Records
8.4 Access to Records

SECTION 9 REPORTS AND DATA
9.1 General, Recurring and Ad Hoc Reports, Timelines, Request Protocol
9.2 Enrollment Report and Capitation Payment
9.3 Encounter Data
9.4 Financial Reporting Requirements
9.5 Clinical Reporting Requirements
9.6 Financial Reports Certification
9.7 Grievances and Appeals Reports
9.8 Fraud and Abuse Reports

SECTION 10 PAYMENTS TO PIHP
10.1 Monthly Payment
10.2 Payment in Full
10.3 Retroactive Payment Adjustments
10.4 Calculation of Rates
10.5 Rate Adjustments
10.6 Recoupment
10.7 Third Party Resources

SECTION 11 SUBCONTRACTS
11.1 Requirements
11.2 Timeliness of Provider Payments
11.3 DMA's Remedies against Subcontractors

SECTION 12 DEFAULT AND TERMINATION
12.1 PIHP Breach and Remedies
12.2 Termination without Cause
12.3 Termination for Cause
12.4 Automatic Termination
12.5 PIHP's Obligations upon Contract Expiration or Termination
12.6 DMA's Obligations upon Contract Expiration or Termination

SECTION 13 PENALTIES, SANCTIONS and TEMPORARY MANAGEMENT
13.1 Options to Help Ensure Compliance
13.2 Monetary Penalties
13.3 Sanctions
13.4 Temporary Management

SECTION 14 PROGRAM INTEGRITY
14.1 General
14.2 Fraud and Abuse
14.3 Provider Payment Suspensions and Overpayments

SECTION 15 TRANSITIONS TO COMMUNITY LIVING
15.1 Staff
15.2 Care Coordination
15.3 Person-Centered Planning
15.4 Internal Quality Assurance and Performance Improvement Program
15.5 Clinical Reporting Requirements
15.6 Assertive Community Treatment (ACT)
15.7 Peer Support Services (PSS)
15.8 Supported Employment (SE)
15.9 One Time Transitional Supports
15.10 Diversion Process
15.11 Communication
15.12 Performance Measures

SECTION 1 - GENERAL PROVISIONS

1.1 Definitions and Construction:

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

1.2 Non-Discrimination:

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

1.3 Financial Status and Viability:

1.3.1: PIHP's annual financial reports shall be audited in accordance with Generally Accepted Auditing Standards (GAAS) and Generally Accepted Accounting Principles (GAAP). by an independent Certified Public Accountant at PIHP's expense. The audit shall include reports specific to the Medicaid contract.

1.3.2: PIHP shall provide to DMA copies of PIHP's most recent annual audit within thirty (30) calendar days of certification to verify PIHP's financial status, solvency and viability. The annual financial audit and cost allocation plans shall be subject to annual independent verification and audit by DMA staff or a firm(s) of DMA's choosing. The costs for such audits shall be the responsibility of DMA.

1.3.3: If determined applicable by DMA, PIHP's annual financial reports may be audited in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A- 87. If determined applicable by DMA, PIHP's cost allocation plan may be audited in accordance with OMB Circular A-122. The DMA Audit Section may also conduct audits of PIHP as determined necessary by DMA. All such audits shall be arranged to occur at dates and times that are mutually agreeable to the Parties, and PIHP shall be provided with reasonable notice of DMA's intent to perform, or cause to be performed, any such audits.

1.4 Departmental Monitoring Team:

1.4.1: DMA will monitor PIHP throughout the term of this Contract. The Department will maintain an Intra-Departmental Monitoring Team (IMT) with the PIHP to provide monitoring and project oversight throughout the course of this Contract. DMA will lead the IMT and have oversight over the Medicaid services covered in this Contract. This IMT shall meet at least four (4) times a year. The IMT will participate in the External Quality Reviews conducted in accordance with 42 CFR Part 438. Subpart E and ensure the effective operation of PIHP and compliance with State and Federal requirements.

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

1.4.3: DMA shall have the right to impose penalties and sanctions, arrange for Temporary Management, as specified under Section 13 - Penalties, Sanctions and Temporary Management, or immediately terminate this Contract under conditions specified in Section 12.4 - Automatic Termination, independent of the actions of the IMT.

1.5 Scope of Monitoring Activities:

1.5.1: The IMT shall conduct routine and random monitoring to: Identify problems, deficiencies, and barriers to desired performance; Develop improvement strategies; Determine the need for Corrective Action Plans; and Monitor any Corrective Action Plans in place (Monitoring Review). The Monitoring Review shall include but may not be limited to a review of:

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

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

1.6 Monitoring Review:

1.6.1: The IMT shall use a Continuous Quality Improvement approach to review the performance of PIHP. The IMT shall routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans.

1.6.2: The IMT shall monitor improvement strategies and Corrective Action Plans to ensure that identified problems are properly addressed. Each Monitoring Review shall document both the challenges and successes of this waiver expansion.

1.7 Conflict of Interest:

1.7.1: As required by 42 CFR § 438.58, no officer, employee or agent of any State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall acquire any personal interest, direct or indirect, in this Contract or in any subcontract entered into by PIHP.

1.7.2: No official or employee of PIHP shall acquire any personal interest, direct or indirect, in any Network Provider, which conflict or appear to conflict with the employee's ability to act and make independent decisions in the best interest of PIHP and its responsibilities under 42 CFR Part 438 and other regulations applicable to Medicaid managed care organizations.

PIHP hereby certifies that:

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

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

1.8 Restricted Risk Reserve Account:

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

1.8.1 Required Minimum Balance: PIHP shall, on a monthly basis, deposit into the restricted risk reserve account a minimum amount equal to two (2%) of the capitation payments received from DMA until the amount in the risk reserve account equals fifteen percent (15%) of the total annualized cost of this Contract. Deposits shall be made within five (5) business days of receiving the monthly capitation payment.

1.8.2 Withdrawals or Disbursements: Withdrawals or disbursements may be made from the restricted risk reserve account in order to fund payments to meet outstanding obligations, such as cost overruns related to program services covered by this Contract, or for any other purpose approved by DMA. For any withdrawals or disbursements that are made, the following requirements shall apply:

a. Withdrawal or disbursement notifications: PIHP shall first obtain DMA's prior written approval for any withdrawals or disbursements. DMA will provide a response within seven (7) calendar days of the request. Expenditures shall conform to the requirements for the expenditure of funds under Section 1915(b) of the Social Security Act (42 U.S.C. 1396b). The restricted risk reserve shall not be used to pay for items that are not directly related to the provision of services.

b. Replenishing restricted risk reserve account for withdrawals/disbursements: If the risk reserve account drops below the minimum balance required, as a result of withdrawals or disbursements specified in Paragraph (1) of this Section 1.8, PIHP shall deposit on a monthly basis into the restricted risk reserve account an amount not less than fifteen percent (15%) of the monthly capitation payments received from DMA until the amount of the withdrawal or disbursement is replenished. PIHP may make contributions to the restricted risk reserve account in excess of the minimum balance required in Paragraph (1) of this Section 1.8.

1.8.3 Earnings: All earnings of the restricted risk reserve account shall remain in and become a part of the restricted risk reserve account.

1.8.4 Reporting: PIHP shall report on the status of the restricted risk reserve account monthly as required by Section 9.4 – Financial Reporting Requirements and Attachment U - Financial Reporting Requirements.

1.8.5 Failure to Make Required Deposits: If PIHP fails to make deposits to the restricted risk reserve account as provided in Paragraphs a. and b. of this Section 1.8, DMA shall send written notice to PIHP's Contract Administrator requesting a Corrective Action Plan. PIHP shall submit a written Corrective Action Plan to DMA within thirty (30) calendar days of the date of the notice. If PIHP fails to submit a Corrective Action Plan that is acceptable to DMA or to implement a Corrective Action Plan that has been approved by DMA, DMA may impose one or more of the sanctions described in Section 12.1 – PIHP Breach; Remedies.

1.8.6 Termination or Expiration of this Contract: Upon PIHP's receipt of DMA's written acknowledgment, which DMA shall send in writing to PIHP's Contract Administrator, that PIHP has met all outstanding obligations incurred pursuant to this Contract, the balance of the restricted risk reserve account upon the date of termination or expiration of this Contract shall become the property of PIHP.

1.9 Financial Reporting and Viability Measures:

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

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

1.10 Disputes:

1.10.1: Disputes that arise out of this Contract shall be promptly investigated by DMA's Contract Administrator. If either Party identifies a dispute or potential problem with contract compliance, the DMA 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.

1.10.2:

a. If PIHP alleges the dispute or potential problem is the fault of the Department or any of its Divisions, agents, employees or subcontractors, the DMA Contract Administrator shall investigate the PIHP's allegations, take immediate steps to cure the problem if substantiated by DMA 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.

b. If DMA alleges the dispute or potential problem, including but not limited to contested over or under payments, recoupments, penalties or adjustments pursuant to Sections 9 or 10 or elsewhere in this Contract, is the fault of PIHP or its agents, employees or subcontractors, the PIHP Contract Administrator shall investigate DMA's allegations, take immediate steps to cure the problem if substantiated by PIHP and shall notify the DMA Contract Administrator in writing of its investigative findings and the timeline for resolution, if any, within five (5) business days of such determination.

1.10.3:

a. If the dispute is not resolved pursuant to Section 1.10.2 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.

b. If the unresolved dispute appears to impact more than one PIHP operating under the 1915(b)/(c) Waiver, the DMA Contract Administrator shall notify Department leadership, who will develop a plan of action with multiple PIHPs for resolving the dispute.

1.10.4: The goal of the resolution process shall be to resolve all problems before they escalate to the next level. The DMA and PIHP Contract Administrators shall schedule telephone and face to face meetings as necessary in order to achieve resolution without conflict where possible.

1.10.5: If PIHP is not satisfied with the results of the above-described resolution process decision, PIHP may invoke any legal or administrative remedy available to it under State and Federal law. Pending appeal, PIHP shall proceed diligently with the performance of this Contract, unless PIHP obtains a stay from a court of competent jurisdiction.

1.11 Disclosure of Information on Ownership and Control:

1.11.1: Pursuant to 42 CFR § 455.104, DMA shall obtain disclosures from PIHP regarding ownership and control interests of PIHP.

1.11.2: DMA acknowledges that PIHP is a local political subdivision overseen by an area board with an area director, as those terms are defined in G.S. § 122C-3(2) & (2a), and that PIHP operates as a local management entity/managed care organization as that term is defined in G.S. § 122C-3(20c).

1.11.3: Pursuant to 42 CFR § 455.104, PIHP shall disclose information to DMA on PIHP ownership and control for the area director and the individuals comprising the area board, including but not limited to name, address, date of birth, and any other information for DMA to perform required background checks and verify exclusion status. Such information shall be disclosed to the DMA Contract Administrator and shall be input to MMIS within thirty (30) calendar days of the execution of this Contract and within thirty (30) calendar days following any change to such information.

1.11.4: Pursuant to 42 CFR § 438.230, PIHP shall submit documentation on ownership and control in regard to PIHP subcontractors as that term is defined at 42 CFR § 438.2, including but not limited to name, address, date of birth, and any other information needed for DMA to perform required background checks and verify exclusion status. Such information shall be disclosed to the DMA Contract Administrator within thirty (30) calendar days of the execution of this Contract, and within thirty (30) calendar following any change to such information. As set forth at 42 CFR § 438.2, a Network Provider is not a subcontractor by virtue of the Network Provider agreement with the PIHP.

1.12 Disclosure of Information on Business Transactions:

1.12.1: In accordance with Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act, contractors that are not Federally qualified HMOs shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act and annually as specified in the Financial Reporting Requirements, Attachment U.

1.12.2: Upon request by DMA, PIHP and providers shall also furnish to DMA and /or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors in accordance with 42 CFR § 455.105(b).

1.12.3: This requirement is detailed further in Attachment Q - Business Transactions.

1.13 Disclosure of Criminal Convictions:

1.13.1 Disclosure of Criminal Convictions: In accordance with 42 C.F.R. § 455.106, PIHP shall require all Providers, including managing employees and persons with an ownership or control interest in the Provider, to disclose any criminal convictions related to Medicare, Medicaid, or Title XIX programs at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by PIHP. In order to verify this information, PIHP shall require all Providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check as outlined in Section 1.13.2 for each managing employee and persons with an ownership and control interest in the Provider at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by PIHP. PIHP shall report all such disclosures or relevant criminal convictions to DMA within twenty (20) business days from the date PIHP receives such disclosures or receives information pursuant to a background check. Pursuant to 42 C.F.R. § 455.106(b)(1), DMA will report such disclosures to HHS-OIG within twenty (20) business days after notification by PIHP.

1.13.2 Criminal Background Checks of Providers and Persons with Controlling Interest: In accordance with 42 C.F.R. § 455.434, PIHP shall require, at enrollment, that providers, managing employees and persons with an ownership or control interest of five percent (5%) or more in a provider complete a background check, including fingerprinting if fingerprinting is required under State law or by the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider.

1.14 Excluded Providers:

1.14.1: PIHP shall not employ or contract with Providers excluded from participation in Federal health care programs, including but not limited to those excluded under Section 1128 or Section 1128A of the Social

Security Act. DMA shall not reimburse PIHP for any services rendered by Providers excluded as identified above.

1.14.2: In addition, PIHP shall not employ or contract with providers excluded from participation in Medicare, Medicaid, and Health Choice.

1.14.3: DMA will notify PIHP in the event that a provider is excluded from participation in Medicare, Medicaid and Health Choice, within twenty (20) business days of such exclusion.

1.14.4: PIHP shall check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider, including the State Exclusion List, HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM), <u>no less frequently than monthly</u> to ensure that PIHP does not pay Federal funds to excluded persons or entities in accordance with 42 CFR § 455.436. PIHP shall also develop and implement policies and procedures for appropriate collection and maintenance of disclosure information.

1.15 <u>Prohibited Affiliations with Individuals Debarred by Federal Agencies:</u>

1.15.1: Pursuant to 42 CFR § 438.610(a), 42 CFR § 438.610(b) and CMS State Medicaid Director Letter dated 2/28/98, PIHP shall not knowingly have a relationship with either of the following:

a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or

b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a).

1.15.2: A "relationship" is described as follows:

a. A director, officer, or partner of PIHP;
b. A person with beneficial ownership of five percent (5%) or more of PIHP's equity; and
c. A person with an employment, consulting or other arrangement with PIHP for the provision of items and services which are significant and material to PIHP's obligations under its contract with the State.

1.16 <u>PIHP Accreditation:</u> PIHP shall be accredited by, and maintain accreditation in, URAC (Utilization Review Accreditation Commission) or NCQA (National Committee for Quality Assurance) or other accreditation body pre-approved by DMA.

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

2.1 <u>Law and Waiver:</u> North Carolina Session Law 2011-264, as amended by Session Law 2012-151, established a public healthcare system capable of managing all public resources available for mental health, intellectual / developmental disabilities and substance use/ abuse (MH/IDD/SA) services through statewide expansion of the 1915(b)/(c) Medicaid waiver, operated since 2005 by Cardinal Innovations Healthcare Solutions, formerly PBH.

2.2 <u>1915(b)/(c) Waiver Expansion Goals:</u> The goals of expansion of the 1915(b)/(c) waiver are to: Establish accountability for the development and management of a local system of healthcare that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for persons in need of MH/IDD/SA services; and Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care for public healthcare beneficiaries in North Carolina through creation of public managed care organizations (MCOs).

2.3 PIHP Authorization: PIHP shall be the single Prepaid Inpatient Health Plan through which all MH/IDD/SA services shall be authorized for Medicaid Enrollees in PIHPs' Catchment Area of Cumberland, Durham, Johnston and Wake Counties.

SECTION 3 - ELIGIBILITY

3.1 Persons Eligible for Enrollment:

To be eligible to enroll in the PIHP established pursuant to this Contract, a person shall be a beneficiary in the North Carolina Medical Assistance (Medicaid) Program in one of the Eligibility Categories listed in Attachment I – Eligibility Categories as determined by the applicable DSS, and with a county of residence for Medicaid eligibility purposes and as set forth in the North Carolina Adult Medicaid Manual of Cumberland, Durham, Johnston or Wake County.

3.2 Persons Ineligible for Enrollment:

The following categories of people receiving Medicaid shall not be eligible to enroll in PIHP:

a. Medicare Qualified Beneficiaries (MQB);
b. Non-qualified Aliens or Qualified Aliens during the five (5) year ban;
c. Medically Needy in deductible status;
d. Children within the age of 0-36 months, except for Innovations Waiver participants;
e. Beneficiaries with Presumptive Eligibility; and
f. Refugee Assistance.

SECTION 4 - ENROLLMENT

4.1 Plan Enrollment:

Individuals enrolled in Medicaid shall be assigned to PIHP based on county of Medicaid eligibility. PIHP shall have no authority or accountability to enroll individuals in the Medicaid program. Medicaid enrollment functions are performed exclusively by County DSS agencies. PIHP shall receive a Global Eligibility File containing data relevant to the Medicaid enrolled individuals residing in each PIHP's respective Catchment Area. All Medicaid Enrollees whose county of eligibility is in any of the following counties (Cumberland, Durham, Johnston, Wake) shall be subject to enrollment in PIHP by the applicable County DSS agency, except those persons listed in Section 3.2 – Persons Ineligible for Enrollment.

4.2 Change of Household Composition:

PIHP shall use best efforts and/or shall require Network Providers to use best efforts, to report to the County DSS any known change in the household composition affecting the Enrollee's eligibility for Medicaid, including changes in family size, marital status or residence, within five (5) business days of such information being reasonably and reliably known to PIHP.

4.3 Children:

Eligibility for services for Children shall begin the first day of the month following the third (3rd) birthday, except for Children participating in the Innovations Waiver. Eligibility for participation in the Innovations Waiver shall begin at birth.

4.4 Effective Date of Enrollment:

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

4.5 Retroactive Disability Determination:

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

4.6 Automatic Disenrollment:

An Enrollee shall be automatically dis-enrolled from PIHP if the Enrollee:

a. Changes county of residence for Medicaid eligibility purposes to a county outside PIHP's Catchment Area

b. Is deceased;

c. Is admitted to a correctional facility for more than thirty (30) calendar days;

d. No longer qualifies for Medicaid or becomes a beneficiary ineligible for enrollment as defined in Section 3.2 – Persons Ineligible for Enrollment; or

e. Is admitted to a facility that meets the definition of an IMD (Institution for Mental Disease) as set forth in 42 CFR § 435.1010 as determined by DMA and is between the ages of twenty-two (22) and sixty-four (64). DMA will notify PIHP in writing of any facility determined to meet IMD criteria. The exception to this item is outlined in the Alternative Service Definition in Attachment BB – In Lieu of Services.

DMA shall automatically reenroll a recipient who is dis-enrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

PIHP shall notify the applicable county Department of Social Services within five (5) business days after PIHP becomes aware of changes to an Enrollee's circumstances that may affect eligibility, including but not limited to changes in address of Enrollee and death of Enrollee.

4.7 Involuntary Disenrollment and Termination from Waiver:

4.7.1: PIHP is specifically prohibited under this Contract from engaging in involuntary disenrollment of Medicaid beneficiaries for reasons other than those listed in Section 4.6-Automatic Disenrollment, or exceptions set forth in this Section 4.7.

4.7.2: PIHP shall not request disenrollment of Enrollees regardless of an adverse change in an Enrollee's health status, an Enrollee's utilization of medical services, an Enrollee's diminished mental capacity, an Enrollee's uncooperative or disruptive behavior resulting from his or her special needs, or any other reason unless specifically authorized by this Contract.

4.7.3: PIHP shall not request disenrollment for any reason during annual review of policies and procedures. At all other times, PIHP may only request disenrollment when an Enrollee's continued enrollment seriously impairs PIHP's ability to furnish services to the Enrollee or to other Enrollees. Such requests must be approved by DMA prior to disenrollment by PIHP.

4.7.4: PIHP shall not consider any requests for disenrollment by Enrollees. Any requests for disenrollment by Enrollees received by PIHP shall be forwarded to DMA, which will consider the request and determine whether such request warrants disenrollment for reasons including but not limited to:

a. Moral or religious objections to the services covered by PIHP;

b. Enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, and not all related services are available within the Network,

and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk; or

c. Poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the Enrollee's health care needs.

4.7.5: In considering an Enrollee's request for disenrollment, DMA shall:

a. Provide that Enrollees and their representatives are given written notice of disenrollment rights at least sixty (60) calendar days before the start of each enrollment period;

b. Ensure access to a State Fair Hearing for any Enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment; and

c. Provide for automatic reenrollment of a recipient who is dis-enrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

4.7.6: PIHP may act to terminate an Enrollee from participation in the NC 1915(c) Innovations Waiver based upon Enrollee's or Enrollee's personal representative's failure to comply with the requirements set forth in the NC 1915(c) Innovations Waiver approved by CMS or for other reasons explicitly authorized in the NC 1915(c) Innovations Waiver approved by CMS. Termination of an Enrollee from waiver participation is an adverse benefit determination subject to due process rights set forth in Attachment M – Enrollee Grievance and Appeal Procedures.

4.8 <u>Dis-enrollment Date:</u>

4.8.1: When an Enrollee changes county of residence for Medicaid eligibility purposes to a county other than one of the PIHP counties, the individual will continue to be enrolled in PIHP until the disenrollment is processed by the Eligibility Information System (EIS).

4.8.2: DMA shall continue to pay PIHP a capitated PMPM payment for the Enrollee until disenrollment is effective in the EIS. Disenrollment due to change of residence is always effective at midnight on the last day of the month. PIHP shall be responsible for all medically necessary MH/IDD/SA services to the Enrollee until EIS disenrollment occurs.

SECTION 5 – MARKETING

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

SECTION 6 - DUTIES AND RESPONSIBILITIES OF PIHP

6.1 <u>Duties of PIHP:</u>

Among other duties and responsibilities of PIHP set out in this Contract, PIHP shall:

6.1.1: Comply with all reporting requirements set forth in this Contract and its Attachments and provide clarification of the contents of such reports as requested by DMA;

6.1.2: Make available both financial and non-financial data involving Enrollees and submit any other data, documentation, or information relating to the performance of PIHP's obligations under 42 CFR Part 438 to DMA as outlined in Section 9 – Reports and Data;

6.1.3: As permitted by HIPAA, provide access to necessary files, data, and reports to Business Associates of DMA and other entities and organizations under contract with DMA for the purpose of conducting audits, studies, data validation, data analysis and similar activities. Any disputes between other DMA contract entities and PIHP shall be resolved by DMA. If PIHP is not satisfied with DMA's resolution, PIHP may invoke any legal or administrative remedy available to it under State and Federal law;

6.1.4: Employ or contract with professional staff who have all necessary clinical, administrative and financial expertise in managed behavioral health care operations to perform all functions of this Contract;

6.1.5: Have sufficient and documented internal controls and systems in place to account for Contract-related and non-Contract-related revenues and expenses separately, and to prevent and detect fraud or program abuse. Such internal controls and systems shall be documented in the annual PIHP Compliance Plan submitted to DMA in accordance with Section 14.2 – Fraud and Abuse;

6.1.6: Comply with all applicable requirements of 42 CFR §438 and other applicable State and Federal Laws, rules, and regulations in order to meet the requirements to operate as a PIHP and meet any additional requirements set forth in this Contract, and submit any other data, documentation, or information relating to the performance of PIHP's obligations under 42 CFR §438 to DMA within the timeframe specified in the request. For purposes of this Contract, the Parties understand, acknowledge and agree that the revisions to 42 CFR Parts 431, 433, 438, 440, 457, and 495 published in the Federal Register on May 6, 2016 ("Final Rule") will be effective as of the latest required implementation date specified in the Final Rule, unless this Contract specifies an earlier implementation date.

6.2 Covered Services:

6.2.1: PIHP shall provide, arrange for, or otherwise bear responsibility for the provision of all Covered Services identified in Attachment J – Schedule of Benefits to eligible Enrollees covered under this Contract, through contractual and/or payment arrangements with Network Providers, out-of-Network providers, if needed to ensure continuity of and access to care in accordance with 42 CFR § 438.206, and/or providers of Emergency and Post Stabilization care services in accordance with 42 CFR § 438.114. These services shall be provided in the manner set forth in this Contract.

6.2.2: The amount, duration, and scope of Covered Services must reasonably be expected to achieve the purpose for which the services are furnished. Covered Services shall be Medically Necessary and meet EPSDT criteria, if applicable, for Children or shall be ordered by the North Carolina Office of Administrative Hearings or a United States District Court, or their respective appellate courts and shall be provided by a qualified Provider.

6.2.3: PIHP shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. PIHP shall comply with requirements for Covered Services as set forth in in the State Plan, the 1915(b)/(c) Waiver, and applicable DMA Clinical Coverage Policies. For clarification of Covered Services, PIHP shall refer to the Bulletins and Manuals, listed in Attachment R – Clinical Coverage Policies, Bulletins and Manuals. Such Bulletins and Manuals are listed for reference purposes only and shall not be deemed to be incorporated into, or amend, this Contract by such reference.

6.2.4: PIHP shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with requesting Providers when appropriate.

6.2.5: PIHP may establish utilization management requirements that are different from State Plan requirements but are not more restrictive. PIHP may place appropriate limits on a service on the basis of criteria such as medical necessity and for utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

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

6.2.7: Attachment T – Mixed Services Payment Protocol specifies payment for mixed services; *e.g.*, whether PIHP or the Enrollee's Medical Plan pays for Medicaid Covered Services.

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

6.3 Emergency Medical Services:

6.3.1: In accordance with Section1932(b)(2) of the Social Security Act and 42 CFR § 438.114, PIHP shall provide coverage for Emergency Medical Services consistent with the prudent layperson standard, as defined in the Emergency Medical Treatment and Labor Act (EMTALA) of 1986 (Section 1867 of the Social Security Act), as amended by the Balanced Budget Act (BBA) of 1997. Such services shall be provided anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with PIHP.

6.3.2: Pursuant to 42 CFR. § 438.114(d):

a. PIHP shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;

b. PIHP shall not refuse to cover emergency services based on the emergency room provider or hospital not notifying the Enrollee's primary care provider, PIHP, or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services;

c. An Enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

6.3.4: As specified in 42 CFR § 438.114(e), post stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR § 422.113(c). PIHP shall be financially responsible for post-stabilization services obtained within or outside the entity that <u>are pre-approved</u> by a plan provider or other entity representative. PIHP shall be financially responsible for post-stabilization care services obtained within or outside PIHP that are <u>not pre-approved</u> by a plan provider or other PIHP representative but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the entity for pre-approval of further post-stabilization care services. PIHP shall be financially responsible for post-stabilization care services obtained within or outside the entity that are <u>not pre-approved</u> by a plan provider or other entity representative but are administered to maintain, improve or resolve the Enrollee's stabilized condition if:

a. PIHP does not respond to a request for pre-approval within one (1) hour;

b. PIHP cannot be contacted; or

c. PIHP representative and the treating physician cannot reach an agreement concerning the Enrollee's care, and a plan physician is not available for consultation. In this situation, PIHP shall give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 42 CFR § 422.133(c)(3) is met.

6.3.5: PIHP's financial responsibility for post-stabilization care services that PIHP has <u>not pre-approved</u> ends when:

a. A physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

b. A physician enrolled with PIHP assumes responsibility for the Enrollee's care through transfer;

c. An PIHP representative and the treating physician reach an agreement concerning the Enrollee's care; or

d. The Enrollee is discharged.

6.3.6: PIHP shall be responsible for educating Enrollees on the availability, location, and appropriate use of Emergency Services and informing Enrollees of their right to use any hospital or other setting for emergency care, as required by 42 CFR § 438.10.

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

6.4 <u>Access and Availability of Services:</u>

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

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

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

a. Anticipated membership numbers, characteristics, and needs, including the cultural and language needs of Enrollees (by way of example and not limitation, the ability of Network Providers to communicate with limited English proficiency Enrollees in their preferred, respective languages);

b. Anticipated service utilization;

c. Numbers and types of Providers required to provide the contracted services, including training, experience, and specialization;

d. The number of Network Providers who are not accepting new referrals;

e. The geographic locations of Providers and Enrollees, considering travel distances, travel times, means of transportation, and physical access for Enrollees with disabilities; and

f. The availability of triage lines, screening systems, and other evolving and innovative technological solutions as approved by DMA.

6.4.4: PIHP shall submit documentation of compliance with State and Federal requirements for availability and accessibility of services, including the adequacy of the Provider Network, as set forth in 42 CFR § 438.206 contained in 42 CFR Parts 430 to 481, edition revised as of October 1, 2015. PIHP shall submit to DMA a written Network development plan, including identification and analyses of Provider Network gaps and requests for approval of exceptions no less than annually if no time is specified. PIHP shall meet the exception process as identified in the annual requirements document, which provides instructions for

conducting each year's "Community Behavioral Health Service Needs, Providers and Gaps Analysis Requirements for North Carolina LME-MCOs".

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

PIHP shall:

a. Establish mechanisms to ensure that Network Providers comply with the timely access requirements specified in Sections 6.5 - Customer Services and 6.6 - Choice of Health Professional;

b. Monitor Network Providers regularly to determine compliance; and

c. Take corrective action if a Network Provider fails to comply. PIHP may, but is not required to, offer plans of correction prior to issuing any sanction or action against a Network Provider.

6.4.6: PIHP shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four (24) hours per day, seven (7) days per week. PIHP shall maintain a record of telephone access-line encounters, including the date of call, type of call, and disposition. PIHP shall educate Enrollees on telephone access and emergency referral procedures.

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

6.4.8: A PIHP that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the PIHP objects to the service on moral or religious grounds. If the PIHP should elect 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 State, with its application for a Medicaid contract and whenever it adopts such a policy during the term of the contract, as well as notify Enrollees of the policy to discontinue coverage.

6.5 <u>Customer Services:</u>

6.5.1 PIHP shall provide Customer Services that are responsive to the needs of Enrollees and their families.

6.5.2 PIHP's Customer Services shall be monitored in the manner described in Section 7 - Quality Assurance and Quality Improvement. Such activities shall include but not be limited to: Performance improvement projects (Section 7.1 - Internal Quality Assurance/Performance Improvement Program); External quality reviews (Section 7.2 - Annual External Quality Reviews); and Enrollee grievance and appeals data.

6.5.3 In all communications with family members of Enrollees contemplated below, PIHP shall comply with HIPAA and all other applicable confidentiality provisions set forth in State and Federal law. PIHP shall:

a. Respond appropriately to inquiries by Enrollees and their family members (including those with limited English proficiency);

b. Connect Enrollees, family members, and stakeholders to crisis services, when clinically appropriate, twenty-four hours (24) per day, seven (7) days per week, 365 days per year;

c. Provide information to Enrollees and their family members on where and how to access behavioral health services;

d. Log, acknowledge and attempt to resolve all grievances and provide written notice of the outcome within ninety (90) calendar days of receipt;

e. Log and acknowledge Enrollee appeals and provide written notice of the outcome as required by 42 CFR § 438.408(e);

f. Train its staff to recognize third-party insurance issues, Enrollee appeals, and grievances and to route these issues to the appropriate individual or PIHP department;

g. Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. Eastern Time Monday through Friday, except for designated State or Federal holidays and days that PIHP is closed due to severe inclement weather;

h. Process referrals twenty-four (24) hours per day, seven (7) days per week, 365 days per year; and

i. Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.

6.6 Choice of Health Professional:

6.6.1: To the extent reasonably possible, PIHP shall offer freedom of choice to Enrollees in selecting a Provider from within PIHP's qualified Provider Network. PIHP shall ensure a choice of at least two (2) Providers for each service, except specialties specifically identified in Attachment N – Network Provider Enrollment and Re-Enrollment or otherwise approved as an exception by DMA in writing. Requests for exceptions may be based on such factors as medical necessity and demand. For example, exceptions may be granted if the demand for services, particularly facility based services, specialized services or services in rural areas, does not fiscally or operationally support two (2) Providers.

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

6.6.3: PIHP shall coordinate its services with the services its Enrollees receive from other MCOs, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) in order to avoid unnecessary duplication. In accordance with 42 CFR § 438.208, PIHP shall share with other MCOs, PIHPs and PAHPs serving the Enrollee the results of its identification and assessment of any Enrollee with special health care needs (see Section 6.11 - Coordination of Care) so that those activities need not be duplicated.

6.7 Facilities and Resources:

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

6.7.1: Sufficient numbers of experienced and qualified utilization and care management staff to meet the terms of this Contract. Utilization managers and care managers for individuals with mental health/substance abuse needs **shall be at minimum** Master's level Behavioral Health professionals **licensed by the State of North Carolina** with a minimum of two (2) years post-Master's experience in a clinical setting with the population served. Nurse Practitioners who are certified as Advanced Practice

Psychiatric Nurse Practitioners; Certified Clinical Nurse Specialists who are certified as Advanced Practice Mental Health Clinical Nurse Specialists; Certified Clinical Supervisors; Registered Nurses with two (2) years' experience in mental health or substance abuse treatment are also authorized to review authorization requests for mental health and substance abuse treatment services. Utilization management and care management for developmental disabilities services shall be completed by a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR § 483.430 (a) and N.C.G.S. § 122C-3;

6.7.2: A designated emergency service facility providing care twenty-four (24) hours per day, seven (7) days per week;

6.7.3: Facilities that meet the applicable Federal, State, and Local requirements pertaining to health care facilities and laboratories. All clinical laboratory testing sites shall have a CLIA identification number and either a CLIA certificate of compliance, a CLIA certificate of registration, or a CLIA certificate of waiver;

6.7.4: A telecommunications system sufficient to meet the needs of Enrollees twenty-four (24) hours per day, seven (7) days per week. The system shall have an intake line with clinical back-up by a licensed Master's level clinician twenty-four (24) hours per day, seven (7) days per week;

6.7.5: Sufficient support staff;

6.7.6: A physician, licensed in the State of North Carolina and board certified in psychiatry, to serve as Medical Director. The Medical Director shall oversee the proper authorization and review of Covered Services to Enrollees. The Medical Director shall ensure that all staff conducting reviews operate within the scope of their areas of clinical expertise;

6.7.7: A full-time Waiver contract manager with at least seven (7) years of management experience, preferably in human services;

6.7.8: A full-time director of management information systems with a minimum of five (5) years of experience in data management and IT project management;

6.7.9: A full-time utilization management director who is a masters-level clinician licensed in North Carolina and has a minimum of five (5) years of utilization review and management experience in mental health, developmental disabilities and substance abuse care;

6.7.10: A full-time clinical director for Innovations (I/DD) services who has a minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in developmental disabilities care;

6.7.11: A full-time quality management director with at least five (5) years of recent quality management experience and two (2) years of managed care experience or experience in mental health, developmental disabilities and substance abuse care. The Quality Management Director shall have a Bachelor's Degree in a human services field or a Master's Degree in a human services field;

6.7.12: A full-time finance director with at least seven (7) years of experience in managing progressively larger budgets;

6.7.13: A full-time provider Network director with at least five (5) years of combined Network operations, provider relations and management experience;

6.7.14: A full-time customer services director with at least five (5) years of combined customer service, clinical and management experience; and

6.7.15: A designated compliance officer and a compliance committee that are accountable to senior management and whose role is to guard against fraud and abuse.

6.8 Information for New Enrollees:

Upon approval of an individual's Medicaid eligibility application, DMA shall send the new Enrollee a written description of the services and benefits provided by PIHP, a written explanation of how to access those services from PIHP, and PIHP contact information. PIHP agrees that any cost sharing imposed on Enrollees shall be in accordance with 42 CFR §§ 447.50 through 447.82.

6.9 Enrollee Written Materials:

6.9.1: Within fourteen (14) business days after an Enrollee makes a request for services, PIHP shall provide the new Enrollee with written information on the Medicaid managed care program. PIHP may send information that directs beneficiaries to the PIHP website and instructs beneficiaries to request additional information by mail if they do not have access to the webpage. Written information shall be made available by PIHP in Spanish and any other non-English languages prevalent in PIHP's Catchment Area. Pursuant to 42 CFR § 438.10(c)(1), "prevalent" means a non-English language spoken by a significant number or percentage of potential Enrollees and Enrollees in the State. For purposes of this Contract, a "significant number" is defined as five (5) percent or greater of PIHP's Enrollees. All new Enrollee material shall include at least the following information, as specified in 42 CFR § 438.10(f) and 42 CFR § 438.10(g), which may be included in multiple documents:

a. A description of the benefits and services provided by PIHP and of any limitations or exclusions applicable to Covered Services. These descriptions must have sufficient detail to ensure that Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan;

b. A description of all Innovations Waiver services and supports;

c. Updates regarding program changes;

d. A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;

e. A description of the Enrollee's responsibilities and rights and protections, as set forth in 42 CFR § 438.100;

f. An explanation of the Enrollee's right to select and change Network Providers;

g. The restrictions, if any, on the Enrollee's right to select or change Network Providers;

h. The procedures for selecting and changing Network Providers;

i. Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);

j. The non-English languages, if any, spoken by each Network Provider;

k. The extent to which, and how, after-hours and emergency coverage are provided, including:

    (1) What constitutes an Emergency Medical Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR § 438.114 and EMTALA;
    (2) The process and procedures for obtaining Emergency Services, including the use of 911 telephone services or the equivalent;
    (3) The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under this Contract; and
    (4) A statement that, subject to the provisions of this Contract, the Enrollee has a right to use any hospital or other setting for Emergency Care.

l. PIHP's policy on referrals for Specialty Care, including:

    (1) Cost sharing if any; and
    (2) How to access Medicaid benefits that are not covered under this Contract.

m. Any limitations that may apply to services obtained from Out-of-Network Providers, including disclosure of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of-Network Providers, and the procedures for obtaining authorization for such services;

n. Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;

o. Information about medically necessary transportation services provided by the Department of Social Services in each county;

p. Identification and explanation of State laws and rules governing the treatment of minors;

q. The Enrollee's right to recommend changes in PIHP's policies and services;

r. The procedures for recommending changes in PIHP's policies and services;

s. The Enrollee's right to formulate Advance Directives;

t. The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;

u. The accommodations made for non-English speakers, as specified in 42 CFR § 438.10(c)(5);

v. The availability of oral interpretation service for non-English languages and how to access the service;

w. The availability of interpretation of written information in prevalent languages and how to access those services;

x. Information on how to report fraud and abuse; and

y. Upon an Enrollee's request, PIHP shall provide information on the structure and operation of PIHP and any physician incentive plans.

6.9.2: PIHP shall comply with the requirements set forth at 42 CFR § 438.10(d)(6) with respect to all printed materials produced for Enrollee use including, but not limited to, the Enrollee Handbook and new Enrollee welcome packet and shall produce all printed materials in a manner that accommodates the special needs of those Enrollees with intellectual and/or developmental disabilities, who are visually limited and/or who have limited reading proficiency. PIHP's Enrollee Handbook, however named, has previously been approved by DMA and is reviewed during the annual External Quality Review conducted pursuant to 42 CFR §§ 438.310 through 438.370 and Section 7.2 – Annual External Quality Reviews. In the event that PIHP makes any substantive updates or revisions to the Enrollee Handbook during the term of this Contract, PIHP shall provide an electronic copy or weblink of same to the DMA Contract Administrator within fifteen (15) working days of such change. If PIHP produces other printed materials for Enrollee use, PIHP shall provide an electronic copy or weblink to the DMA Contract Administrator within fifteen (15) working days of such publication. If DMA identifies material errors in the Enrollee Handbook or other printed materials intended for Enrollee use, DMA may notify PIHP of such errors and PIHP shall correct material errors within a reasonable timeframe following such notification that is prior to the next printing.

6.9.3: PIHP shall translate all printed materials produced for Enrollee use in the catchment area's prevalent languages and shall make oral interpretation of printed materials produced for Enrollee use available free of charge to all Enrollees upon request in non-English languages.

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

6.9.5: At least once each year, PIHP shall notify all Enrollees of their right to request and obtain a copy of written materials produced for Enrollee use.

6.10 Enrollee Notice of Provider Termination:

When DMA, PIHP or Provider terminates a Provider Agreement with a Network Provider, PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination. PIHP shall make good faith efforts to give that notice within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.

6.11 Coordination of Care:

PIHP's Care Coordination responsibilities include deliberate organization of Enrollee care activities among individuals involved in the Enrollee's care to facilitate the appropriate delivery of health care services, connect Enrollees to the appropriate level of care, and identify and address Enrollee needs and barriers to treatment engagement as outlined in this section.

6.11.1: PIHP shall develop and implement policies and procedures that address the requirements of this section, including a process for identifying Enrollees who meet Special Healthcare Needs Population criteria as outlined in subsection 6.11.3(c) below, and for collaborating with the Department's Primary Care Case Management (PCCM) vendor as outlined in subsection 6.11.3(j) below. PIHP's coordination of care obligations shall apply to all Medicaid eligibles for whom PIHP receives a capitation payment, including but not limited to Medicare/Medicaid dual eligibles and participants in the Innovations Waiver.

6.11.2: PIHP may provide coordination of care functions to Enrollees who do not meet Special Healthcare Needs Population criteria through any mechanism it so chooses, but shall not duplicate case management functions required to be performed by providers who receive Medicaid funding to provide case management services as outlined in Clinical Coverage Policy No. 8A, 8A-1 and 8A-2. In order to prevent duplication of Medicaid-funded services, PIHP is prohibited from authorizing case management or other services to a particular Enrollee that duplicate the care coordination required to be provided under this section, or required to be provided as part of an enhanced service, for such Enrollee.

6.11.3: PIHP shall offer the same level of care coordination to Medicare/Medicaid dual eligibles for whom the PIHP is paid a capitation payment as is offered to Medicaid-only Enrollees. PIHP shall have an expedited process to receive and respond to inquiries from medical providers, PCCM care managers and State and local agencies, including but not limited to the Department of Social Services (DSS) and the Department of Juvenile Justice (DJJ). This expedited process shall be designed and implemented by PIHP to result in the successful reaching of specific, appropriate staff and in the quick provision of help to callers.

Clinical care coordination functions include, but are not limited to:

a. Identification of clinical needs;
b. Determination of level of care through case review;
c. Enrollee contacts;
d. Arranging for assessments;
e. Clinical discussions with Enrollee's treatment providers; and
f. Assistance with development and monitoring of Enrollee treatment plans, including but not limited to Person-Centered Plans and Individual Service Plans.

Administrative care coordination functions include, but are not limited to:

a. Addressing additional support services and resources;

b. Assisting Enrollees with obtaining referrals and arranging appointments;
c. Educating Enrollees about other available supports as recommended by clinical care coordinators; and
d. Monitoring Enrollee attendance in treatment.

6.11.3 (a) Care Coordination Staff Qualifications: For Enrollees receiving care coordination, the applicable functions outlined herein shall be performed by licensed or otherwise qualified care coordinators depending upon the population served:

a. PIHP shall employ or contract with master's level licensed clinicians to perform Care Coordination for Enrollees with MH/ SU diagnoses;

b. PIHP shall employ or contract with individuals who meet Qualified Professional status as set forth at 10A NCAC 27G.0104 to perform Care Coordination for Enrollees with Intellectual/Developmental Disabilities, including master's level licensed clinicians;

c. If the Enrollee is dually diagnosed, the primary diagnosis shall determine staffing – if the primary diagnosis is MH/SU, the care coordinator must be a master's level licensed clinician; if the primary diagnosis is IDD, the care coordinator may be a Qualified Professional;

d. Administrative care coordination functions may be carried out by non-licensed staff working in a consultative role with the clinical (master's level licensed clinician or QP) care coordination staff.

6.11.3 (b) Coordination of Care for all Enrollees: In accordance with 42 CFR §438.208(b), PIHP shall perform coordination of care for all Enrollees by performing or subcontracting the following functions:

a. Ensuring that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity, as well as an alternative contact if the primary designee cannot be reached;

b. Providing Enrollees with education about clinically relevant MH/IDD/SU services and supports, as well as education about other types of clinically relevant Medicaid services, non-Medicaid services, and unpaid community supports;

c. Providing linkage to medically necessary psychological, behavioral, educational, and physical evaluations;

d. Conducting an initial screening of each Enrollee's needs, within 90 days of the effective date of enrollment for all new Enrollees, including subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful;

e. Sharing with DMA, the PCCM and other MCOs, PIHPs, and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities;

f. Encouraging the Enrollee to enroll in a PCCM medical home and coordinating care with the PCCM care manager as outlined in subsection (j) below;

g. Coordinating and monitoring the services the PIHP furnishes to the Enrollee:
    (1) Between settings of care, including assisting hospitals, facilities and other institutional providers with discharge planning for short term and long-term hospital and institutional stays when the admission is primarily based on the Enrollee's behavioral health diagnosis, but not duplicating the hospital's role in discharge planning as outlined at 10A NCAC Subchapter 13B;
    (2) With the services the Enrollee receives from the PCCM any other MCO, PIHP, or PAHP;
    (3) With the services the Enrollee receives from DMA FFS Medicaid; and
    (4) With the services the Enrollee receives from community and social support providers.

h. Ensuring that each provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards; and

i. Ensuring that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

6.11.3 (c) Special Healthcare Needs Population Criteria: In accordance with 42 CFR §438.208(c), PIHP shall perform coordination of care for Enrollees with special health care needs or who need Long Term Services and Supports (LTSS). PIHP shall prioritize and assign care coordination for Enrollees within the following Special Healthcare Needs Population(s) and may identify additional priority populations. PIHP shall be responsible for determining whether an Enrollee referred for Care Coordination meets the following Special Healthcare Needs Population criteria:

a. Intellectual and/or Developmental Disabilities:

(1) Individuals who are functionally eligible for, but not enrolled in, the Innovations Waiver and who are not living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID); or

(2) Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past thirty (30) calendar days, admitted to a facility operated by the Department of Correction (DOC) or the Division of Juvenile Justice of the Department of Public Safety (DJJ) for whom PIHP has received notification of discharge.

b. Child Mental Health:

(1) Children who have a current CALOCUS Level of VI and a diagnosis within the following diagnostic ranges:

ICD-9	ICD-10
293.0	F05
293.81	F06.2
293.82	F06.0
293.83	F06.30
293.84	F06.4
293.89	F06.1
294.10	F04
294.11	F02.81
294.8	F06.0
294.9	F06.8
295.40	F20.81
295.70	F25.9
295.90	F20.9
296.20	F32.9
296.21	F32.0
296.22	F32.1
296.23	F32.2
296.24	F32.3
296.25	F32.4
296.26	F32.5
296.30	F33.9
296.31	F33.0
296.32	F33.1
296.33	F33.2
296.34	F33.3

296.35	F33.41
296.36	F33.42
296.40	F31.10
296.41	F31.11
296.42	F31.12
296.43	F31.13
296.44	F31.2
296.45	F31.73
296.46	F31.74
296.50	F31.30
296.51	F31.31
296.52	F31.32
296.53	F31.4
296.54	F31.5
296.55	F31.75
296.56	F31.76
296.7	F31.9
296.80	F31.9
296.89	F31.81
296.99	F34.8
297.1	F22
298.8	F23
298.9	F29
300.00	F41.9
300.01	F41.0
300.02	F41.1
300.09	F41.8
300.11	F44.4, F44.6
300.12	F44.0
300.13	F44.1
300.14	F44.81
300.15	F44.9
300.19	F68.8
300.22	F40.02
300.23	F40.10
300.29	F40.8, F40.218, F40.240, F40.241
300.3	F42
300.4	F34.1
300.6	F48.1
300.7	F45.21, F45.22
300.82	F45.1, F45.9
300.89	F45.8, F48.8
300.9	F48.9, F99
300.99	Not in DSM-5
302.2	F56.6
302.3	F65.1
302.4	F65.2
302.6	F64.2
302.1	Not in DSM-5
302.70	R37
302.71	F52.0
302.72	F52.21, F52.8
302.73	F52.31
302.74	F52.32
302.75	F52.4
302.76	F52.6
302.79	F52.1, F52.8
302.81	F65.0

ICD-9	ICD-10
302.82	F65.3
302.83	F65.51
302.84	F65.52
302.85	F64.1
302.89	F65.81, F65.89, F66
302.9	F65.9
307.0	F98.5
307.1	F50.00
307.20	F95.9
307.21	F95.0
307.22	F95.1
307.23	F95.2
307.3	F98.4
307.45	F51.8
307.46	F51.3
307.47	F51.8
307.50	F50.9
307.51	F50.2
307.52	F98.3
307.53	F98.21
307.59	F50.8, F98.29
307.6	F98.0
307.7	F98.1
307.9	F63.3, R45.1
308.3	F43.0
309.81	F43.10, F43.12
311	F32.9
312.23	F91.2
312.31	F63.0
312.32	F63.2
312.33	F63.1
312.34	F63.81
312.39	F63.3, F63.89
312.81	F91.1
312.82	F91.2
312.89	F91.8
312.9	F91.9
313.81	F91.3
313.89	F94.2, F94.1, F93.8, F98.8
995.51	T74.32XA, T76.32XA
995.52	T74.02XA, T76.02XA
995.53	T74.22XA, T76.22XA
995.54	T74.12XA, T76.12XA
V61.21	Z69.010;

or

(2) Children with an MH or SUD diagnosis who are currently, or have been within the past thirty (30) calendar days, in a facility including a Youth Development Center and Youth Detention Center operated by the DJJ or DOC, inpatient hospital setting, Cumberland Hospital, Psychiatric Rehabilitation Treatment Facility (PRTF) or therapeutic group home for whom PIHP has received notification of discharge.

c. Adult Mental Health:

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

ICD-9	ICD-10
295.40	F20.81
295.70	F25.9

295.90	F20.9
296.20	F32.9
296.21	F32.0
296.22	F32.1
296.23	F32.2
296.24	F32.3
296.25	F32.4
296.26	F32.5
296.30	F33.9
296.31	F33.0
296.32	F33.1
296.33	F33.2
296.34	F33.3
296.35	F33.41
296.36	F33.42
296.40	F31.10
296.41	F31.11
296.42	F31.12
296.43	F31.13
296.44	F31.2
296.45	F31.73
296.46	F31.74
296.50	F31.30
296.51	F31.31
296.52	F31.32
296.53	F31.4
296.54	F31.5
296.55	F31.75
296.56	F31.76
296.7	F31.9
296.80	F31.9
296.89	F31.81
296.99	F34.8
298.9	F29
309.81	F43.10, F43.12

d. Substance Use Disorders:

Individuals with a substance dependence diagnosis and current ASAM Patient Placement Criteria (PPC) Level of 3.7 or higher.

e. Co-occurring Diagnoses:

(1) Individuals with both a mental illness diagnosis and a substance use diagnosis and current LOCUS/CALOCUS of Level 5 or higher OR current ASAM PPC Level of 3.5 or higher; or

(2) Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis and current LOCUS/CALOCUS of Level 4 or higher; or

(3) Individuals with both an intellectual or developmental disability diagnosis and a substance use diagnosis and current ASAM PPC Level of 3.3 or higher.

f. At-Risk for Crisis Enrollees shall include the following (to the extent not included within one of the above populations):

(1) Enrollees who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or

(2) Enrollees for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; or

(3) Enrollees discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis or general hospital unit following admission for a MH, SU or IDD condition.

g. Children with Complex Needs shall include the following (to the extent not included within one of the above populations): Medicaid eligible children ages 5 and under age 21 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.

6.11.3 (d) Care Coordination Functions for Special Healthcare Populations: In accordance with 42 CFR §438.208(c), PIHP shall perform coordination of care for Enrollees who meet Special Healthcare Population criteria by performing applicable functions listed in subsection (b) above as well as the following functions, as clinically indicated:

a. Implement mechanisms to assess each Enrollee identified as meeting Special Healthcare Populations criteria in order to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. Assessment mechanisms must use appropriately qualified health care professionals, including the Enrollee's primary care physician and/or PCCM medical home;
b. Develop engagement strategies, including identification of barriers to treatment and referral;
c. Answer any questions that the Enrollee/ Legally Responsible Person (LRP) may have regarding available services;
d. Provide information to assigned Enrollees about their rights, protections and responsibilities, including the right to change providers, the grievance and complaint resolution process, and the reconsideration and Fair Hearing process;
e. Coordinate and link all Medicaid-funded services for the Enrollee, as appropriate;
f. Follow up and attempt to resolve any issues related to the Enrollee's health, safety or service delivery, bringing any unresolved issues to the attention of the appropriate PIHP staff member and designated behavioral health provider or medical provider for resolution;
g. Assist with development of, or ensure that the treating provider produces, a treatment or service plan meeting the following criteria for Enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring AND for Enrollees who require LTSS:
    (1) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans;
    (2) Includes Enrollee participation and direction in the treatment planning process. The Care Coordinator must review the team composition with the Enrollee to make sure that the people the Enrollee would like to have at the meeting are invited. The Enrollee/ LRP must sign the treatment plan in order for the service authorization request to be processed by PIHP. In the event that the Enrollee/ LRP does not agree with the treatment plan as developed, he or she will be given the option of submitting an alternate treatment plan or submitting the treatment plan as developed with a written statement or notation of his or her disapproval of the treatment plan;
    (3) Developed in consultation with the PCCM care manager, if applicable, and any providers caring for the Enrollee. The Care Coordinator must review with the team all issues that were identified during the assessment process and must review all clinically relevant information in the PCCM web-based Care Management Information System;
    (4) Complies with Quality Monitoring and the Continuous Quality Improvement Process to ensure that individual treatment plans are developed consistent with 42 C.F.R. § 438.208 and Part 456;
    (5) Is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee per 42 CFR §441.301(c)(3); and

(6) Allows Enrollees with special health care needs to directly access specialists as appropriate for the Enrollee's condition and identified needs.

6.11.3 (e) Care Coordination Functions for Individuals under Age 21: In accordance with 42 CFR §438.208(c), PIHP shall perform coordination of care for Enrollees under age 21 within the Special Healthcare Needs population(s) by performing applicable functions listed in subsections (b) and (d) above as well as the following functions, as clinically indicated:

a. Utilize strategies consistent with the "System of Care" philosophy;
b. Participate in Child and Family Team (CFT) meetings as the mechanism for developing the PCP;
c. Ensure youth and family/ LRP participation and direction in the treatment planning process to meet their unique needs. The Care Coordinator must review the team composition with the youth and family/ LRP, including, if applicable, any social worker actively involved with the Enrollee or family, to assure the people they would like to participate in the meeting are invited, including but not limited to relevant public and private providers including the PCCM medical home and PCCM care manager (if applicable), schools and natural and community supports who will actively participate in the implementation, monitoring and evaluation of the PCP. The LRP must sign the treatment plan in order for the service authorization request to be processed by PIHP. In the event that the LRP does not agree with the treatment plan as developed, he or she will be given the option of submitting an alternate treatment plan or submitting the treatment plan as developed with a written statement or notation of his or her disapproval of the treatment plan;
d. Ensure completion of a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community, including sensitivity to racial, ethnic, linguistic and cultural differences, and use them to build strategies for development of the PCP and to meet treatment or habilitative goals;
e. Promote service delivery within the context of families and develop strategies built on social networks and natural or informal supports;
f. Design strategies with consideration given to maximizing the skills and competencies of family members to create greater self-sufficiency for parents and youth;
g. Make significant efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs;
h. Ensure regular updates to each PCP to take into account changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency;
i. Ensure development of proactive and reactive crisis plans in conjunction with the PCP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when, and provide every member of the CFT with a copy of the plan; and
j. Ensure that the majority of care coordination is performed in the community at locations and during times that are most convenient for the family and conducive to the active participation of CFT members.

6.11.3 (f) Care Coordination Functions for At-Risk for Crisis Enrollees: When the PIHP is notified of an emergency or inpatient admission, in collaboration with the admitting inpatient facility that bears primary responsibility for discharge planning, PIHP shall provide the following care coordination activities for all Enrollees who meet At-Risk for Crisis criteria as defined above, including but not limited to the following:

a. Notifying an Enrollee's assigned behavioral health provider of emergency or inpatient utilization if connected to a provider;
b. Consulting with any assigned behavioral health provider and PCCM care manager to address appropriate level of care;
c. Directly identifying and addressing barriers to appropriate treatment for Enrollees not yet connected to appropriate treatment providers (e.g., transportation, need for further clinical assessment, identification of available resources, referrals);
d. Assisting the facility and/or the Enrollee's behavioral health provider with the development of a crisis plan, and sharing this plan with future providers to be included in the treatment plan; and

e. Monitoring connectedness to treatment until Enrollee is no longer considered At-Risk or is well-connected to treatment.

6.11.3 (g) Care Coordination Functions for Children with Complex Needs: In accordance with 42 CFR §438.208(c) and the executed settlement agreement entered in *Disability Rights North Carolina v. Richard Brajer in his official capacity as Secretary of DHHS. Eastern District, Western Division, file number 5:16-cv-854,* PIHP shall coordinate with the DHHS Statewide Coordinator and identified case managers (if targeted case management has been authorized under EPSDT and does not duplicate the care coordination functions performed by PIHP under this Contract) to provide coordination of care for Enrollees who meet Children with Complex Needs criteria by performing applicable functions listed in this Section, 6.11, Care Coordination.

6.11.3 (h) Care Coordination Functions for NC Innovations Waiver Participants: In accordance with 42 CFR §438.208(c), PIHP shall perform coordination of care for Enrollees who are participants in the Innovations Waiver by performing applicable functions listed in subsections (b) and (d) above as well as the following functions, as clinically indicated:

a. Guiding the development and submission of the Individual Support Plan (ISP), based on assessed need and living arrangements, at least annually;
b. Explaining the individual budgeting tool, the service authorization process, and the mechanisms available to the Enrollee/ LRP to modify their budget;
c. Assisting the Enrollee/LRP in choosing a qualified provider to implement each service in the ISP including providing a list of available providers and arranging provider interviews;
d. Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal;
e. Maintaining close contact with Enrollee/ LRP (if applicable), providers, PCCM care manager (if applicable), 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;
f. Informing Enrollee/LRP of option to participate in individual/family directed supports and linking to a Community Navigator if additional information is needed;
g. Assisting in the appointment of the representative for self-direction is needed;
h. Assessing the employer of record, managing employer, and representative, if applicable, to determine the areas of support needed to self-direct services and linking to a Community Navigator as needed;
i. Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the Enrollee;
j. Completing annual re-assessment of the Enrollee's level of care;
k. Ensuring that the Enrollee/ LRP completes the Freedom of Choice statement annually;
l. Completing the NC Innovations Risk/ Support Needs Assessment prior to the development of the ISP and updating at least annually or as significant changes occur with the Enrollee;
m. Providing timely notification to Utilization Management of necessary updates to the LOC and timely processing of updates needed to the ISP, based If an individual chooses not to participate in the Innovations Waiver and may be eligible for Medicaid or other Medicaid funded services, the Care Coordinator shall inform the individual of the other services and supports that may be available in lieu of Innovations Waiver services.
n. 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;
o. Monitoring of service delivery to verify that:
    (1) At least one service is utilized monthly, per Innovations Waiver eligibility requirements, with the exception of children under the age of 21 with a diagnosis of Autism Spectrum Disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD;
    (2) Services are furnished in accordance with the ISP;
    (3) Enrollee is offered a choice of providers where required;
    (4) Enrollee has access to services and services meet the Enrollee's needs;
    (5) Issues of health and welfare (rights restrictions, abuse/neglect/exploitation, back-up staffing) and non-waiver service needs (medical care) are addressed and documented as appropriate;

(6) Services utilized do not exceed authorization;
(7) Enrollee is satisfied with the services being rendered.

Monitoring shall take place in all service settings and shall include contacts with other members of the ISP team and review of service documentation using the standard Innovations Waiver monitoring checklist. Monitoring must occur face to face on a monthly basis for Enrollees whose services are provided by guardians or relatives living in the home of the Enrollee, Enrollees who live in residential programs, Enrollees who choose the individual family directed service option, and Enrollees who are new to the Innovations Waiver for the first six (6) months. All other monitoring visits shall occur on a schedule agreed to by the ISP team, no less than quarterly, to meet the Enrollee's health and safety needs. In any month where no face to face monitoring occurs, the care coordinator shall contact the Enrollee/ LRP by telephone to ensure that there are no issues that need to be addressed.

6.11.3 (i) Due Process Principles under the NC Innovations Waiver: PIHP shall comply with the following due process principles as they relate to Enrollees who are participants in the Innovations Waiver, including but not limited to development of the Enrollee's individual budget and ISP:

a. PIHP shall utilize a DMA-approved template to notify the Enrollee/ LRP of the results of any new Supports Intensity Scale® (SIS®) evaluation and to inform the Enrollee/ LRP in writing of the opportunity and process for raising concerns regarding SIS® evaluations and results. The process for raising concerns shall include an opportunity to discuss the results of the SIS® evaluation with PIHP and the potential for results to be adjusted if it is determined that particular support needs of the individual were not accurately captured, as well as the opportunity to file a grievance regarding SIS® evaluations and results. The failure to request a grievance shall not waive the Innovations Waiver Enrollee's ability to argue that the results of the SIS® are incorrect in requesting services, or during reconsideration review or the State fair hearing.

b. PIHP shall ensure that the SIS®, or any other similar evaluation, is used as a tool in guiding the enrollee and Care Coordinator in creating an Enrollee's plan of care, and that the results of the SIS®, or any other similar evaluation, do not constitute a binding limit on the services that may be requested by the Enrollee or approved by the PIHP.

c. To the extent an employee of PIHP facilitates or assists in making an Innovation Waiver Enrollee's request for authorization of services, PIHP shall ensure that an Enrollee's request for services is made in a manner consistent with the desires of the Enrollee and that those desires are reflected in the Enrollee's plan of care, including desires for the type, amount, and duration of services. Review of requests for authorization of services shall be made in accordance with 42 CFR § 438.210(d).
   (1) PIHP shall discuss the duration of the services expected by the Enrollee/ LRP, and shall ensure that proposed plans of care request authorization for each service at the duration requested by the Enrollee during the plan year.
   (2) PIHP shall assist the Enrollee/ LRP in developing plans of care and shall explain options regarding the services available to the Enrollee.
   (3) PIHP shall inform Innovations Waiver Enrollees that they may make a new request for services at any time by requesting an update or revision to the Enrollee's plan of care.

d. Care Coordinators may not exercise prior authorization authority over the Individual Support Plan.

e. If PIHP authorizes a requested service for a duration less than the duration requested in the plan of care, PIHP shall provide written notice with appeal rights and clinical reasons for the decision at the time of the limited authorization.

f. If PIHP denies a request for authorization of services by an Enrollee, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of

service, PIHP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404.

(1) An appeal filed by an Enrollee must not prevent any authorized services from being provided pending the outcome of the appeal. PIHP must not prevent the Enrollee from making a new request for services during a pending appeal.

(2) PIHP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all Enrollees from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to appeal the denial, reduction, or termination of a service. PIHP shall not attempt to influence, limit, or interfere with an Enrollee's right or decision to file or pursue a grievance or request an appeal.

g. If PIHP reduces, suspends, or terminates an Enrollee's services during an existing authorization period, PIHP shall, upon request of the Enrollee, continue the Enrollee's benefits as set forth in 42 CFR § 438.420, if all the requirements of 42 CFR § 438.420 are met.

h. 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 Waiver and other trainings relevant to due process procedures, whether related to the waiver or otherwise. PIHP shall train new employees within 15 business days of a new employee's start date and shall conduct due process training at least annually for all relevant staff. PIHP further agrees to update any materials publicly posted on PIHP's website that are inconsistent with the terms of this subsection 6.11.3 (i) or inconsistent with any trainings provided by the Department.

6.11.3 (j) Integration of Care and Collaboration with the Department's PCCM Vendor: At present, PIHP and PCCM use different risk assessment methods and analytics for determining acuity, severity, and impactability for Enrollees, requiring both vendors to collaborate regarding care integration needs in order to reach the best possible clinical judgment of the Enrollee's current medical and MH/IDD/SU condition, complexity and risk level. Accordingly, PIHP shall collaborate with the Department's PCCM vendor to best meet the needs of the Enrollee as outlined below in areas that increase efficiency, reduce redundancy, broaden reach across populations and avoid duplicate interventions and planning. The PIHP's obligations are subject to reciprocal collaboration from the PCCM vendor and regional PCCM networks as required by the Department's contract with the PCCM:

a. Whenever an Enrollee is receiving care coordination, PIHP shall check the PCCM Care Management Information System or contact the regional PCCM network to determine whether the Enrollee is also being managed by a PCCM care manager;

b. PIHP shall coordinate care with each Enrollee's primary care provider, PCCM care manager, or medical home for Enrollees receiving care coordination;

c. PIHP shall invite any assigned PCCM care managers to participate in the development of an Enrollee's PCP or ISP, if the Enrollee/ LRP agrees;

d. PIHP shall invite any assigned PCCM care managers to participate in the development and implementation of crisis plans so that both parties may respond appropriately to Enrollee crises;

e. PIHP, with the assistance of PCCM, shall encourage, support and facilitate communication between Primary Care Providers and PIHP Network Providers regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons determined to have need;

f. PIHP and PCCM shall develop and implement the following referral pathways:

(1) 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 referring provider or PCCM care manager within five (5) business days;

(2) If Care Coordination is not warranted, PIHP shall notify referral source and offer other options for assistance from PIHP in getting the Enrollee connected to treatment;
(3) PIHP shall initiate Care Management and physical health referrals to PCCM as such needs are identified, and receive and document feedback from PCCM regarding the referral status; and

g. 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, in order to monitor hospital activity and inform prompt care coordination;
h. For facilities not supplying ADT feeds, PIHP shall make best efforts to develop relationships with local emergency departments, hospitals and facilities in order to receive timely notification of Enrollee admissions, discharges and emergency utilization.

6.11.3 (k) Outcomes: PIHP shall regularly report on and meet or exceed the objective outcome measures for care coordination effectiveness as referenced in Attachment K.

6.12 Education and Training for Enrollees:

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

a. Behavioral Health Referral;
b. Access to Care;
c. Appeals and Grievances and Enrollee/ Member Rights;
d. Suicide Prevention;
e. Signs of Mental Illness;
f. Risks of Substance Abuse;
g. Substance Abuse Prevention;
h. Community Navigator;
i. Self-Directed Service Model(s);
j. Supports Intensity Scale (SIS); and
k. Individual Budgeting Tool.

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

6.12.3 Education and Training for Innovations Waiver Participants: PIHP shall develop stakeholder group(s) consisting of Innovations Waiver Enrollees, families, advocates, and Providers to provide recommendations regarding implementation of Innovations Waiver services and policies. PIHP shall keep meeting minutes and attendance records for each of these stakeholder meetings. PIHP shall make these records available for review by DMA and shall report on these efforts at IMT meetings.

6.13 Enrollee Rights:

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

a. The right to be treated with respect and due consideration of dignity and privacy;
b. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
c. The right to participate in decisions regarding health care, including the right to refuse treatment;

d. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
e. The right to request and receive a copy of his or her medical record, except as set forth in 45 CFR § 164.524 and N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.

6.13.2: PIHP shall also include language in the PIHP's written policies and procedures regarding the right of Enrollees who live in Adult Care Homes to report any suspected violation of an Enrollee right to the appropriate regulatory authority as outlined in N.C.G.S. § 131D-21.

6.14 Anti-Gag Clause:

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

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

6.15 Support Services:

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

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

6.15.1 Transportation: PIHP shall provide information about the availability of non-emergency transportation for Enrollees through available public and private services. PIHP shall provide Enrollees with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county.

6.15.2 Interpreter Services: Interpreter services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with PIHP. PIHP shall make oral interpretation services available free of charge to each Enrollee in communications between Enrollee and PIHP. This applies to non-English languages as specified in 42 CFR § 438.10 (d)(4). PIHP shall not be obligated to pay for interpreter services at the Provider level; that obligation shall be on each Provider.

6.15.3 Coordination and Referral to Community Resources: PIHP shall provide referrals to available community services, including but not limited to those identified in Attachment J – Schedule of Benefits. PIHP shall have staff who are familiar with these resources and shall maintain a written description of appropriate referral procedures.

6.16 Payment to Out-of-Network Providers:

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

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

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

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

6.17 Advance Directives:

6.17.1: PIHP shall maintain and implement written policies and procedures concerning Advance Directives as specified in Article 3, Part 2 of N.C.G.S. Chapter 122C. PIHP shall distribute written information regarding Advance Directive policies to adult Enrollees, including a description of applicable State and Federal laws and links to the (1) Medical Care Decisions and Advance Directive brochure as found in the Medicaid Bulletin Article on Advance Directives, August 2009 and (2) DMA website Advance Directives page.

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

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

6.17.3: As specified in 42 CFR § 438.3(j), the written information provided by PIHP shall reflect changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change.

6.18 Payments from Enrollees:

6.18.1: PIHP shall not require co-payments, deductibles, or other forms of cost sharing from Enrollees for Medicaid services covered under this Contract, nor shall PIHP charge Enrollees for missed appointments.

6.18.2: Enrollees who obtain services from Out-of-Network Providers without PIHP authorization, except those services specified in Sections 6.3 – Emergency Medical Services and 6.16 – Payment to Out of Network Providers, shall be responsible for payment of costs associated with such services.

6.18.3: As specified in 42 CFR § 438.114(e), PIHP shall limit charges to Enrollees for post-stabilization care services to an amount no greater than what the organization would charge the Enrollee if he or she had obtained the services through PIHP. Enrollees shall not be held liable for payments to Providers in the event that PIHP or its subcontractors become insolvent or DMA does not pay PIHP.

6.19 Inpatient Hospital Services:

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

6.19.2: PIHP shall be responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Enrollees who are hospitalized on or after the effective date of their enrollment in PIHP, and PIHP shall

remain responsible for these costs until such Enrollees are discharged from the hospital, or until the last day of the month in which the Enrollee is enrolled, whichever is earlier.

6.20 Confidentiality:

PIHP shall comply with all applicable State and Federal confidentiality laws, rules, and regulations.

6.21 Indian Health Services:

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

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

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

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

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

6.22 Innovations Services:

PIHPs shall ensure that Innovations Providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4).

SECTION 7 - QUALITY ASSURANCE and QUALITY IMPROVEMENT

7.1 Internal Quality Assurance, Performance Improvement Program:

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

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

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

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

a. Meet or exceed CMS, DMA, and PIHP defined minimum performance levels on standardized quality measures annually as described in Attachment K – Statistical Reporting Measures and Late Submission Sanctions;

b. Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and Enrollee satisfaction;

c. Have in effect mechanisms to detect both over and underutilization of services;

d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with behavioral health care needs;

e. Include all demographic groups, care settings, and types of services over multiple review periods;

f. Measure the performance of Network Providers and conduct peer review activities such as identification of practices that do not meet Plan standards' recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by Providers;

g. Measure Provider performance through medical record audits;

h. Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of PIHP;

i. Develop, adopt and implement clinically appropriate practice parameters and protocols/guidelines and provide PIHP's Providers enough information about the protocols/guidelines to enable them to meet the established standards; and

j. Evaluate access to care for Enrollees in accordance with Sections 6.4 – Access and Availability of Services, 6.5 – Customer Services and 6.6 – Choice of Health Professional, and implement a process for ensuring that Network Providers achieve and maintain these standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

7.1.5: By no later than August 31 of each calendar year, PIHP shall submit to DMA a revised and updated QA/PI program and a report on PIHP's progress toward performance improvement goals during the previous twelve (12) months.

7.1.6: At no additional cost to DMA, PIHP shall develop and implement the PIHP-specific performance improvement projects described in Attachment L – Requirements for Performance Improvement Projects.

7.1.7: At DMA's request, PIHP shall participate in at least one (1) statewide performance improvement project each year at PIHP's own expense.

7.2 <u>Annual External Quality Reviews:</u>

7.2.1: Pursuant to 42 CFR §§ 438.310 through 438.370, DMA shall contract with an external quality review organization (EQRO) to conduct an annual independent external quality review (EQR). Three (3) activities shall be mandatory during these reviews: (1) Determining PIHP compliance with Federal Medicaid managed care regulations; (2) Validating all performance measures produced by the PIHP; and (3) Validating all performance improvement projects undertaken by PIHP. CMS-published protocols shall be utilized by the organization conducting the EQR activities.

7.2.2: EQR shall also include: (1) Validation of Provider and Enrollee satisfaction surveys; (2) Validation of encounter data in accordance with CMS requirements and protocols; and (3) Within DMA's discretion,

optional EQR activities as described in 42 CFR § 438.358(c). An additional EQR activity is the independent external review required by NC Session Law 2013-85, which shall be made every six (6) months and which shall be reviewed by the Secretary of the Department of Health and Human Services in determining certification of PIHP compliance in accordance with G.S. 122C-124.2(a).

7.3 Inspection and Monitoring:

7.3.1: Pursuant to 42 CFR § 438.66, DMA shall monitor PIHP's Enrollee enrollment and disenrollment practices and PIHP's implementation of the grievance and appeal procedures required by Federal law.

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

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

7.4 Utilization Management:

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

7.4.2: PIHP shall use a DMA-standardized Authorization Request Form. PIHP shall use LOCUS and CALOCUS scores for medical necessity reviews for mental health services and ASAM for substance abuse services, except for Children ages three (3) through six (6). PIHP shall use EPSDT criteria when evaluating requests for services for Children.

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

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

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

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

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

type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

7.4.7: For conditions identified in EPSDT screenings, PIHP shall ensure that Medically Necessary MH/IDD/SA services meeting EPSDT criteria are furnished to Children. PIHP shall further ensure that PIHP Network Providers shall coordinate with agencies conducting the screenings.

7.4.8 Practice Guidelines: PIHP shall establish a Clinical Advisory Committee that includes licensed Network Providers. Practice Guidelines shall be developed in consultation with this committee. Practice guidelines shall be based on valid and reliable clinical evidence (Evidence Based Practice) or a consensus of professionals in the field. PIHP may also use Clinical Practice Guidelines promulgated by peer-reviewed organizations such as the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. Practice guidelines shall address the needs of Enrollees and shall be reviewed and updated periodically as appropriate and in accordance with changes and developments in clinical research. Practice Guidelines shall be disseminated to Providers and, upon request, to Enrollees. All utilization management decisions, Enrollee education decisions, coverage of services decisions, and all other decisions covered by the Practice Guidelines shall be consistent with the Practice Guidelines.

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

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

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

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

7.4.13 Timeframes for Standard Decisions: PIHP shall issue a decision to approve or deny a service within fourteen (14) calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:

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

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

7.4.14 Timeframes for Expedited Decisions: In those cases in which a Licensed Practitioner acting within the scope of his or her practice indicates, or PIHP determines, that adherence to the standard timeframe (pursuant to 42 CFR § 438.210(d)(i) and (ii)) could seriously jeopardize an Enrollee's life or health or ability to attain, maintain, or regain maximum function, PIHP shall issue a decision to approve or deny a service within seventy two (72) hours after it receives the request for services, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:

a. The Enrollee requests the extension; or
b. PIHP justifies (to DMA upon request):

1. A need for additional information; and
2. How the extension is in the Enrollee's interest

7.4.15 Notice of Termination, Suspension or Reduction of Services: When PIHP decides to terminate, suspend, or reduce a previously authorized Medicaid-covered service (meaning a service for which the authorization has not yet expired), PIHP shall mail notice of the Action at least ten (10) calendar days before the effective date of the action. PIHP may shorten the period of advance notice to five (5) days if:

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

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

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

7.5 <u>Grievances and Appeals:</u>

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

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

7.5.2: PIHP shall use Enrollee grievance and appeal data for QA/PI and shall report Enrollee grievances and appeals to DMA by number, type, and outcome by no later than forty-five (45) calendar days after the end of each quarter of the State fiscal year.

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

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

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

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

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

7.5.8 Reporting: PIHP shall submit quarterly reports regarding all Enrollee grievances and appeals that identify the following, reported separately: The total number of Enrollees served, total number of grievances categorized by reason, reported separately; The number of grievances referred to second level review or appeal, reported separately; and The number of grievances resolved at each level, total time of resolution and outcome, reported separately. Reports shall be due to DMA from PIHP on a quarterly basis, consistent with the reporting measure provisions and schedule in Attachment K – Statistical Reporting Measures and Late Submission Sanctions.

7.6 Network Provider Qualification:

The Parties agree, consistent with law and system design, that DMA screens and determines Provider enrollment into and disenrollment from the North Carolina Medicaid and medical assistance plan or program and that from that pool of enrolled Providers, PIHP has full authority to create and manage its Closed Provider Network, including credentialing, contracting and termination, subject to applicable law and this Contract, including but not limited to Sections 7.6 – 7.13.

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

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

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

7.6.4 Exclusions: PIHP shall consult the United States Department of Health and Human Services, Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), and the System of Award Management (SAM) to ensure that Providers who are excluded from participation in Federal programs are not enrolled in PIHP Network. In accordance with 42 CFR §455.436, the PIHP will search the State Exclusion List (which is related to other screening methods in accordance with 42 CFR §455.452), Social Security Administration's Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES), LEIE and the SAM upon enrollment, reenrollment, credentialing, or re-credentialing of Network Providers, and shall search the LEIE and the SAM at least monthly thereafter. The Department shall monitor PIHP's compliance with the requirements of 42 CFR §455.436 as part of the External Quality Review conducted pursuant to 42 CFR §§ 438.310 through 438.370 and Section 7.2 – Annual External Quality Reviews.

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

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

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

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

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

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

7.6.9 On-site Reviews: For all initial enrollments, PIHP shall complete an on-site review within six (6) months of service initiation.

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

a. Data collected through PIHP's Utilization Management Program;

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

7.7 Credentialing:

7.7.1 Effect of Final Rule: The parties understand, acknowledge and agree that, pursuant to 42 CFR § 438.602(b)(1) and effective no later than July 1, 2018, DMA must screen, enroll, and periodically revalidate, all PIHP Network Providers, in accordance with the requirements of 42 CFR part 455, subparts B and E. The parties further understand, acknowledge and agree that Screening is a required element of the process for a provider to be enrolled in the NC Medicaid program, that Credentialing is the process conducted by the PIHP to verify that the provider is qualified to deliver services, and that certain components of such activities may duplicate or overlap. In implementing the requirements of 42 CFR § 438.602(b)(1), the parties intend to reduce administrative burden for providers and ensure quality control and consistency in conducting such activities, and will negotiate an amendment to this Contract to reflect any changes deemed necessary.

7.7.2 Policies, Records, Screening: Credentialing of Providers shall be conducted in accordance with the procedures delineated in Attachment O – Credentialing and Re-Credentialing. PIHP shall maintain written policies and procedures governing the credentialing and re-credentialing of its Network Providers that comply with applicable Federal and State laws, rules and regulations, and PIHP accreditation guidelines. PIHP shall maintain records of its credentialing and re-credentialing activities in order to demonstrate its compliance with these policies and procedures. Upon request, PIHP shall make its records available to DMA for inspection and copying during normal business hours. PIHP's credentialing and re-credentialing criteria shall be consistent with State and Federal laws, rules and regulations governing practitioners who provide the Covered Services. In accordance with 42 CFR § 455.450, PIHP shall screen all initial applications including applications for a new practice location and any application received in response to a re-enrollment or revalidating of enrollment request based on a category risk level of limited, moderate, or high in accordance with N.C.G.S. § 108C-3 and 42 CFR §455.450. If a Provider could fit within more than one (1) risk level described in 42 CFR § 455.450, the highest level of screening is applicable.

7.7.3 Hospital Credentialing: In order to decrease the administrative burden on hospitals/ health systems directly enrolled with the NC Medicaid program, PIHP may accept and rely upon DMA's credentialing of hospitals licensed under Chapter 131E of the North Carolina General Statutes, if it so chooses, including all facilities and sites enrolled with DMA and affiliated with the hospital/ health system in the State's MMIS and all practitioners billing through the hospital/health system's NPI(s). The Department agrees to accept all liability for such credentialing and to indemnify and hold harmless PIHP from and against all claims, damages, losses and expenses, including but not limited to attorney's fees, arising out of or resulting from the credentialing of hospitals performed by DMA or its contractor and relied upon by PIHP in accordance with this Contract.

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

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

in amounts that equal or exceed the limits established by PIHP, which may include exception criteria to ensure adequate access to the services covered under this Contract. Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain

Automobile Liability Insurance. PIHP shall review its insurance limits annually and revise them as needed. PIHP shall require all Network Providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the provider gives thirty (30) calendar days' prior written notice to PIHP. PIHP shall require Network Providers to submit certificates of coverage to PIHP. Upon DMA's request, PIHP shall submit copies of these certificates to DMA.

7.8 Written Agreements:

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

a. To participate in PIHP's utilization management, care management, quality management, access, finance, qualification/accreditation and credentialing processes;

b. To offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Enrollees;

c. To make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary;

d. To comply with all Network requirements for reporting, inspections, monitoring, and Enrollee choice requirements;

e. To participate in the compliance process and the Network continuous quality improvement process;

f. To be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in PIHP's web based billing process; and

g. To 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 PIHP and the Provider.

7.8.2 Policies and Procedures: PIHP shall develop and implement policies and procedures for monitoring Provider compliance with these requirements.

7.9 Site Visits:

7.9.1: In accordance with 42 CFR. § 455.432, PIHP shall conduct pre-enrollment site visits for any Providers designated as moderate or high risk for fraud, waste and abuse.

7.9.2: In accordance with 42 CFR § 455.450, PIHP shall screen all initial applications including applications for a new practice location and any application received in response to a re-enrollment, re-credentialing or revalidating of enrollment request based on a category risk level of limited, moderate, or high. If a Provider could fit within more than one (1) risk level described in 42 CFR § 455.450, the highest level of screening, as defined in 42 CFR § 455.450, is applicable.

7.10 Termination of Providers:

7.10.1 Mandatory Terminations and Denials: In accordance with 42 CFR § 455.416, PIHP must, with respect to enrollment in the PIHP Closed Provider Network, and DMA must, with respect to enrollment in the NC Medicaid Program:

a. Terminate the enrollment of any Provider where any person with a five percent (5%) or greater

direct or indirect ownership interest in the Provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart;

b. Deny enrollment or terminate the enrollment of any Provider where any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years, unless DMA or PIHP determines that denial or termination of enrollment is not in the best interests of the Medicaid program or PIHP's Provider Network, and DMA or PIHP documents that determination in writing;

c. Deny enrollment or terminate the enrollment of any Provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other state;

d. Terminate the Provider's enrollment or deny enrollment of the Provider if the Provider or a person with an ownership or control interest or who is an agent or managing employee of the Provider fails to submit timely or accurate information, unless DMA or PIHP determines that termination or denial of enrollment is not in the best interests of the Medicaid program or PIHP's Provider Network, and DMA or PIHP documents that determination in writing;

e. Terminate or deny enrollment if the Provider, or any person with a five percent (5%) or greater direct or indirect ownership interest in the Provider, fails to submit sets of fingerprints in a form and manner to be determined by DMA within thirty (30) calendar days of a CMS or a DMA request, unless DMA or PIHP determines that termination or denial of enrollment is not in the best interests of the Medicaid program, and DMA or PIHP documents that determination in writing; or

f. Terminate or deny enrollment if the Provider fails to permit access to Provider locations for any site visits required under 42 CFR § 455.432, unless DMA or PIHP determines that termination or denial of enrollment is not in the best interests of the Medicaid program or PIHP's Provider Network, and DMA or PIHP documents that determination in writing.

7.10.2 Other Terminations and Denials: In accordance with 42 CFR § 455.416, PIHP may terminate or deny the Provider's enrollment in PIHP's Provider Network if PIHP, CMS or DMA:

a. Determines that the Provider has falsified any information provided on documentation submitted related to screening, credentialing or enrollment in the PIHP Closed Provider Network or the NC Medicaid Program, including but not limited to the enrollment, credentialing, or re-credentialing application; or

b. Cannot verify the identity of any Provider applicant.

7.10.3: In the event PIHP terminates a Provider's enrollment in PIHP's Provider Network for any reason set forth in 7.10.1 or 7.10.2, PIHP shall also terminate the Provider's written agreement with PIHP.

7.10.4: The Parties understand, acknowledge and agree that enrollment in the NC Medicaid Program is distinct from enrollment in PIHP's Provider Network, that PIHP has the authority to deny or terminate Provider enrollment in its Closed Provider Network, and that PIHP has no authority to suspend or terminate a Provider's enrollment in the NC Medicaid Program. Nevertheless, nothing in this Section 7.10 shall preclude PIHP from denying or terminating enrollment in PIHP's Provider Network, or from terminating Provider's written agreement with PIHP, for any other reason or as otherwise authorized by law or written agreement.

7.10.5: DMA shall report to PIHP any denials or terminations DMA takes on Provider enrollment on a monthly basis.

7.10.6: PIHP shall report any denials it takes on a Provider application to join PIHP's Network and any termination of a Provider's written agreement with PIHP that is initiated by PIHP to DMA Program Integrity on a monthly basis. Such monthly reports shall include but may not be limited to denials of credentials,

enrollment, or contracts, or terminations of credentials, enrollment, or contracts, and program integrity reasons which include fraud, waste and abuse.

7.10.7: PIHP shall report denials and terminations in accordance with the provisions and report format in Attachment Z - Terminations, Provider Enrollment Denials, Other Actions). In accordance with 42 CFR § 1002.3(b)(3), PIHP shall notify DMA when it takes action against a Provider for program integrity reasons. DMA will report to HHS-OIG any actions DMA takes to limit a Provider's participation in the program.

7.11 Provider Manual:

7.11.1 Manual Requirements: PIHP shall develop, maintain, and distribute a Provider manual that provides information and education to Providers about PIHP. This distribution may occur by making the manual available electronically on PIHP's website. The manual shall be regularly reviewed and updated to reflect changes to applicable Federal and State laws, rules, and regulations, Department or PIHP policies, procedures, bulletins, guidelines or manuals, or PIHP business processes as necessary. PIHP's Provider Manual, however named, has previously been approved by DMA and is reviewed during the annual External Quality Review conducted pursuant to 42 CFR §§ 438.310 through 438.370 and Section 7.2 – Annual External Quality Reviews. In the event that PIHP makes any substantive updates or revisions to the Provider Manual during the term of this Contract, PIHP shall provide an electronic copy or weblink of same to the DMA Contract Administrator within fifteen (15) working days of such change. If DMA identifies material errors in the Provider Manual, DMA may notify PIHP of such errors and PIHP shall correct material errors within a reasonable timeframe following such notification that is prior to the next printing. At a minimum, the Provider manual shall cover the areas listed below:

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

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

7.12 Provider Reimbursement:

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

7.13 Provider-Preventable Conditions:

a. PIHP shall report all identified Provider-preventable conditions in a form and with the frequency, which may be specified by the State.

b. PIHP shall not make payment to a Provider for Provider-preventable conditions that meet the following criteria as per 42 CFR 447.26:
   (1) Is identified in the State plan;
   (2) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
   (3) Has a negative consequence for the Enrollee;
   (4) Is auditable; and
   (5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

c. PIHP shall require all Providers to report Provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

SECTION 8 – HEALTH INFORMATION AND RECORDS

8.1 Health Information Systems:

8.1.1 Minimum Requirements: PIHP's information systems need to provide and perform, at a minimum, the following components in a manner consistent with industry and CMS standards:

a. Real-time access to claims history, member and provider information;
b. Receipt of inbound member demographic and eligibility files from the State via an 834 Enrollment Report;
c. Maintenance of member demographic, enrollment and disenrollment information in accordance with the information contained in DMA's Global Eligibility File;
d. Production of error reports for mismatched eligibility and establish a correction process;
e. Maintenance of Provider data including NPI, taxonomy and demographics for billing and rendering/attending providers;
f. Maintenance of Provider Fee Schedules with effective and termination dates;
g. Linkage of Provider data to claims and clinical modules in the system;
h. Receipt of inbound claims in both paper and electronic HIPAA 837I and 837P formats;
i. Receipt of sub-capitated Provider encounters in the same format as fee-for-service contracted Providers;
j. Time stamping and tracking of all claims received;
k. Rejection of incomplete claims upfront and provide error reports to Providers;
l. Adjudication of claims, resulting in payments and denials to Providers;
m. Creation of system generated remittance advice in HIPAA 835 and paper formats and payments to Providers in electronic fund transfer (EFT) and paper checks if necessary;
n. Maintenance of edits in claim system to identify non-eligible claims, members or services;
o. Application of reason codes explaining why a payment is less than the amount billed by the Provider;
p. Application of adjustments to processed claims with adjustment reasons, including audit trails of all data activity;
q. Maintenance of third party liability information data to ensure coordination of benefits;
r. Coordination of benefits during the claims adjudication process;
s. Maintenance of authorization data to match to the claims for adjudication;
t. Documentation of software maintenance cycle which describes how changes are implemented into the production environment including version control;
u. System backups and retrieval with disaster recovery contingency processes that are established and tested routinely;

v. Data repositories used for statistical and financial reporting and the creation of encounter data for submission to DMA in a format pre-approved by DMA and within ten (10) business days of DMA's request;

w. On-line reporting capabilities for daily monitoring of clinical and claim operations;

x. Reporting for claims that have been received but not paid used to monitor claims payment timeliness;

y. Random claims auditing for all claims processed;

z. Capitation payment reconciliations;

aa. Maintenance of security standards for data consistent with Federal and State personal health information (PHI) security standards;

bb. The sending of eligibility inquiries using a HIPAA 270 and the receiving of responses using a HIPAA 271; and

cc. Reconciliation of 820 Payment Order Reports with Global Eligibility Files.

8.1.2 Maintenance/Updating/Data Security: PIHP shall maintain, and update as necessary, health Information Systems with the ability to receive, maintain and utilize data extracts from DMA and that collect, analyze, integrate, and report data for Enrollees with behavioral health, developmental disability, and substance abuse treatment needs. At a minimum, the Information Systems shall provide information on utilization management, Provider Network management, quality management, financial operations, grievances, appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. PIHP shall be able to transfer data electronically using secure File Transfer Protocols (FTP) and file formats as requested by DMA. The extracts that will be sent to the PIHPs via FTP are:

Medicaid Institutional File (Sent on a monthly basis no later than the 18th of the month);
Medicaid Professional File (Sent on a monthly basis no later than the 18th of the month);
Medicaid Provider File (Sent on a monthly basis no later than the 18th of the month);
Global Eligibility File (Incremental file will be sent on a daily basis); and
Global Eligibility File (Full file will be sent on a Quarterly Basis).

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

8.1.4 Service Utilization Data: PIHP shall collect service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.

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

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

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

8.1.6. PIHP Documentation of Information: PIHP shall document all information reasonably required to perform PIHP's obligations under this Contract, and obtained through paper, telephone, fax, or electronic methods, in one or more electronic databases, and PIHP shall enter that data into PIHP's database(s). All documentation must be available to DMA in an electronic format.

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

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

PIHP shall make all collected data available to DMA no later than ten (10) business days or to CMS within the timeframe specified by CMS. PIHP shall provide reports of collected data to DMA as requested herein, in a frequency, form and format necessary to meet operational needs, as described in this Contract.

8.2 Clinical Records:

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

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

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

a. PIHP is to notify DMA Program Integrity about the abandonment at 1-800-662-7030;
b. PIHP is to notify the Provider of PIHP's report to DMA Program Integrity regarding the abandonment via trackable mail; and
c. PIHP is to secure the records and complete an inventory log of the records.

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

8.2.2.1 Documentation for all Enrollees:

a. Demographic information, including:
    (1) Name;
    (2) Medicaid ID number;

(3) Birth date;
(4) Sex;
(5) Address and phone number; and
(6) Parent or guardian if under eighteen (18) or adjudicated incompetent;

b. Referral or Utilization Management contact information:
(1) Date of the contact;
(2) Service requested; and
(3) If the requested service meets medical necessity;

c. The amount, duration, and scope of the authorized service; and the basis of, or the information used to make, the medical necessity determination;

d. If the requested service does not meet medical necessity:
(1) The rationale for the denial, including the criteria or benefits provision used;
(2) The proposed alternative service that does not meet medical necessity for the individual, if any;
(3) The notice of adverse action, including the timetable and method for informing the Enrollee and Provider of the denial, reduction, or termination of the authorization for the requested service and the Enrollee Grievance and Appeal rights; and
(4) Documentation that the denial of the authorization was made by a physician or practitioner operating within the scope of his/her license;

e. The name and credentials of the individual conducting the review;

f. The name, signature, and credentials of the individual who made the decision to deny, reduce or terminate authorization for the requested service; and

g. A record of the services authorized by PIHP and billed by Network Providers.

8.2.2.2 Additional Information to be Obtained as Appropriate:

a. For 24-hour care:
(1) Date of the admission;
(2) Date of discharge;
(3) For inpatient discharges, evidence of an appropriate discharge plan; and
(4) For inpatient discharges, follow-up authorization for outpatient care.

b. Coordination of care information, which should include:
(1) Name of primary care/CCNC physician or other key Providers; and
(2) Other systems of care involved, such as educational system, Department of Social Services, and Criminal Justice.

c. In the presence of clinical risk factors (risk of harm to self or others), evidence of education, outreach and follow up as appropriate for the individual.

8.3 Financial Records:

8.3.1 Detailed Records: PIHP and the Network Providers shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract, including provision of Covered Services and all relevant information relating to individual Enrollees for the purpose of audit and evaluation by DMA and other Federal or State personnel. Records shall be maintained in compliance with all State and Federal requirements including HIPAA for use in treatment, payment or operations.

8.3.2 Availability of Records: Records shall be maintained and available for review by authorized Federal and State personnel during the entire term of this Contract and for a period of ten (10) years

thereafter, in accordance with 42 CFR §438.3(h), unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.

8.4 Access to Records:

8.4.1 Disclosure of Records and Requests for Information: All disclosure of records shall be performed in compliance with applicable Federal and State confidentiality laws, including but not limited to HIPAA, the HIPAA Privacy Rule codified at 45 CFR Part 160 and Subparts A and E of Part 164, 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), and N.C.G.S. Chapter 122C. Any records requested pursuant to monitoring, audit or inspection as called for in this Contract shall be produced immediately for on-site review or sent to the requesting authority by mail within fourteen (14) calendar days following the request. Written agreements between PIHP and Network Providers shall contain provisions requiring all Network Providers to comply with requests for information and that all requested records shall be provided to PIHP or DMA within fourteen (14) calendar days of the date of the request, at the sole cost and expense of the Network Provider. DMA shall have unlimited rights to use, disclose, and duplicate information and data developed, derived, documented, or furnished by PIHP and in any way relating to this Contract.

8.4.2 Requests from Medicaid Fraud Control Units: PIHP shall cooperate fully with requests for information by any state's Medicaid Fraud Control Unit, including the North Carolina Department of Justice's Medicaid Investigations Division (MID). The MID is a Medicaid fraud control unit approved by the Secretary of the U. S. Department of Health and Human Services under 42 Code of Federal Regulations § 455.300 (re-codified as 42 CFR §§ 1007.1 – 1007.21) and authorized by 42 CFR § 431.107(b) to request that Medicaid providers furnish access to records. The MID is a health oversight agency as defined in the Health Insurance Portability and Accountability Act (HIPAA) in 45 CFR § 164.501 and the Preamble, 65 Fed. Reg. 82462 at 82492. The MCO is required to produce requested information to the MID in its capacity as a health oversight agency. 45 CFR § 164.512(d).

Disclosure is permitted under HIPAA pursuant to 45 CFR § 164.512(a). Since this information is requested by a health oversight agency and is required by law, no other requirements need to be met under the applicable Federal regulations. 45 CFR § 164.12(d) (1).
Upon request by the NC DOJ MID, PIHP shall, in a timely manner, produce all requested documents, data, and information in PIHP's possession, custody, or control. Upon request from MID, PIHP shall also furnish contact information for relevant employees and make them available for interviews concerning investigations conducted by the MID of providers contracted with PIHP.

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

8.4.3 Redactions: In the absence of written patient consent or a court order sufficient to comply with 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), PIHP shall redact all patient-identifying information from records provided directly to the MID involving alcohol or drug abuse programs. The redactions shall be limited to those necessary to prevent the MID from determining the identities of the Enrollees receiving services from alcohol or drug abuse programs. PIHP shall produce the redacted records along with documentation specifying what information has been redacted from those records.

PIHP shall not make any other alterations or redactions to the requested documents, data, or information without first obtaining written permission from the MID. Upon receipt of written patient consent or a court order sufficient to comply with 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), PIHP shall produce un-redacted copies of records involving alcohol or drug abuse programs.

SECTION 9 - REPORTS AND DATA

9.1 General, Recurring and Ad Hoc Reports, Timelines, Request Protocol

9.1.1 Recurring Reporting Requirements:

(a) Requirements for recurring reports, including acceptable reporting formats, instructions, and timetables for submission, are as set forth in this Contract.

(b) DMA reserves the right to modify from time to time the form, content, instruction, and timetables for collection and reporting of data pursuant to the terms of this Contract. DMA will involve PIHP in the decision process prior to implementing changes in format and will ask PIHP to review and comment on format changes. DMA will make every effort to give notice of changes at least sixty (60) calendar days prior to the effective date of any proposed change to recurring reports. New reports that require changes to PIHP's internal Information System require a ninety (90) day notice. Examples of this would be: Change Service Requests (CSR), Service Tickets, Changes to the DMA monthly data extracts generated from fee for service claims (Professional/Institutional/Pharmacy), and structural changes to the Global Eligibility File.

(c) The timetable for implementation of new and/or modified reports shall be mutually agreed upon by DMA and PIHP, taking into consideration the complexity and availability of the information needed, unless otherwise mandated by law or legislation. PIHP may request a reasonable extension of time to comply with the new or modified reporting requirements, which shall not be unreasonably refused.

(d) DMA will furnish such technical assistance as may be required to implement Contract modifications to reporting requirements and in filing reports and data as may be permitted by the DMA's available resources.

9.1.2 Ad Hoc Data, Reports:

9.1.2.1: Exceptions to the 60 or 90 day timeframes outlined in Section 9.1.1 may include but shall not be limited to *ad hoc* requests from DMA to PIHP Contract Administrator. The DMA Contract Administrator shall furnish PIHP with timely notice of *ad hoc* reporting requirements, including acceptable reporting formats, instructions, and timetables for submission.

9.1.2.2: If the *ad hoc* request is made to all PIHPs, DMA shall schedule an in-person or telephonic meeting with the PIHP Contract Administrators within three (3) business days of the request in order to review the request and ensure that all PIHPs submit the data requested in the same format and under the same instructions.

9.1.2.3: *Ad hoc* data and reports reasonably requested by DMA shall be submitted by PIHP to DMA at times mutually agreed upon by DMA and PIHP, unless a specific timeline is dictated by one of the following:

a. Federal Legislative Requests—PIHPs will be sent the request within 24 hours of request.
b. State Legislative Requests—PIHPs will be sent the request within 24 hours of receipt.
c. Centers for Medicare and Medicaid (CMS)--PIHPs will be sent the request within 24 hours of receipt.
d. State and Federal Auditors--PIHPs will be sent the request within 24 hours of receipt.

9.1.2.4: In the event DMA requests revisions to any *ad hoc* reports, including revisions to any reports already submitted to DMA that will require resubmission, the DMA Contract Administrator shall notify the PIHP Contract Administrator of the requested revision(s) and deadline for submission as soon as practicable. PIHP may request a reasonable extension of time to comply with the new or modified reporting requirements.

9.1.3 Timelines: Reports or other data shall be received on or before the scheduled due date. All required reports shall be received by DMA no later than 11:59:59 p.m. Eastern Time on the applicable due dates.

In the event any due date report falls on a date PIHP is closed, the due date will automatically extend to the next PIHP business day. Requests for extensions shall be submitted to DMA in writing. All reports remain due on the scheduled due dates unless DMA approves the extension request in writing. Such approval from DMA shall not be unreasonably withheld.

9.1.4 Request Protocol: The data request will be sent by the DMA Contract Administrator to the PIHP Contract Administrator, and shall copy the designated contact with the DMA Business Technology Resource Management Team, the DHHS staff person who requested the data, and the DHHS staff who are the most knowledgeable about the request.

9.2 <u>Enrollment Report and Capitation Payment:</u>

9.2.1 Enrollment Report: DMA shall provide to PIHP a monthly 834 Enrollment Report no earlier than the fourth to the last working day before the end of each month and no later than close of business on the first day of the ensuing month. The 834 Enrollment Report shall list all Enrollees who will be enrolled in PIHP during the ensuing month. The list of Enrollees in the 834 Enrollment Report shall serve as the basis for the ensuing month's capitated payment to PIHP.

9.2.2 Capitated Payment Determination: DMA shall use the list of Enrollees in the 834 Enrollment Report as the basis for the ensuing month's capitated payment to PIHP, and DMA shall pay PIHP a capitated payment for each Enrollee listed on each 834 Enrollment Report according to the rate methodology listed in Attachment P – Capitation Rates and Rate Setting Methodology.

9.2.3 Payment Order Report: DMA shall provide PIHP with an 820 Payment Order Report based on the checkwrite schedule provided by CSRA, the DHHS fiscal agent for the NCTracks System. The 820 Payment Order Report will be sent to PIHP within the first ten (10) business days of the month.

9.2.4 Reconciliation: PIHP shall reconcile the 834 Enrollment Report to the Global Eligibility File and the 820 Payment Order Report.

9.2.5 Inconsistency: In the event that the list of Enrollees identified by DMA in any 834 Enrollment Report does not accurately reflect the Enrollees who should be enrolled in PIHP for any given month, PIHP shall so notify DMA, and the Parties will establish a process and procedure for resolving any such discrepancies in a timely fashion, including a process and procedure for ensuring that PIHP receives all capitated payments and any accrued interest due to PIHP pursuant to Section 10 - Payments to PIHP.

9.2.6 Effective Dates: All enrollment and disenrollment, with the exception of Innovations Waiver Enrollees, shall be effective on the first day of the calendar month for which the enrollment or disenrollment is listed on the 834 Enrollment Report.

9.2.7 Innovations Waiver Effective Dates: Enrollment for Innovations Waiver Enrollees shall be effective retroactive to the date that all eligibility requirements for participation in Innovations were met.

9.3 <u>Encounter Data:</u>

9.3.1 Submission of Data: Pursuant to 42 CFR § 438.818, PIHP shall submit electronic records of paid or fully adjusted (zero paid) encounters to DMA or its contractor for the purposes of rate setting, quality assurance, performance measurement, waiver amendments, renewals, mandatory external review activities, and other activities deemed necessary by DMA. PIHP shall submit enrollee encounter data within fifteen (15) Business Days of the close of the month in which the encounter occurred, was paid for, or was processed, whichever is later, unless there are extenuating circumstances, including but not limited to issues associated with the MMIS such as communicated defects in the MMIS system, but no later than one hundred eighty (180) days from the paid encounter date. PIHP shall report all encounters that occur up to ninety (90) calendar days past the date of the termination of this Contract. Encounter data shall be submitted for all claims, including Part D claims to the extent PIHP has access to such information, as well as zero paid claims. PIHP shall institute processes to ensure the validity and completeness of the data it submits to DMA.

9.3.2 Validation of Data: All encounter data submitted to DMA shall be subjected to systematic data quality edits to verify both data content and the accuracy of claims processing. DMA shall validate the encounter data submitted by PIHP against Enrollee and provider eligibility criteria required by CMS, testing for timeliness, accuracy and completeness. DMA shall only deny encounter data submitted by PIHP if the denial is based on encounter criteria required by CMS.

9.3.3 Sanctions for Late or Incomplete Data: PIHP shall be subject to sanctions for late or incomplete submissions for claims with dates of service July 1, 2017, forward.

9.3.4 Approval Rate and Penalties: PIHP shall meet or exceed a ninety-five percent (95%) approval rate for Enrollee encounter data on a monthly basis. Penalties for a failure to meet this approval rate will not be assessed until January 1, 2018. During the first six (6) months after the Effective Date of this Contract, both Parties shall monitor approval rates, but no penalties will be assessed if PIHP falls below 94.99% in any given month. DMA shall not calculate the approval rate prior to ninety (90) calendar days from the last day of the calendar month being reviewed. If, due to errors solely attributable to PIHP, the calculation results in an approval rate lower than 95%, the Penalty will be calculated using the monthly administrative portion of the Capitation Payment. PIHP shall be subject to the following penalties for the month for which the PIHP failed to meet the percentage:

a. Approval rate higher than 74.49 % and lower than 95%: Penalty of .250%
b. Approval rate 74.49 % or lower but higher than 50.49%: Penalty of .375%
c. Approval rate is 50.49% or less: Penalty of .500%.

9.3.5 Effect of Consolidation: If this Contract is terminated prior to DMA's imposition of any penalty described above, and PIHP merges or otherwise consolidates with another PIHP, the penalty shall remain in effect solely as to the administrative capitation amount attributable to the PIHP being acquired until the newly merged PIHP reports all encounter data according to **the Financial Reporting Requirements in Attachment U – Financial Reporting Requirements, unless waived by the Secretary of DHHS.**

9.3.6 Certification: Pursuant to 42 CFR §§ 438.604 & 606, encounter data must be certified by **either** the PIHP's Chief Executive Officer, the PIHP's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the PIHP's Chief Executive Officer or Chief Financial Officer.

9.3.7 Minimum Required Data Elements: All encounter data submitted by PIHP to DMA or its contractor shall include, at a minimum, the following data elements:

a. Medicaid Identification Number
b. Member Name
c. Member Date of Birth
d. Member Gender
e. Rendering Provider NPI
f. Rendering Provider Taxonomy
g. Billing Provider Tax ID
h. Billing Provider NPI
i. Billing Provider Taxonomy
j. Claim Type
k. Billed Amount
l. Paid Amount
m. Units/Quantity
n. Form Type
o. Place of Service
p. Dates of Service
q. Procedure Code
r. Modifier(s)

s. Diagnosis
t. Third Party Liability
u. PIHP NPI/atypical number
v. PIHP taxonomy number

9.3.8 Submission Requirements. Encounter data submissions shall comply with the requirements of the DMA Encounters Manual and shall be in accordance with the following:

9.3.8.1: PIHP's systems shall conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and DMA Companion guides;

9.3.8.2: PIHP shall submit encounter data that meets established X12 EDI Transaction Standards supported by MMIS. The supported standards are:

820–Premium Payment
834–Member Enrollment and Eligibility Maintenance
835–Remittance Advice
837P–Professional claims
837I–Institutional claims
270/271–Eligibility Inquiry and Response
999--Implementation Acknowledgment

Changes to the X12 EDI Transaction Standards shall be communicated to PIHP by DMA with a minimum of ninety (90) calendar days to implement. National Correct Coding Initiative Edits will be sent as updated by CMS within 90 days of receipt by DMA, and PIHP shall have a maximum of ninety (90) calendar days to implement.

9.3.8.3: PIHP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe as requested by DMA to comply with DMA's data quality standards as defined within this Contract or subsequent written amendment.

9.3.8.4: Within fifteen (15) business days of the end of a payment cycle, PIHP shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If PIHP has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within fifteen business days of the end of the last payment cycle during the calendar week.

9.3.8.5: The encounter data files shall contain claim adjustments, including, but not limited to, adjustments necessitated by payment errors processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom PIHP has a capitation arrangement.

9.3.8.6: For multiple services that are submitted in a single claim, encounter data files shall be submitted with sufficient detail to compare the data to PIHP's applicable reimbursement methodology for the individual services.

9.3.8.7: If structural changes are made to the files, PIHP shall review, test, and implement changes to its internal Management Information System within 90 days in order to ensure appropriate receipt of the file. The 90 day change review period shall begin prior to the planned implementation date generated by the DHHS Change Service Request (CSR) process. In addition, emergency changes as identified via defects or through the DHHS File Maintenance Request (FMR) process may not be subject to the 90 day timeframe. Proprietary information submitted under this provision will be considered non-public information.

9.3.8.8: Within fifteen (15) business days of the end of a payment cycle, PIHP shall generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If PIHP has more than one (1) payment cycle within the same calendar week, the

encounter data files may be merged and submitted within fifteen business days of the end of the last payment cycle during the calendar week.

9.3.8.9 Sub-capitation: In the event PIHP has entered into capitated reimbursement arrangements with Providers, PIHP shall require submission of all utilization and encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims. PIHP shall require this submission from Providers as a condition of the capitation payment and shall take necessary actions to enforce this Contract provision to ensure timely receipt of complete and accurate data.

9.3.8.10 Error Correction: DMA shall reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by DMA, to ensure accurate processing or encounter data quality, and shall return these transactions to PIHP for resolution as outlined in this section. PIHP shall, unless otherwise directed by DMA, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. Addressing the errors means that PIHP has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. DMA may require resubmission of the transaction with reference to the original in order to document resolution.

9.3.8.11: Claims with errors that are not resolved as described in Section 9.3.8.10 may not be included in the rate setting process for the following year.

9.3.8.12 Eligibility and Enrollment Files. PIHP and DMA shall receive, process, update, and submit all eligibility/enrollment files in a HIPAA-compliant format:

(a) PIHP shall submit updates to its beneficiary eligibility/enrollment databases MCO assignment within one (1) business day of receipt of the quarterly full GEF file.
(b) PIHP shall receive daily updates to its beneficiary eligibility/enrollment databases MCO assignment within one (1) business day of receipt of the daily incremental GEF file.
(c) PIHP's information system shall be able to identify a distinct DMA enrollee across multiple populations and systems within PIHP's control.
(d) PIHP shall be responsible for establishing connectivity to DMA's and/or the State's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable DMA and State policies, standards and regulations.

9.3.8.13 External Quality Review of Encounter Data as part of the EQR, DMA shall conduct general data validity, integrity and completeness audits using the defined EQR protocol. Control totals shall be audited and verified. PIHP shall participate with the DMA EQR Vendor to perform the CMS-mandated Information Systems Capabilities Assessment (ISCA) as outlined in Attachment V of the CMS EQR Protocol.

PIHP shall also work with DMA and its EQR vendor pertaining to any testing initiative as required by this Contract and PIHP shall, in accordance with the EQR PROTOCOL 4 VALIDATION OF ENCOUNTER DATA REPORTED BY PIHP, enable DMA to:

(a) Review the State requirements for collecting and submitting encounter data;
(b) Review the MCO's capacity to produce accurate and complete encounter data;
(c) Analyze PIHP electronic encounter data for accuracy and completeness;
(d) Review medical records for confirmation of findings of analysis of encounter data; and
(e) Submit findings to the State.

9.3.8.14 Encounter Data Reports: PIHP shall submit reports to DMA based on outlined formats and timeframes as set forth in Section 9 – Reports and Data.

DMA shall provide PIHP with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. DMA may change the content, format, or

frequency of reports at DMA's discretion with a minimum of ninety (90) calendar days' notice to PIHP.

9.3.8.15 Dispute Resolution:
In the event PIHP is unable to submit encounter data as required by this Contract and Federal regulations due to an error or malfunction primarily attributable to the State eligibility and claims processing systems, PIHP shall not incur penalties that may have otherwise been incurred for failure to submit the encounter data at issue. In order for the Parties to determine whether the error or malfunction is primarily attributable to the State eligibility and claims processing systems, PIHP shall submit written notice to DMA describing the error or malfunction which resulted in PIHP's inability to submit encounter data as required by this Contract and Federal regulations. A final determination of whether the error or malfunction is primarily attributable to the State eligibility and claims processing systems shall be made by the DHHS CIO or designated representatives, the DMA Director and DMA staff as deemed necessary by the DMA Director, and PIHP representatives as designated by PIHP. In the event there is an impasse, DMA will issue a final decision notice to the PIHP Contract Administration. If PIHP is not satisfied with the final determination, PIHP may invoke any legal or administrative remedy available to it under State and Federal law. Any such penalty will be stayed until PIHP exhausts all due process rights provided by law. Pending appeal, PIHP shall proceed diligently with the performance of this Contract.

9.4 Financial Reporting Requirements:

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

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

9.5 Clinical Reporting Requirements:

9.5.1: PIHP shall submit utilization data, report on performance and integrated care measurements, and implement and report on performance improvement projects as described in Attachment K – Statistical Reporting Measures and Late Submission Sanctions and Attachment L – Requirements for Performance Improvement Projects, respectively. Integrated care measures, as described in Attachment K, shall be implemented on a pilot basis during SFY 2018. Reports shall identify trends and patterns, when appropriate, and describe how the findings are used in PIHP's clinical management and decision making processes.

9.5.2: DMA and PIHP may mutually agree, in writing, on modifications to Attachment K and L, respectively, to include additional quality measures as necessary over the term of this Contract, except when State or Federal authority mandates modification. DMA shall provide guidance to PIHP in meeting the clinical reporting requirements of this Contract. DMA shall work with PIHP vendors to collect and report additional State-wide performance and outcome measures.

9.5.3: PIHP shall submit clinical reports that are timely, accurate, and complete. The submission of late, inaccurate, or otherwise incomplete reports shall constitute a failure to report, and PIHP shall be subject to corrective actions or penalties and sanctions as specified in Section 13 – Penalties, Sanctions and Temporary Management.

9.5.4: The DMA Contract administrator shall furnish PIHP with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission and such technical assistance in filing reports and data as may be permitted by the DMA's available resources.

9.5.5: DMA reserves the right to modify from time to time the form, content, instructions, and timetables for collection and reporting of data. DMA agrees to involve PIHP in the decision process prior to implementing changes in format, and DMA shall ask PIHP to review and comment on format changes before they go into effect.

9.5.6: The timetable for new reports shall be negotiated by PIHP and DMA, taking into consideration the complexity and availability of the information needed.

9.6 Financial Reports Certification:

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

a. PIHP's Chief Executive Officer (CEO);
b. PIHP's Chief Financial Officer (CFO) or Chief Business Officer (CBO); or
c. An individual who has been authorized to sign for, and who reports directly to, PIHP's CEO, CFO or CBO.

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

9.7 Grievances and Appeals Reports:

PIHP shall submit data, documentation, reports and other information relating to the performance of PIHP's obligations under 42 CFR §438 subpart F to DMA as specified in Attachment K – Statistical Reporting Measures and Late Submission Sanctions.

9.8 Fraud and Abuse Reports: In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y.

PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Z – Terminations, Provider Enrollment Denials, Other Actions.

Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section 9.8.

SECTION 10 - PAYMENTS TO PIHP

10.1 Monthly Payment:

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

10.1.1: In full consideration of all services rendered by PIHP under this Contract, DMA shall remit to PIHP the Capitation Rate determined using the methodology in Attachment P – Capitation Rates and Rate Setting Methodology by **multiplying the number of Medicaid Eligibles in each Rate Cell** (whose county of residence for Medicaid purposes is within PIHP's geographic area as determined by the monthly cutoff date

in DMA's Medicaid Eligibility data system) **<u>by the payment rates for the respective Rate Cells</u>. The payment amount will be pro-rated for partial-month eligibility.**

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

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

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

10.1.5: PIHP shall not use Title XIX funds to pay for:

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

10.1.6: PIHP shall maintain separate accounting for revenue and expenses for the Title XIX program in accordance with CMS requirements as delineated in Section 9.4 - Financial Reporting Requirements and Attachment U – Financial Reporting Requirements.

10.2 <u>Payment in Full:</u>

10.2.1: PIHP shall accept the capitation rate paid each month by DMA for each Medicaid beneficiary listed on the 820 Premium Payment Remittance transaction, including retroactive payments and adjustments as described in Section 10.1 - Monthly Payment, as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. This provision does not eliminate an obligation of DMA to pay additional funds to PIHP or make adjustments that may otherwise be required pursuant to this Contract.

10.2.2: Enrollees shall be entitled to receive all Medically Necessary Covered Services for the entire period for which payment has been made by DMA. Interest generated through investment of funds paid to PIHP pursuant to this Contract shall be the property of PIHP.

10.3 <u>Retroactive Payment Adjustments:</u>

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

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

10.4 <u>Calculation of Rates:</u>

10.4.1: PIHP and DMA shall negotiate capitation rates in good faith, and PIHP shall have the right to request adjustments to the capitation rates at any time. These rates shall be certified as compliant with the

Centers for Medicare and Medicaid Services requirements under 42 CFR § 438.6(c) by actuaries meeting the qualification standards of the American Academy of Actuaries.

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

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

10.4.5: Attachment P – Capitation Rates and Rate Setting Methodology describes the rate setting methodology for the capitated payments. Using the methodology in Attachment P, the rates shall be recalculated each year. DMA shall notify PIHP at least ninety (90) calendar days prior to the effective date of the new rates. PIHP shall have fourteen (14) business days to review the proposed rates. At the end of the fourteen (14) business day review period, PIHP may choose to accept the new rate, negotiate rate changes, or to terminate the Contract with DMA in accordance with Section 12 - Default and Termination.

10.5 Rate Adjustments:

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

10.6 Recoupment:

If PIHP:

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

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

1. Request a refund of the overpayment; or
2. Recoup the overpayment by withholding payments due in any one or more subsequent months.

DMA may also recoup erroneous overpayments made to PIHP as a consequence of keying errors or system errors. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Enrollee information and the recoupment amount. DMA shall provide at least ten (10) days' notice to PIHP of the intent to recoup overpayments and shall offer PIHP the opportunity to contest any such alleged overpayments consistent with Section 1.10 – Disputes. DMA shall not take any collection action under this Contract against PIHP, including, but not limited to, recoupment while the dispute is pending and unresolved, unless otherwise allowed by law.

10.7 Third Party Resources:

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

10.7.2: PIHP shall contractually require its Network Providers to report any third party coverage of its Enrollees to the appropriate DSS within five (5) business days of obtaining the information from a source other than DSS.

10.7.3: If PIHP does not identify and/or begin collection activities against third party resources within twelve (12) months from the date of service, PIHP shall relinquish all rights to such resources, and DMA may collect and retain any third party recoveries that it should discover.

SECTION 11 - SUBCONTRACTS

11.1 <u>Requirements:</u>

11.1.1: PIHP may enter into subcontracts for the performance of its administrative functions and for the provision of Covered Services to Enrollees and for the following administrative functions: Information Technology/System; Claims Processing; Customer Service; Provider Enrollment; Credentialing, and Monitoring; Professional Consultation and Peer Review. PIHP shall be fully responsible for adhering to and otherwise fully complying with all terms and conditions of this Contract.

11.1.2: All subcontracts as that term is defined at 42 CFR 438.2, which specifically excludes written agreements with Network Providers shall comply with the provisions of 42 CFR § 438.230 and shall:

a. Clearly identify the functions that are subcontracted;

b. Specify the procedures and criteria for the extension, re-negotiation, and termination of the subcontract;

c. Fully disclose the method and amount of compensation or other consideration to be received from PIHP;

d. Provide that PIHP shall monitor the subcontractor's performance on an ongoing basis, at least annually, and subject it to formal review according to a periodic schedule consistent with industry standards;

e. Contain a provision that, upon PIHP's identification of deficiencies or areas for improvement in the subcontractor's performance, PIHP may either revoke the delegation of activities or obligations or require the subcontractor to take corrective action;

f. Contain no provision which provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services from Enrollees;

g. Prohibit the subcontractor, without PIHP's prior written consent, from assigning the subcontract and subcontracting with lower tier subcontractors;

h. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including without limitation, the obligation to comply with all applicable Federal and State laws and regulations,, all rules, policies and procedures of the Department and DMA and all standards governing the provision of Covered Services and information to Enrollees, all quality assurance requirements, all record keeping and reporting requirements, and the obligation to maintain the confidentiality of information;

i. Specify that the subcontractor agrees that the State, CMS and HHS Inspector General, the Comptroller General or their designees, have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the subcontractor or of the subcontractor's contractor that pertain to any aspect of services and activities performed or determination of amounts payable under PIHP's contract with the State. The right to audit shall remain in force for ten (10) years from the final date of the contract term or from the date of completion of any audit, whichever is later;

j. Specify the subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. If the State, CMS or the HHS

Inspector General determines that there is reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time without notice; and

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

11.2 Timeliness of Provider Payments:

11.2.1: Payments to Providers by PIHP shall be made on a timely basis, consistent with claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act and 42 CFR § 447.45.

11.2.2: PIHP shall ensure that ninety percent (90%) of all Clean Claims for Covered Services, for which no further written information or substantiation is required in order to make payment, are paid within thirty (30) calendar days of the date of approval and that ninety-nine percent (99%) of such claims are paid within one hundred eighty (180) calendar days of the date of receipt.

11.2.3: PIHP shall not be responsible for processing or payment of claims that are submitted ninety (90) days after the date of service. Date of receipt is the date PIHP receives the claim, as indicated by electronic data records and the 835 Health Care Claim Payment/Advice Transaction (Electronic Remittance Advice [ERA]) generated for the Provider. The date paid is the date of the check or other form of payment.

11.2.4: Within eighteen (18) calendar days after PIHP receives an invoice/claim from a Provider, PIHP shall:

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

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

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

11.3 DMA's Remedies against Subcontractors:

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

SECTION 12 - DEFAULT AND TERMINATION

12.1 PIHP Breach and Remedies:

12.1.1: If PIHP breaches any material term of this Contract, DMA may issue a written notice of breach to PIHP that describes the material breach and requires PIHP to submit to DMA, within thirty (30) calendar days, a Corrective Action Plan for DMA's approval. If PIHP does not timely cure the breach to DMA's satisfaction, DMA may impose one or more or all of the sanctions listed below:

a. The suspension, recoupment, or withholding of monthly capitation payments;
b. The assessment of refundable or non-refundable penalties;

c. The assessment of monetary damages; and
d. Termination of this Contract.

12.1.2: Notwithstanding the foregoing, DMA shall have the right to impose any of these sanctions, or any other available sanctions, against and in accordance with 42 CFR § 438.710, without first giving PIHP an opportunity to cure the breach.

12.2 Termination without Cause:

12.2.1: This Contract may be terminated without cause by either party by giving one hundred twenty (120) 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 one hundred twenty (120) notice period expires. In the event of termination by either party without cause:

a. DMA and PIHP shall work together to minimize any disruption of services to clients;
b. PIHP shall perform all of the duties specified in Section 12.5-PIHP's Obligations upon Contract Expiration or Termination;
c. DMA and PIHP shall resolve any outstanding obligations under this Contract; and
d. PIHP shall pay DMA in full any refunds or other sums due to DMA under this Contract.

12.2.2: If PIHP exercises its right to terminate this Contract without cause, DMA may require PIHP to pay the non-Federal share of reasonable transition costs (*i.e.*, the costs of NC FAST, MMIS, and Enrollee notifications).

12.3 Termination for Cause:

DMA shall have the right to terminate this Contract immediately for cause, and to provide Medicaid benefits to Enrollees through other options in the State Plan, if DMA determines that only one (1) or more than one (1) of the following has occurred:

a. 12.3.1 PIHP or one of its subcontractors has substantially failed to comply with the material terms of this Contract, and PIHP knew or should have known of the noncompliance and failed to take appropriate action immediately to correct the problem;

b. PIHP or one of its subcontractors has substantially failed to comply with the applicable requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act, and PIHP knew or should have known of the noncompliance and failed to take appropriate action immediately to correct the problem;

c. PIHP has substantially failed to comply with the requirements of any applicable State or Federal law, statute, rule, or regulation, and PIHP failed to take appropriate action immediately to correct the problem;

d. The performance of PIHP or one of its subcontractors has threatened to place the health or safety of any Enrollee in jeopardy, and PIHP knew or should have known of the issue and failed to take appropriate action immediately to correct the problem;

e. PIHP has become subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);

f. PIHP has fraudulently misled any Enrollee or has fraudulently misrepresented the facts or law to any Enrollee, and PIHP failed to take appropriate action immediately to correct the problem;

g. 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 PIHP, its agents or employees;

h. Current ratio: PIHP's current assets divided by current liabilities (Current Ratio) is less than 1.00 at any point in time;

i. Defensive interval: PIHP has failed to ensure that Defensive Interval is not less than thirty (30) calendar days at any point in time. Defensive Interval = (Cash + Current investments) / ((Operating expense – Non-cash expense)/Period being measured in days));

j. Medical Loss Ratio (MLR) – The Medical Loss Ratio, calculated consistent with the formula set forth in the final 42 CFR § 438.8 issued by the Centers for Medicare and Medicaid Services in 2016 (see below in this Subsection k.) falls below eighty-five percent (85%) for the rating period. For purposes of calculating the MLR, the numerator shall consist of the total of Medical Claims Expenses (including IBNR expense), Payments Made Outside of the Claim System, plus at least the following Quality Improvement Activities as reflected on Schedule O in the DMA Financial Reporting Template:

(1) Improve Health Outcomes
- Care Coordination – DD Treatment Planning
- Care Coordination – MH/SA Treatment Planning
- Health information technology to support Care Coordination
- Accreditation fees directly related to quality of care
- Implementing ICD-10 as the standard medical data code set
- Chronic disease management

(2) Activities to prevent hospital readmissions
- Health information technology to support hospital readmissions
- Comprehensive discharge planning
- Patient-centered education and counseling
- Personalized post-discharge reinforcement and counseling by an appropriate health care professional

(3) Improve patient safety and reduce medical errors
- Prospective prescription drug utilization review aimed at identifying adverse drug interactions
- Health information technology to support patient safety and reduced medical errors

(4) Wellness & Health Promotion Activities
- Public Health education campaigns that are performed in conjunction with State or local health departments
- Actual rewards, incentives, bonuses, reductions in copayment that are not already reflected in premiums or claims should be allowed as quality improvement activities
- Health information technology to support wellness and health promotion activities
- Wellness assessments
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition
- Coaching or education programs and health promotion activities designed to change member behavior and conditions

As appropriate, DMA may add additional Quality Improvement Activities to the list of items that comprise the numerator of the MLR calculation.

For purposes of calculating the MLR, the denominator shall consist of the Capitation Payment. The denominator shall not include any payments for the prior year's dates of service. MLR shall be calculated by dividing the numerator by the denominator.

k. PIHP loses accreditation with NCQA or URAC.

12.4 Automatic Termination:

12.4.1: This Contract shall immediately and automatically terminate without further obligation to DMA if:

a. 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

b. In the event that the sum of all contractual obligations of DMA for Medical Assistance Benefits, exceeds the balance of funds available to DMA for Medical Assistance Benefits for a contract year in which this Contract is effective, then DMA shall have the option to immediately terminate or amend this Contract.

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

12.5 PIHP's Obligations upon Contract Expiration or Termination:

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

a. Continue to perform all of PIHP's obligations as described in this Contract until 11:59:59 p.m. on the last day of the calendar month for which DMA has paid the monthly capitation rate;

b. Continue to provide authorization and payment for inpatient psychiatric hospital services and any services directly related to psychiatric inpatient care, to any Enrollees who are hospitalized on the termination date, until each such Enrollee is discharged, or until 11:59:59 p.m. on the last day of the calendar month for which DMA has paid the monthly capitation rate, whichever occurs first;

c. Provide DMA with a report of all active authorizations and authorization limits, as of the date of termination;

d. Provide DMA with a list of all Enrollees who are hospitalized, and where each Enrollee is hospitalized, if known to PIHP, as of the date of termination;

e. Provide DMA with a list of all Enrollees in psychiatric residential treatment facilities (PRTFs) authorized by PIHP, and where each PRTF Enrollee is hospitalized, as of the date of termination;

f. Arrange for the transfer of all Enrollees to other appropriate Medicaid Providers or managed care entities;

g. Promptly provide DMA with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;

h. Take such action as may be necessary, or as DMA may direct, for the protection of property related to this Contract, which is in the possession of PIHP and in which DMA has an interest;

i. Arrange for the secure maintenance of all PIHP records for audit and inspection by DMA, CMS, and other authorized government officials, in accordance with Section 8-Health Information and Records;

j. Provide for the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;

k. Provide for the preparation and delivery of all reports, forms and other documents to DMA as may be required pursuant to this Contract or any applicable policies and procedures of DMA; and

l. Notify all Enrollees in writing of the pending expiration or termination of this Contract no less than forty-five (45) calendar days prior to the date of the expiration or termination. If DMA terminates this Contract immediately for cause, pursuant to Section 12.3-Termination for Cause, PIHP shall provide notice of termination to Enrollees as promptly as possible after PIHP receives the notice of termination from DMA. Similarly, if this Contract is terminated immediately because of a lack of funds, pursuant to Section 12.4-Automatic Termination, PIHP shall provide notice of termination to Enrollees as promptly as possible after PIHP receives the notice of termination from DMA. In all cases, PIHP's notification letter must be approved by DMA before PIHP mails the notice to Enrollees.

The obligations set forth in this Section 12.5 shall survive the expiration or termination of this Contract and shall remain fully enforceable by DMA against PIHP. In the event that PIHP fails to fulfill each obligation set forth in this Section 12.5, DMA shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of PIHP, and PIHP shall refund to DMA all sums expended by DMA in so doing.

12.6 <u>DMA's Obligations upon Contract Expiration or Termination:</u>

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

a. Continue to pay the monthly capitation rate through the effective date of expiration or termination;

b. Continue to provide the monthly list of Enrollees eligible to be enrolled in PIHP through the effective date of expiration or termination;

c. Continue to provide all data required to be shared with PIHP through the effective date of expiration or termination;

d. Provide assistance to PIHP with respect to the transfer of Enrollees to other appropriate Medicaid providers or managed care entity;

e. Provide assistance with the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;

f. Provide assistance with the preparation and delivery of any reports, forms or other documents to PIHP as may be required pursuant to this Contract or State or Federal law; and

The obligations set forth in this Section 12.6 shall survive the expiration or termination of this Contract and shall remain fully enforceable by PIHP against DMA. In the event that DMA fails to fulfill each obligation set forth in this Section 12.6, PIHP shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of DMA, and DMA shall refund to PIHP all sums expended by PIHP in so doing.

SECTION 13 – PENALTIES, SANCTIONS and TEMPORARY MANAGEMENT:

13.1 **<u>Options to Help Ensure Compliance:</u>** DMA shall have the right to use any one (1) or more of the following options to help ensure compliance with the provisions of this this Contract:

a. Corrective Action Plan: To be developed by PIHP at the written request of DMA. Each Corrective Action Plan must be approved by DMA in writing and shall be monitored by the Monitoring Team and DMA (See Section 1.6- Monitoring Review). DMA shall not be required to offer a Corrective Action Plan prior to taking any other action against PIHP;

b. Penalties and Sanctions: (See Section 13.2- Monetary Penalties; Section13.3- Sanctions);

c. Temporary Management: (See Section 13.4- Temporary Management); and

d. Termination: (See Section 12- Default and Termination).

Prior to imposing any of the sanctions identified in 42 CFR Part 438, Subpart I and/or Sections 13.2 – Monetary Penalties and 13.3 - Sanctions, DMA shall provide written notice to PIHP in accordance with 42 CFR § 438.710.

13.2 Monetary Penalties:

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

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

DMA shall have the right to assess monetary penalties pursuant to Section 11.2- Timeliness of Provider Payments, Section 9.4- Reporting Requirements, Section 14.4- Reporting to DMA Program Integrity, and Attachments X – Criminal Convictions, Y – Audits/Self-Audits/Investigations, and Z – Terminations, Provider Enrollment Denials, Other Actions).

13.3 Sanctions:

13.3.1: DMA shall have the right to impose sanctions authorized by 42 CFR § 438.702, except that, for violations under paragraphs 42 CFR § 438.700(d) (1) and (d) (2), only the sanctions specified in 42 CFR § 438.702, paragraphs (a) (3), (a) (4), and (a) (5) may be imposed.

13.3.2: Sanctionable actions include, but shall not be limited to, failure to provide medically necessary services that PIHP is required to provide, under law or under this Contract, imposition of premiums on Enrollees or charges in excess of the premiums or charges permitted under the Medicaid program, discrimination among Enrollees on the basis of health status or need for health care services, and any actions for which a fine may be imposed by DMA pursuant to the terms of this Contract.

13.3.3: Sanctions may include, but shall not be limited to, the following:

a. Financial penalties as specified in this Contract;
b. Civil monetary penalties as specified in 42 CFR § 438.704;
c. Appointment of temporary management for PIHP;
d. Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to dis-enroll;
e. Suspension of new enrollment including default enrollment; and
f. Suspension of payment for Enrollees enrolled after the effective date of the sanction and until CMS or the State is satisfied the reason for the sanction no longer exists and is not likely to recur.

13.4 Temporary Management:

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

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

SECTION 14: PROGRAM INTEGRITY

14.1 General:

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

14.1.2: PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors', compliance with the requirements of this Section 14.

14.1.3: PIHP shall include Program Integrity requirements in its written agreements with Providers participating in PIHP's Closed Provider Network.

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

14.2 Fraud and Abuse:

14.2.1 Compliance Plan: PIHP shall establish and implement a written Compliance Plan consistent with 42 CFR § 438.608 that is designed to guard against fraud and abuse. The written Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.

14.2.2 Compliance Officer and Compliance Committees: PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 CFR § 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under this Contract in accordance with 42 CFR 438.608(a)(1)(iv).

14.2.3 Program Integrity Unit and Contact Person: PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.

14.2.4 Program Integrity Meetings: PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID").

PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA. Nothing herein shall be construed to prohibit informal discussions between DMA and PIHP representatives regarding specific program integrity issues.

14.2.5 Minimum Requirements for Compliance Plan: PIHP's written Compliance Plan shall, at a minimum, include:

a. A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act;

b. Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;

c. Enforcement of standards through well-publicized disciplinary guidelines; and

d. Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations.

14.2.6 Requirements of 42 CFR § 438.608: In accordance with 42 CFR § 438.608 (a)(vii),PIHP shall establish and implement systems and procedures that require: 1) Utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under this Contract; 2) Prompt response to compliance issues as identified; 3) Investigation of potential compliance problems as identified in the course of self-evaluations and audits; 4) Correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence; 5) Monitoring of ongoing compliance as required under this Contract; and 6) making documentation of investigations and compliance available as requested by the State.
In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse. At a minimum, such policies and procedures shall include:

a. Policies and procedures for detecting and investigating fraud and abuse;

b. Process for capturing and tracking complaints; Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.

c. In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.

d. Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations;

e. Process for handling self-audits and challenge audits;

f. Process for using data mining to determine leads;

g. Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;

h. If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(68), including information about rights of employees to be protected as whistleblowers.

i. Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template; and

j. Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.

14.2.7 Identification of Over/Under Payments: PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.

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

14.2.9 Provider Information to DMA Program Integrity: In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:

a. Subject (name, Medicaid provider ID, address, provider type);
b. Source/origin of complaint;
c. Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;
d. Description of suspected intentional misconduct, with specific details including:
    (1) The category of service;
    (2) Factual explanation of the allegation;
    (3) Specific Medicaid statutes, rules, regulations or policies violated; and
    (4) Dates of suspected intentional misconduct.
e. Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;
f. All communications between PIHP and the Provider concerning the conduct at issue, when available;
g. Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs; and
h. Sample/exposed dollar amount, when available.

14.2.10 Enrollee Information to DMA Program Integrity: In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:

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

14.2.11 Mutual Agreement on Forms, Tools and Letters: PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools and letters that meet the requirements of State and Federal law, rules and regulations and are consistent with the forms, tools and letters utilized by other PIHPs.

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

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

14.2.14 Monthly and Quarterly Reports: PIHP shall submit to DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month.

14.2.15: On a quarterly basis, DMA shall review a sample of cases where PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.

14.3 Provider Payment Suspensions and Overpayments:

14.3.1 Investigation Timelines: Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral.

a. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP.

b. If the MFCU/ MID indicates that payment suspension will impact the investigation, DMA shall temporarily withhold the suspension notice and notify PIHP.

c. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur:

   (1) PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or

   (2) Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.

d. In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.

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

14.3.3 PIHP Provision of Information/Personnel: PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.

14.3.4 Prior DMA Approval Before Administrative Action: PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/ MID.

Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/ MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.

14.3.5: In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. § 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the Provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.

14.3.6: Recovery Audit Contractors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. DMA shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.

14.3.7: The MFCU/ MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the State by the MFCU/ MID for fraudulent claims paid by PIHP. DMA shall examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.

SECTION 15: TRANSITIONS TO COMMUNITY LIVING

15.1 Staff:

15.1.1: PIHP shall have staff to perform "transition planning functions" for the TCL Special Healthcare Population.

15.1.2: The staff shall:

a. Except for Certified Peer Support Specialists, meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training;

b. Assure that discharge/transition planning occurs timely for individual described for the TCL Special Healthcare Population; and

c. Ensure the development of an effective transition plan for each member who has agreed to transition in the TCL Special Healthcare Population.

15.1.3: PIHP shall have staff or contractors to perform "diversion" and "in-reach" activities for the TCL Special Healthcare Population. The in-reach staff or contractors must be Certified Peer Support Specialists within six (6) months of being hired.

15.2 Care Coordination:

15.2.1 The population identified in the DOJ Settlement Agreement is a required "Special Healthcare Population", and Care Coordination shall include clinical functions performed by a licensed Care Coordinator. Administrative functions may be performed by unlicensed staff. Members of the TCL Special Healthcare Population shall receive Care Coordination for at least ninety (90) calendar days after transitioning to the community. The continued need for Care Coordination after the ninety (90) day timeframe shall be based on whether the Enrollee meets special healthcare needs population criteria following the ninety (90) day timeframe.

15.2.2 PIHP shall provide "transition planning" for the TCL Special Healthcare Population. Transition planning is the process of developing a person-centered recovery transition plan to assist an

individual in transitioning from an Adult Care Home or other congregate community living arrangement to a more integrated community living arrangement. This plan shall be used by the treatment provider to develop the person-centered recovery treatment plan. The transition plan shall follow the guidelines set forth by DHHS in support of the DOJ Settlement Agreement.

15.2.3 PIHP shall work in concert with the facility staff and shall serve as lead contact with the individual leading up to the transition from an Adult Care Home or State Psychiatric Hospital. Barriers to transitions shall be documented in the individual's record and addressed by PIHP at the local level where feasible. In situations where identified barriers cannot be addressed by PIHP at the local level, PIHP shall request assistance from DHHS to address any identified barriers preventing an individual from transitioning to the community.

15.2.4 For individuals who have transitioned to the community and experience an admission to a State hospital or inpatient psychiatric facility, PIHP shall provide care coordination for at least ninety (90) calendar days after the individual's discharge from the State hospital or inpatient psychiatric facility. The continued need for Care Coordination after the ninety (90) day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the ninety (90) day timeframe.

15.2.5 For individuals residing outside of PIHP's catchment area or choosing to move outside of PIHP's catchment area, PIHP shall collaborate to ensure behavioral health services and necessary supports are in place prior to the individual's transition to the community. Out of Network agreements shall be issued if there is no provider within the PIHP Network who can deliver medically necessary services to the individual.

15.2.6 PIHP shall provide "diversion" and "in-reach activities" for the TCL Special Healthcare Population. These activities shall follow the guidelines set forth by DHHS in support of the August 2012 Settlement Agreement between the State of North Carolina and the United States Department of Justice as located on the DHHS website.

15.2.7 In-reach activities shall be documented using DHHS's Transitions to Community Living (TCL) Database and shall include, at a minimum, the following, as appropriate:

a. Full explanations of the benefits and financial aspects of clinically appropriate community-based integrated settings, including supportive housing;
b. Facilitating and accompanying individuals on visits to support housing apartments;
c. Assessing Adult Care Homes residents' interest in supportive housing; and
d. Exploring and addressing the concerns of any Adult Care Home residents who decline the opportunity to move to supportive housing or who are ambivalent about moving to supportive housing despite being qualified for such housing.

15.2.8 PIHP shall maintain up-to-date data on Enrollees involved in the in-reach or transition process. Complete and accurate data shall be entered into the TCL database by the tenth (10th) of each month for the previous month. Any documents generated or received by PIHP related to any aspect of the Transitions to Community Living Initiative (TCLI) shall be stored and maintained pursuant to the State Record Retention requirements.

15.2.9 PIHP shall deliver ad hoc reports related to Care Coordination to DMA in accordance with Section 9.1 -Reports and Data of this Contract.

15.2.10 PIHP shall assist local Departments of Social Services and DHHS with securing placement locations and coordinating the delivery of services for Enrollees residing in an ACH determined to meet Institution for Mental Disease (IMD) criteria. PIHP shall track and monitor the placement locations and initiate in-reach activities for those Enrollees relocating to another ACH.

15.2.11 PIHP, through the provision of in-reach, transition coordination, and care coordination services, whether provided directly by the PIHP staff or contracted through a Provider, shall be responsible for the oversight of the SA/IH Program funds for each TCL participant and for assuring that eligibility

information is provided to the Department of Social Services as required to maintain program eligibility.

15.3 Person-Centered Planning:

15.3.1 A person-centered service plan shall be developed for each Enrollee with an approved housing slot, or receiving Assertive Community Team (ACT) or Individual Placement and Support – Supported Employment (IPS-SE) services, which shall be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the Enrollee in a coordinated manner. The individualized Person Centered Plan shall include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis. Person Centered Plans shall: Be evidence-based, recovery focused, and community based; Be flexible and individualized to meet the needs of each Enrollee; Help Enrollees to increase their ability to recognize and deal with situations that may otherwise result in crisis; and Increase and strengthen Enrollees' networks of community and natural supports as well as their use of these supports for crisis prevention and intervention.

15.3.2 PIHP shall provide access to the services and supports that are medically necessary for Enrollees who are transitioning through TCL.

15.3.3 PIHP shall ensure that an actionable person centered plan is in place and that a service provider has been identified and delivering services prior to an Enrollee's discharge from an ACH, inpatient psychiatric facility or state psychiatric hospital.

15.3.4 PIHP shall engage with Adult Care Home (ACH) Providers to provide information on assessment, referrals, and crisis access. PIHP shall also provide equal access to services and supports for individuals who choose to reside in an ACH over transitioning into the community through TCL.

15.3.5 PIHP shall develop and implement transition plans for individuals in ACHs residing in ACHs and State Psychiatric hospitals as outlined in the In-Reach and Transition Manuals.

15.4 Internal Quality Assurance and Performance Improvement Program:

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

b. QOL surveys shall be administered by the PIHP:
   (1) Prior to the Enrollee transitioning out of the facility;
   (2) Eleven (11) months after the Enrollee's transition out of the facility; and
   (3) Twenty-four (24) months after the Enrollee's transition out of the facility.

c. PIHP shall report the survey results to DHHS in accordance with the US DOJ Settlement Guidelines.

d. PIHP shall submit TCL related performance measure data on a monthly basis as required by DHHS.

e. PIHP shall implement at least one (1) Quality Improvement Project or at least one (1) Quality Assurance Project per year related to TCL. The TCL Quality Improvement Project shall count towards the total number of QIPs required under this Contract.

f. PIHP shall establish and implement a written policy and procedure to address adverse events as defined by DHHS for the TCL Special Healthcare Population. PIHP shall report the aggregate number of adverse events to DHHS upon DHHS request.

15.5 Clinical Reporting Requirements:

a. PIHP shall be responsible for reporting on discharge-related measures for the TCL Special Healthcare Population, including but not limited to:
   (1) Housing vacancies;
   (2) Discharge planning and Transition processes;
   (3) Referral processes and subsequent admissions;

(4) Time between applications for services to discharge destination;
(5) Actual date of admission to community-based settings;
(6) Information related to both successful and unsuccessful placements; and
(7) Problems or barriers to placing or keeping Enrollees in the most integrated setting.

b. PIHP shall report TCL personal outcomes data to DHHS upon request.
c. PIHP shall follow the report schedule and format of the US DOJ Settlement Guidelines.
d. PIHP shall assure that Enrollees receiving services from agencies or residing in facilities that are closed get assessed within seven (7) business days of notification to PIHP of closure and are linked to services based on medical necessity.

15.6 Assertive Community Treatment (ACT):

a. PIHP shall contract only with Providers who are in fidelity to the Tool for Measurement of ACT (TMACT) model in accordance with the DOJ Settlement Agreement and current policy.
b. PIHP shall provide current ACT programs with reasonable training and technical assistance to meet the current service definition requirements.
c. PIHP shall contract with a sufficient number of Providers for ACT services for Enrollees with SMI/SPMI, including those in the TCL Special Healthcare Population, in accordance with the DMA Clinical Policy.
d. PIHP shall link a specific number of individuals to ACT, as determined by the DOJ settlement and communicated by DHHS to the PIHPs, and report the number to DHHS upon request.
e. PIHP shall monitor ACT providers to evaluate the quality of service delivery and compliance to the ACT service definition. PIHP shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the ACT service definition, up to and including termination of the Provider's contract to participate in the PIHP Network, as applicable.

15.7 Peer Support Services (PSS):

a. PIHP shall be required to provide evidence-based Peer Support Services (PSS) as a Medicaid 1915 (b)(3) service in accordance with the Waiver service description.
b. PIHP shall contract with a sufficient number of Providers for PSS services for Enrollees with SMI/SPMI, including those in the TCL Special Healthcare Population in accordance with the Waiver service description.
c. PIHP shall monitor PSS providers to evaluate the quality of service delivery and compliance to the Waiver service description. PIHP shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the PSS service definition, up to and including termination of the Provider's contract to participate in the PIHP Network, as applicable.

15.8 Supported Employment (SE):

a. PIHP shall contract only with Providers who are in fidelity to the Individual Placement and Support – Supported Employment (IPS-SE) model in accordance with the DOJ Settlement Agreement and current policy.
b. PIHP shall provide current IPS-SE programs with reasonable training and technical assistance to meet the current Waiver service description.
c. PIHP shall contract with a sufficient number of Providers for IPS-SE services for Enrollees with SMI/SPMI, including those in the TCL Special Healthcare Population, in accordance with waiver service descriptions.
d. PIHP shall link a specific number of individuals to IPS-SE, as determined by the DOJ settlement and communicated by DHHS to PIHP, and report the number to DHHS upon request.
e. PIHP shall monitor IPS-SE Providers to evaluate the quality of service delivery and compliance to the Waiver service description. PIHP shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the IPS-SE service definition, up to and including termination of the Provider's contract to participate in the PIHP Network, as applicable.

15.9 One Time Transitional Supports:

a. PIHP shall offer one (1) time Transitional supports as a Medicaid 1915 (b)(3) service for the TCL Special Healthcare Population.
b. PIHP will define the use/amount of "1 (one) time Transitional supports" based on the identified needs of the Enrollee.

15.10 Diversion Process:

a. PIHP shall assign staff or contract with staff to carry out the requirements of the DOJ Settlement related to diverting Enrollees from admission to licensed Adult Care Homes.
b. PIHP shall produce for DHHS PIHP's criteria and analysis that demonstrates adequate staffing levels.
c. PIHP shall, directly or through contractors, ensure that:
   (1) Enrollees are educated on their individual Community Integration Plan (CIP);
   (2) Enrollees receive assistance as needed to implement the CIP;
   (3) Medicaid services are offered to Enrollees whether moving to the community or to an Adult Care Home; and
   (4) Enrollees who choose to be admitted to an ACH are referred for In-Reach, per the in-reach requirements of the DOJ Settlement.
d. PIHP shall maintain up-to-date data on Enrollees in the diversion process. Complete and accurate data shall be entered by PIHP into the TCL reporting system by the tenth (10th) of each month for the previous month's information. Any documents generated or received by PIHP related to any aspect of TCLI shall be stored pursuant to State Record Retention requirements.
e. PIHP shall deliver ad hoc reports related to Diversion processes to DMA in accordance with Section 9.1 -Reports and Data of this Contract.

15.11 Communication:

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

15.12 Performance Measures: PIHP shall be responsible for reporting monthly on the performance measures below in this Section. The numerator and denominator requirements will be included in the LME-MCO Performance Measurement Guidelines Manual.

a. The percent of PIHP's cumulative monthly number of required Enrollees served by fidelity IPS-SE Providers;
b. The percent of persons who transitioned to supportive community housing with transition management services, ACT, and/or CST services in place no later than twenty (20) to forty (40) days prior to transition;
c. The percent of persons who transitioned to supportive housing within ninety (90) days of assignment to a transition team;

d. The percent of Quality of Life surveys completed before individual's transition dates or within thirty (30) calendar days before or after eleventh (11th) and twenty-fourth (24th) month anniversaries in supportive housing; and
e. The percent of In-Reach and Transition Coordinators hired per funding allocation.

See the following page for Attachment C.

ATTACHMENT C

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUSINESS ASSOCIATE ADDENDUM

This Agreement is made effective the 1st day of July, 2017, by and between North Carolina Department of Health and Human Services – Division of Medical Assistance ("Covered Entity") and Alliance Behavioral Healthcare ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled (identify contract) DMA-MCO-2018-1 (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.

c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected heath information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

d. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.

e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.

h. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.

e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528,.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
   1) would not violate the Privacy Rule if done by Covered Entity; or
   2) would not violate the minimum necessary policies and procedures of the Covered Entity.
b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
   1) the disclosures are Required By Law; or
   2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

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

c. **Effect of Termination**.

1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2) In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

Robert Robrow

PLEASE PRINT NAME

SIGNATURE

6-27-17

Date

See the following page for Attachment D.

ATTACHMENT D
Data Protection

Data Protection

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

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

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

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

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

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

Risk Assessment and Recipient Notification
When a privacy or security incident has occurred, the Business Associate shall:

- notify DHHS immediately, but no later than 24 hours;
- provide detailed information, providing complete and accurate answers to questions from DHHS within 1 business day unless otherwise agreed upon by both DHHS and the Business Associate;
- investigate the incident to determine what, if any, information was disclosed and provide this to DHHS within 5 days
- complete a risk assessment within 5 business days of the event and make a preliminary assessment regarding the presence of significant risk of compromise to the data;

- provide a list of all recipients affected within 5 business days of the event;
- update DHHS as more information becomes available;
- provide all additional information required by HIPAA (including 45 CFR 164.410) and NC Identity Theft statutes within 5 days of the event;
- perform action to mitigate the compromise of the data and harm to the individuals involved and report this to DHHS within 10 days;
- determine the cause of the incident and perform remediation such as training, and policy/process changes to prevent these events in the future and report this to DHHS within 10 days;
- pay all costs of notification or provide the notification, at the discretion of the DHHS;
- promptly provide any information requested related to privacy/security issues to DHHS and remediate problems raised by DHHS staff.

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

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

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

Policies
The Business Associate shall comply with NC DIT Security standards Chapter 13 (Detecting and Responding to IS Incidents, (**http://it.nc.gov/statewide-resources/policies**) as well as the DHHS Privacy and Security Information Incident Management Policy
http://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security

The Off-Site Storage Security Standard (**http://it.nc.gov/statewide-resources/policies**)

The Business Associate shall comply with all DHHS Privacy and Security Policies (**http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/**) including the HIPAA Breach Notification for Unsecured PHI policy.

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

Record Retention: Records shall not be destroyed, purged, or disposed of without express written consent of the Division. State basic records retention policy requires all grant records to be retained for a minimum of five years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years. Records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involved this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five-year period described above, whichever is

later. Records involved in Temporary Assistance for Needy Families (TANF) and MEDICAID and Medical Assistance grants and programs must be retained for a minimum of ten years.

See the following page for Attachment E.

ATTACHMENT E
CONSOLIDATED FEDERAL CERTIFICATIONS AND DISCLOSURES

The undersigned states that:

(a) He or she is the duly authorized representative of the Contractor named below;

(b) 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;

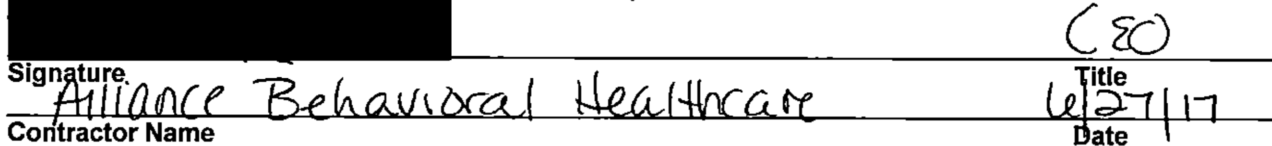
(c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;

(d) [Check the applicable statement]

[ ] He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the 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

[X] 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.



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

[redacted]	CEO
Signature	**Title**
Alliance Behavioral Healthcare	6/27/17
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

4600 Emperor Blvd, Durham NC 27703

Street

414 E. Main St Durham NC 27701

City, State, Zip Code

2803 Slater Rd. Morrisville, NC 27650

5000 Falls of Neuse Rd. Raleigh 27609
Street

711 Executive Place Fayetteville, NC 28303
City, State, Zip Code

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, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies,** by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The 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

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	☐ a. initial filing ☐ b. material change **For Material Change Only:** Year___________ Quarter___________ Date Of Last Report:______________

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier (if known) ____________________ Congressional District (if known) ____________________	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District (if known) ____________________
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number (if applicable) ____________________
8. Federal Action Number (if known)	9. Award Amount (if known) $
10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*): *(attach Continuation Sheet(s) SF-LLL-A, if necessary)*	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*): *(attach Continuation Sheet(s) SF-LLL-A, if necessary)*
11. Amount of Payment (*check all that apply*): $ ______________________________ € actual € planned	13. Type of Payment (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: ____________________
12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. In-kind; specify: Nature ______________ Value ________	

14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11 (*attach Continuation Sheet(s) SF-LLL-A, if necessary*):
15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

<table>
<tr><td>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.</td><td>Signature: ____________
Print Name: ____________
Title: ____________
Telephone No: ____________ Date: ____________</td></tr>
<tr><td>Federal Use Only</td><td>Authorized for Local Reproduction
Standard Form - LLL</td></tr>
</table>

See the following page for Attachment F.

ATTACHMENT F

Contractor Certifications Required by North Carolina Law, Including the Certification of Eligibility Under the Iran Divestment Act

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
- 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): http://www.ethicscommission.nc.gov/library/pdfs/Laws/EO24.pdf
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: 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_143B139.6C.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

(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. 143-59.1and -59.2 shall be guilty of a Class I felony.

Alliance Behavioral Healthcare

Contractor's Name

[redacted]	6-27-17
Signature of Contractor's Authorized Agent	Date
[redacted]	CEO
Printed Name of Contractor's Authorized Agent	Title
[redacted]	6-27-17
Signature of Witness	Date
Carol Hammett	General Counsel
Printed Name of Witness	Title

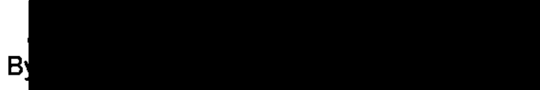
The witness should be present when the Contractor's Authorized Agent signs this Certification and should sign and date this document immediately thereafter.

CERTIFICATION OF ELIGIBILITY
Under the Iran Divestment Act

Pursuant to G.S. 143C-6A-6, any person identified as engaging in investment activities in Iran, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 143C-6A-4, is ineligible to contract with the State of North Carolina or any political subdivision of the State. The Iran Divestment Act of 2015, G.S. 143C-6A-1 *et seq.* requires that each vendor, prior to contracting with the State certify, and the undersigned on behalf of the Vendor does hereby certify, to the following:

1. That the vendor is not identified on the Final Divestment List of entities that the State Treasurer has determined engages in investment activities in Iran;
2. That the vendor shall not utilize on any contract with the State agency any subcontractor that is identified on the Final Divestment List; and
3. That the undersigned is authorized by the Vendor to make this Certification.

Vendor: Alliance Behavioral Healthcare

By:  6-27-17

Signature Date

Rob Robinson CEO

Printed Name Title

The State Treasurer's Final Divestment List can be found on the State Treasurer's website at the address www.nctreasurer.com/Iran and will be updated every 180 days. For questions about the Department of State Treasurer's Iran Divestment Policy, please contact Meryl Murtagh at *Meryl.Murtagh@nctreasurer.com* or (919) 814-3852.

See the following page for Attachment G.

ATTACHMENT G
Vendor Certification of Compliance with N.C.G.S. § 133-32 and Executive Order 24

Background

A. N.C. General Statute §133-32 makes it unlawful for any vendor, contractor, subcontractor, or supplier who: (1) Has a contract with a governmental agency; or (2) Has performed under such a contract within the past year; or (3) Anticipates bidding on such a contract in the future; to make gifts or to give favors to any governmental officer or employee who is charged with the duty of: (1) Preparing plans, specifications, or estimates for public contract; or (2) Awarding or administering public contracts; or (3) Inspecting or supervising construction.

B. By means of Executive Order 24, signed on October 1, 2009, Governor Perdue expanded the prohibitions in N.C. General Statute §133-32 to ban the giving of gifts and favors to *any* employee of the Cabinet agencies—the Departments of Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, and Transportation and the Office of the Governor—regardless of the nature of their official duties.

C. Executive Order 24 can be viewed online at:
http://www.governor.state.nc.us/NewsItems/ExecutiveOrderDetail.aspx?newsItemID=665

D. N.C. General Statute §133-32 can be viewed online at:
http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl

Certifications

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

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

Alliance Behavioral Healthcare
Vendor Name

[redacted] | 6-27-17
Signature of Vendor's Authorized Agent | Date

Rob Robinson | CEO
Printed Name of Vendor's Authorized Agent | Title

[redacted] | 6-27-17
Signature of Witness | Date

Carol Hammett | General Counsel
Printed Name of Witness | Title

See the following page for Attachment H.

ATTACHMENT H

DEFINITIONS

Ad hoc: Reports or data requested by DMA that are not expressly required in this Contract on a routine, regularly recurring basis.

Adverse Benefit Determination: Pursuant to 42 C.F.R. § 438.400, "adverse benefit determination" is defined as the denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of PIHP to act within the timeframes provided in 42 CFR § 438.408(b)(1) & (2) regarding the standard resolution of grievances and appeals; the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Enrollee financial liabilities; and, for a rural area resident with only one PIHP , the denial of an Enrollee's request to obtain services outside the Network under any of the following circumstances or where the Parties mutually agree that other circumstances warrant out-of-network agreements:

a. When services from any other Provider (in terms of training, experience, and specialization are not available in the PIHP Network;

b. From a Provider not part of the PIHP Closed Network who is the main source of a service to the Enrollee—provided that the Provider is given the same opportunity to become a participating Provider as other similar Providers. If the Provider does not choose to join the Network or does not meet the qualifications, the Enrollee shall be given a choice of participating Providers and shall be transitioned to a participating Provider within sixty (60) calendar days;

c. Because the only plan or Provider available does not provide the service the Enrollee seeks because of moral or religious objections; or

d. Because the Enrollee's Provider determines that the Enrollee needs related services that would subject the Enrollee to unnecessary risk if received separately and not all related services are available within the Network.

Applicant: A Provider who is seeking to participate in the Closed Network of PIHP, as set forth at N.C.G.S. § 108D-1(1).

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

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

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

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

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

Catchment Area: The geographic part of the State of North Carolina served by PIHP, as defined in N.C.G.S. § 122C-3(5).

CFR: Code of Federal Regulations

Children: Enrollees who have not reached their respective twenty-first (21st) birthdays, unless otherwise defined in this Contract.

Clean Claim: Means as defined in 42 CFR § 447.45(b).

Closed Provider Network (also referred to as Network, Closed Network, Provider Network, and PIHP Closed Provider Network): The group of providers that have contracted with PIHP to furnish covered mental health, intellectual or developmental disabilities, and substance abuse services to Enrollees, as set forth at N.C.G.S. § 108D-1(2).

CMS: Centers for Medicare and Medicaid Services

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

Contract Term: The period of time during which this Contract is in effect.

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

Credentialing: The pre-contract screening and decision process, including primary source verification (PSV), conducted by PIHP to verify that the Applicant is qualified to deliver services to Enrollees and eligible to participate and be enrolled and contracted in PIHP's Closed Provider Network. The process includes obtaining a provider enrollment application, verifying the information received from the Applicant, and assessing the required qualifications, certifications, endorsements and licensure of the Applicant, as well as additional credentialing elements required by PIHP's accrediting body. In addition, this also includes criminal background and Federal and State database checks. PIHP is not required to enroll or contract with a credentialed provider. Enrollment in the PIHP Closed Network is distinct from Enrollment in the NC Medicaid Program.

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

DHHS or Department: The North Carolina Department of Health and Human Services, which is the designated single state Medicaid agency for the State of North Carolina.

Days: Except as otherwise noted, refers to calendar days. The terms "working day" and "business day" shall each mean a day on which DMA and PIHP are officially open to conduct their affairs.

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

DMA: The Division of Medical Assistance, which is overseen by DHHS.

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

DRG: Diagnostic Related Grouping

DSS: A county Department of Social Services.

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

a. Placing the health of the Enrollee (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

b. Serious impairment to bodily functions, or

c. Serious dysfunction of any bodily organ or part.

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

a. Are furnished by a Provider that is qualified to furnish such services; and

b. Are needed to evaluate or stabilize an emergency medical condition as defined above.

Emergent Need (Mental Health): A life threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self.

Emergent Need (Substance Abuse): A life threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance abuse or dependence.

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

Enrollment: When referring to Enrollees, this means an action taken by DMA to add a Medicaid beneficiary's name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area. When referring to Providers, this means the process of submitting a credentialing application for consideration to become a Provider in the PIHP Closed Network, unless the context is referring to the process of submitting an online enrollment application via NCTracks for consideration to become a Provider in the NC Medicaid or Health Choice programs.

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

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

Enrollment Report or 834 Enrollment Report: A transaction set that represents a benefit enrollment and maintenance document, is used to enroll Medicaid beneficiaries, and has been specified by HIPAA 5010 standards for the electronic exchange of enrollment information.

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

External Quality Review (EQR): The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the healthcare services that PIHP or its contractors furnish for Medicaid recipients.

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

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

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

FTP: File Transfer Protocol

Global Eligibility File (GEF): A report created by the State or its agents that contains information about Enrollees, and the respective aid categories for which they have been approved, in the State Medicaid program.

Grievance: Pursuant to 42 C.F.R. 438.400, an expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an "adverse benefit determination" as defined in this Attachment H. The term is also used to refer to the overall system that includes grievances and appeals handled at PIHP level and access to the State Fair Hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by PIHP to make an authorization decision.

Grievance and Appeal System: The processes PIHP implements to handle appeals of an adverse benefit determination and handle grievances, as well as the processes to collect and track information about grievances and appeals.

HHS: U.S. Department of Health and Human Services

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

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

IBT or **Individual Budget Tool**: The IBT is used during the annual service planning process for Enrollees on the Innovations Waiver. The IBT is composed of four (4) tables that specify the IBT amounts that an Enrollee assigned to a particular level is authorized to receive without additional authorization (in the form of a temporary increase or intensive review during the utilization review process).

ICD: The International Classification of Diseases diagnostic tool for epidemiology, health management and clinical purposes.

ICF/IID: Intermediate Care Facilities for Individuals with Intellectual Disabilities

IMT or **Intra-Departmental Monitoring Team**: A team led by DMA and consisting of qualified DMA and DMH staff who provide monitoring of PIHP throughout the course of this Contract.

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

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

In lieu of services: Alternative services or settings that are substituted for services or settings covered under the State Plan or that are otherwise covered by this Contract but that are more medically appropriate, cost-effective substitutes for the State Plan services included within Attachment J-Schedule of Benefits.

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

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

Institution for mental diseases: Means as defined in 42 CFR § 435.1010. An Intermediate Care Facility for Individuals with Intellectual Disabilities is not an IMD.

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

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

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

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

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

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

Medically Necessary Treatment Services or Supplies: According to NCGS § 58-3-200, Covered Services or supplies that are : (1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under N.C.G.S. § 58-3-255, not for experimental, investigational, or cosmetic purposes; (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) Within generally accepted standards of medical care in the community; and (4) Not solely for the convenience of the insured, the insured's family, or the provider.

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

NC Medicaid Program: The fee-for-service program operated by DHHS for the provision of health care services to Medicaid beneficiaries based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA. Enrollment into the PIHP Closed Network is distinct from Enrollment into the NC Medicaid Program.

NC Tracks: The multi-payer Medicaid Management Information System for the NC Department of Health and Human Services

Network Provider: Means as defined in 42 CFR 438.2.

OAH: North Carolina Office of Administrative Hearings

OIG: United States Department of Health and Human Services Office of the Inspector General

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

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

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

Payment Order Report or 820 Payment Order Report: A transaction set that provides the format for transmitting information related to Capitation Payments.

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

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

Primary Care Case Management (PCCM): A system under which a primary care case manager contracts with the State to furnish case management services which include the location, coordination, and monitoring of primary health care services (to Medicaid beneficiaries).

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

Provider: Any person or entity providing mental health (MH), individuals with developmental disabilities (IDD) and/or substance abuse (SA) services.

PSV: Primary Source Verification

OIG: United States Department of Health and Human Services Office of the Inspector General.

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

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

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

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

Screening: A required element of the process for a provider to be enrolled by NC DHHS in the NC Medicaid program in accordance with the requirements of 42 CFR Part 455, subparts B and E. Enrollment in the NC Medicaid program is distinct from enrollment in the PIHP Closed Network.

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

State: The State of North Carolina.

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

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

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

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

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

Urgent Need (Mental Health): A condition in which a person is not actively suicidal or homicidal; denies having a plan, means or intent for suicide or homicide but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention will progress to the need for emergent services and care.

Urgent Need (Substance Abuse): A condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of 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.

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

See the following page for Attachment I.

ATTACHMENT I
ELIGIBILITY CATEGORIES

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

* **Children who have not reached their respective third (3rd) birthdays are NOT eligible for any services covered under this Contract EXCEPT for Innovations Waiver services.**

RATE CELLS FOR CAPITATED PAYMENTS

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

See the following page for Attachment J.

ATTACHMENT J

SCHEDULE OF BENEFITS

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

1. All services described in DMA Clinical Coverage Policies 8A through 8P located on the DMA website at http://dma.ncdhhs.gov/providers/clinical-coverage-policies;

2. Inpatient services for psychiatric and substance abuse Diagnostic Related Groupings (DRGs) provided under 2A-1 Acute Inpatient Hospital Services;

3. All services received during an emergency room visit, including all professional services, pharmacy, x-ray and lab services that are directly related to evaluation/treatment of a MH/DD/SA diagnosis and billed with Revenue Codes 450-459, 900-919 and fall within the ICD-10 Codes listed in Attachment CC-ICD-10 Codes;

4. All 1915(c) Home and Community Based Waiver (HCBS) waiver services as defined in the Innovations Waiver;

5. All psychiatric inpatient hospital stays, identified by DRGs 876, 880-887, 894-897;

6. All Section 1915(b)(3) waiver services as defined in the 1915(b) MH/DD/SAS waiver;

7. All Medically Necessary Treatment services provided by psychiatrists, licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified clinical nurse specialists, or certified nurse practitioners.

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

See the following page for Attachment K.

ATTACHMENT K

STATISTICAL REPORTING MEASURES AND LATE SUBMISSION SANCTIONS

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

PIHP shall complete and submit the quarterly reports listed below to DMA by June 30 of each year, and the annual report by November 15th of each year. The annual reports submitted shall contain data collected from July 1st through June 30th of the preceding State fiscal year. Note, however, that PIHP shall submit Grievance and Appeal Reports to DMA on a quarterly basis consistent with Section 7.5-Grievances and Appeals. Failure to submit reports in accordance with the timeline listed below may result in the imposition of the sanctions outlined below. PIHP shall use the HEDIS Technical Specifications outlined in the current DMA Performance Measures Guidelines Manual that are applicable to the subject reporting year. PIHP may seek and receive written approval from DMA for revisions or amendments to the HEDIS specifications, provided it does so before April 1. For all measurements without pertinent HEDIS specifications, PIHP shall use technical specifications provided by DMA in the DHHS Performance Measures Guidelines Manual. DMA will provide PIHP with the description and data measurement requirements for each measure noted below on or before April 1. Each annual report shall contain an explanation of how the data was calculated. Questions regarding reporting requirements shall be addressed to DMA's Contract Administrator for Program Issues or through quarterly IMT meetings. As used below, "member" includes all of PIHP's Medicaid Enrollees, unless some other meaning is specified.

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

A. EFFECTIVENESS OF CARE MEASURES

1. **Readmission Rates for Mental Health**
2. **Readmission Rates for Substance Abuse**
3. **Ambulatory Follow-Up within seven (7) calendar days of Discharge for Substance Abuse facility**
4. **Ambulatory Follow-Up within seven (7) calendar days of Discharge for Mental Health**

B. ACCESS/AVAILABILITY

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

C. PATIENT AND PROVIDER SATISFACTION

1. **Grievances/Appeals (*):** Report separately all Medicaid Enrollee grievances, and appeals including the total number of Enrollees served, total number of grievances categorized by reason, reported separately; the number of grievances referred to second level review or appeal, reported separately; and the number of grievances resolved at each level, total time of resolution and outcome, reported separately. Reports are due to DMA on a quarterly basis, consistent with PIHP Complaint reporting schedule.
2. **Experience of Care and Health Outcomes Survey:** PIHP shall participate in an Experience of Care and Health Outcomes Survey on an annual basis. The External Quality Review Organization (EQRO) will work with PIHP to gather data on the Enrollees in the PIHP's catchment area in order to complete the annual survey within the timeframe requested by DHHS.
3. **DHHS Provider Satisfaction Survey:** PIHP shall participate with the EQRO in a DHHS Provider Satisfaction Survey on an annual basis. EQRO will work with PIHP to gather data on the Network Providers in the PIHP's catchment area in order to complete the annual survey within the timeframe requested by DHHS.

D. USE OF SERVICES

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

E. HEALTH PLAN STABILITY

1. Network Capacity

F. PLAN DESCRIPTIVE INFORMATION:

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

G. HEALTH AND SAFETY

1. Critical Incident Reports

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
Section 9.2	Encounter Data	Monthly	$100 per calendar day	None
L.A.1	Follow up after hospitalization for mental illness	Annually	$100 per calendar day	None
L.A.2	Readmission Rates for Mental Health	Annually	$100 per calendar day	None
L.A.3	Readmission Rates for Substance Abuse	Annually	$100 per calendar day	None
L.A.4	Ambulatory Follow-up within 7 Calendar Days of Discharge for Substance Abuse Therapy	Annually	$100 per calendar day	None
L.A.5	Ambulatory Follow-up Within 7 Days of Discharge for Mental Health	Annually	$100 per calendar day	None
L.B.1	Initiation and Engagement of Alcohol and Other Drug Dependence Programs	Annually	$100 per calendar day	None
L.B.2	Call Answer Timeliness	Annually	$100 per calendar day	None

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
L.B.3	Call Abandonment	Annually	$100 per calendar day	None
L.B.4	Service Availability/Accessibility	Annually	$100 per calendar day	None
L.B.5	Payment Denials	Annually	$100 per calendar day	None
L.B.6	Out of Network Services	Annually	$100 per calendar day	None
L.C.2	Grievances/Appeals	Quarterly	$100 per calendar day	None
L.D.1	Inpatient Discharges and Average Length of Stay	Annually	$100 per calendar day	None
L.D.2	Percentage or Members Receiving Inpatient Day/Night Care, Ambulatory and Other Support Services	Annually	$100 per calendar day	None
L.D.3	Chemical Dependency Utilization Inpatient Discharges and Average Lengths of Stay	Annually	$100 per Calendar Day	None
L.D.4	Chemical Dependency Utilization Percentage of Members Receiving Inpatient, Day/Night, Ambulatory and Other Support Services	Annually	$100 per calendar day	None
L.D.5	Identification of Alcohol and Other Drug Services	Annually	$100 per calendar day	None
L.D.6	Integrated Care	Annually	$100 per calendar day	None
L.E.1	Integrated Care	Annually	$100 per calendar day	None
L.F.1	Unduplicated Count of Medicaid Members	Annually	$100 per calendar day	None
L.F.2	Diversity of Medicaid Membership	Annually	$100 per calendar day	None
V.A	Balance sheet	Monthly	$100 per calendar day	None
V.B	Medicaid risk reserve balance	Monthly	$100 per calendar day	None
V.C	Medicaid income statement	Monthly	$100 per calendar day	None

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
V.D	Total profitability	Monthly	$100 per calendar day	None
V.D1	Medicaid profitability	Monthly	$100 per calendar day	None
V.D2	Non-Medicaid profitability	Monthly	$100 per calendar day	None
V.E	Medicaid-only medical services lag	Monthly	$100 per calendar day	None
V.E1	Medicaid cash summary	Monthly	$100 per calendar day	None
V.F	Medicaid statistics current year	Monthly	$100 per calendar day	None
V.F1	Medicaid statistics prior year	Monthly	$100 per calendar day	None
V.G	Medicaid claim aging	Monthly	$100 per calendar day	None
V.H	Medicaid claim processing	Monthly	$100 per calendar day	None
V.I	B3 services current year	Quarterly	$100 per calendar day	None
V.I1	B3 services prior year	Quarterly	$100 per calendar day	None
V.J	Medicaid third party liability and coordination of benefits	Quarterly	$100 per calendar day	None
V.K	Medicaid fraud and abuse tracking	Quarterly	$100 per calendar day	None
V.L	Supplemental working area	As needed	$100 per calendar day	None
V.M.	Alternative Payment Arrangements	Monthly	$100 per calendar day	None
V.N.	Fund Balance	Monthly	$100 per calendar day	None
V.O.	Medical Loss Ratio	Monthly	$100 per calendar day	None
V.P.	Reinvestment	Monthly	$100 per calendar day	None
V.AA.	Cost allocation plan	Annually	$100 per calendar day	None
V.BB	Audited financial statements	Annually	$100 per calendar day	None
V.CC	OMB circular A-133 audit	Annually	$100 per calendar day	None
V.DD	Related party transactions and obligations	Annually	$100 per calendar day	None

Report Citation	Statistical Reporting Measure and/or Financial Reporting Requirement	Report Frequency	Late Penalty Amount per Report	Opportunity to Cure
V.EE	Physician incentive arrangements	Annually	$100 per calendar day	None

H. Benchmarks and Penalties

Beginning January 1, 2018, the following measures, shall have a benchmark and corresponding penalty for each benchmark not met. PIHP shall implement a written corrective action plan, approved by DMA, for any in which PIHP performance is below the benchmark. DHHS staff shall notify PIHP in writing within fifteen (15) calendar days of the end of the applicable reporting period, with supporting documentation for DMA's determination. PIHP shall have fifteen (15) calendar days to develop and submit a corrective action plan to DMA for approval. Following DMA approval of any corrective action plan, PIHP shall demonstrate improvement as specified in the corrective action plan within sixty (60) calendar days of receipt of approval of the corrective action plan. If the corrective action plan does not result in the improvement specified in the corrective action plan within the sixty (60) calendar days, PIHP shall incur a penalty for each month following the sixty (60) days for each measure not met. PIHP shall be subject to a separate penalty for each benchmark not corrected as part of the corrective action plan. Penalties shall continue until PIHP demonstrates to DMA compliance with the corrective action plan.

Measure	Benchmark	Penalty
Medical Care Coordination – IDD with health visit in last year	90%	$100,000
Follow Up After Discharge: Detox/FBC (SUD) within 0-7 days	40%	$100,000
Follow Up After Discharge: Community Hospitals (MH) within 7 days	40%	$100,000

See the following page for Attachment L.

ATTACHMENT L

REQUIREMENTS FOR PERFORMANCE IMPROVEMENT PROJECTS

PIHP shall develop and implement performance improvement projects as referenced in Attachment B-Scope of Work, Section 7.1-Internal Quality Assurance/Performance Improvement Program and in compliance with 42 C.F.R. § 438.240 and the CMS Quality Framework. Project topics will be determined jointly by PIHP and DMA from the list of clinical and non-clinical focus areas listed below. Using EQR Protocol 3, Validation of Performance Improvement Projects, PIHP shall be evaluated annually by the EQR vendor. Over the term of this Contract, PIHP shall develop and implement a minimum of three (3) performance improvement projects. During year one of this Contract, PIHP shall develop and implement a minimum of two performance improvement projects. One project shall focus on a clinical area and one shall focus on a non-clinical area. During year two of the Contract, PIHP shall develop and implement at least one additional performance improvement project for a total of three performance improvement projects. Baselines will be established the first year of each project and PIHP shall set benchmarks for each project based on currently accepted standards, past performance data, or available national data. PIHP shall obtain the approval of DMA before terminating any of the required performance improvement projects. Reports on all performance improvement projects shall be submitted to DMA no later than August 31st of each year.

a. Primary, secondary and/or tertiary prevention of acute mental illness conditions;
b. Primary, secondary and/or tertiary prevention of chronic mental illness conditions;
c. Care of acute mental illness conditions;
d. Recovery/outcome measures;
e. Care of chronic mental illness conditions;
f. High-volume services;
g. High-risk services;
h. Continuity and coordination of care;
i. Availability, accessibility, and cultural competency of services;
j. Quality of Provider/patient encounters; or
k. Appeals and grievances.

1. Topics shall be identified through continuous data collection and analysis by PIHP of comprehensive aspects of patient care and member services. Topics shall be systematically selected and prioritized to achieve the greatest practical benefit for Enrollees.

2. The Quality Assurance/Performance Improvement program shall provide opportunities for Enrollees to participate in the selection of project topics and the formulation of project goals.

3. PIHP's performance improvement for each selected topic is measured using one or more quality indicators. All indicators measure changes in health status, functional status, or satisfaction. Indicators shall be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. PIHP shall select some indicators for which data are available that allow comparison of PIHP's performance to that of similar Medicaid Behavioral Health/ IDD Prepaid Inpatient Health Plans or to local, State, or national benchmarks.

4. PIHP shall establish a baseline measure of its performance on each selected indicator, shall measure changes in performance, and shall continue measurement for at least one year after the desired level of performance is achieved.

5. A project demonstrates improvement by achieving a benchmark level of performance defined in advance by CMS or DMA. Benchmarks shall be based on currently accepted standards, past performance data, or available national data.

6. When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, the sample must be sufficiently large to detect the targeted amount of improvement.

7. The sample or subset of the study population shall be obtained through random sampling. The samples used for the baselines and repeat measurements of the indicators shall be chosen using the same sampling frame and methodology.

8. PIHP must be able to demonstrate that any observed improvement is reasonably attributable to interventions undertaken by PIHP (i.e., a project and its results have face validity).

9. PIHP must be able to sustain any observed performance improvements for at least one year after the performance improvement is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed.

10. PIHP is expected to collect and use data from multiple sources, such as medical record reviews, focused care studies, claims and encounter data, HEDIS, grievances, utilization review and member satisfaction surveys. PIHP is expected to use findings from performance improvement projects to analyze:

    a. The delivery of services;
    b. Quality of care;
    c. Over and under-utilization of services;
    d. Disease management strategies; and
    e. Outcomes of care.

See the following page for Attachment M.

ATTACHMENT M

ENROLLEE GRIEVANCE AND APPEAL PROCEDURES

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

Pursuant to 42 C.F.R. § 438.400, adverse benefit determination means the denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of PIHP to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) & (2) regarding the standard resolution of grievances and appeals; the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities. For a rural area resident with only one MCO, the denial of a Medicaid Enrollee's request to obtain services outside the network under any of the following circumstances:

a. When services from any other Provider in terms of training, experience, and specialization are not available in the Network

b. From a Provider not part of the PIHP closed network who is the main source of a service to the Enrollee—provided that the Provider is given the same opportunity to become a participating Provider as other similar Providers. If the Provider does not choose to join the Network or does not meet the qualifications, the Enrollee is given a choice of participating Providers and is transitioned to a participating Provider within sixty (60) calendar days.

c. Because the only plan or Provider available does not provide the Enrollee's requested service due to moral or religious objections.

d. Because the Enrollee's Provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

e. DMA determines that other circumstances warrant out-of-network treatment.

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

PIHP shall have only one level of internal appeal for Enrollees. Enrollees must exhaust the internal PIHP appeal process before requesting a State Fair Hearing.

A. General Requirements of Grievance and Appeal System:

1. PIHP shall:

   a. Provide Enrollees any reasonable assistance in completing forms and other procedural steps, including but not limited to, providing interpreter services and toll free numbers with TTY/TDD and interpreter capability;

   b. Acknowledge receipt of each grievance and appeal;

c. Ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making nor are a subordinate of any such individual; and

d. Ensure that decision makers on grievances regarding clinical matters and appeals are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:

i. An appeal of a denial based on lack of medical necessity;
ii. A grievance regarding PIHP's denial of a request for an expedited resolution of an appeal; or
iii. Any grievance or appeal involving clinical issues.

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

a. The Enrollee's right to a State Fair Hearing, how to obtain a State Fair Hearing, and representation rules at a State Fair Hearing;

b. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;

c. The availability of assistance in filing;

d. The toll free numbers to file oral grievances and appeals; and

e. The Enrollee's right to request continuation of benefits in accordance with 42 C.F.R. § 438.420 during an appeal or State Fair Hearing regarding PIHP's decision to reduce, suspend or terminate a previously authorized service (meaning a service for which the authorization has not yet expired), and that if PIHP's adverse benefit determination is upheld in a State Fair Hearing, the Enrollee may be liable for the cost of any continued benefits; and

f. Any appeal rights that the State chooses to make available to Providers to challenge the failure of the PIHP to cover a service.

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

1. PIHP shall maintain records of each grievance or appeal that include a copy of the original grievance or appeal (if submitted in writing), and at a minimum all of following:

(a) A general description of the reason for the appeal or grievance;
(b) The date received;
(c) The date of each review or, if applicable, review meeting;
(d) Resolution at each level of the appeal or grievance, if applicable;
(e) Date of resolution at each level, if applicable; and
(f) Name of the person for whom the appeal or grievance was filed.

2. PIHP shall provide for the retention of the records described above for five (5) years following a final decision or the close of the grievance or appeal. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later. The record must be maintained in a manner accessible to the State and available upon request to CMS.

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

1. The Enrollee requests the extension; or

2. PIHP demonstrates (to the satisfaction of DMA, upon DMA's request) that there is need for additional information and demonstrates how the delay is in the best interest of the Enrollee.

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

D. **Service Authorizations and Notices of Adverse Benefit Determinations:**

1. Requests for service authorizations must be processed within the following timeframes and requirements:
   a. For standard authorization decisions, PIHP must provide notice within fourteen (14) calendar days following receipt of request for the service, with a possible extension of up to fourteen (14) additional calendar days if:
      ii. The Enrollee or Provider requests extension; or
      iii. PIHP demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.
   b. PIHP must make an expedited service authorization decision within 72 hours after receipt of the request, when following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, with a possible extension of up to fourteen (14) additional calendar days if:
      i. The Enrollee requests an extension; or
      ii. PIHP demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.

   c. If PIHP extends the timeframe, it must give the written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

   d. A decision not reached within the timeframes specified in §438.210(d) constitute an untimely denial and, consequently, an adverse benefit determination. Service authorizations are considered untimely if they are not made within the standard timeframe or expedited timeframe, whichever is applicable.

   e. PIHP must notify the requesting Provider and Enrollee of any decision to deny a service authorization request, either in whole or part, or to authorize a service in a limited manner, including type, level, amount, duration, or scope, that is less than requested. The notice of adverse benefit determination to the Provider need not be in writing; however, the Enrollee notice must be in writing. The notice to Enrollees shall include due process rights in accordance with 42 C.F.R. § 438.400 any time PIHP takes these actions.

2. In accordance with 42 C.F.R. § 438.404, the Notice of Adverse Benefit Determination must be in writing consistent with the requirements in 42 C.F.R. § 438.10 and explain the following:

   1. The adverse benefit determination PIHP has taken or intends to take.
   2. The reasons for the adverse benefit determination, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies or evidentiary standards used in setting coverage limits.
   3. The Enrollee's right to request an appeal of PIHP's adverse benefit determination, including information on exhausting PIHP's internal appeal and the right to request a State Fair Hearing..
   4. The procedures for requesting an appeal of the adverse benefit determination by PIHP.
   5. The circumstances under which expedited resolution is available and how to request it.
   6. The Enrollee's right to have benefits continue pending resolution of the appeal as set forth in 42 C.F.R. § 483.420, how to request that benefits be continued, and the circumstances under which Enrollee may be required to pay the costs of these services.

3. PIHP shall make the information and notices described in this Attachment M readily available orally and in writing in the Enrollee's primary language and in each prevalent non-English language in its service area. DMA shall ensure that its templates use easily understood language and format. PIHP shall ensure that written materials provided by DMA pursuant to this Attachment M are made available to Enrollees in alternative formats, and are presented in an appropriate manner that takes into consideration those with special needs.

4. PIHP shall inform all Enrollees and potential Enrollees that information is available in alternative formats and how to access those formats. PIHP shall make these services available free of charge.

5. For all Notices of Adverse Benefit Determination and Notices of Appeal Resolution, the date of mailing shall be the date specified on the Notice. PIHP shall establish and monitor internal mail cut-off times to ensure that all notices are mailed on the date they are dated.

F. **Timeframes for Notice of Adverse Benefit Determination:**

1. For adverse benefit determinations related to standard authorization requests and expedited authorization decisions, PIHP shall give written notice to the Enrollee or legally responsible person within the timeframes specified in 42 C.F.R. § 438.210(d).

2. PIHP shall give written notice to the Enrollee or legally responsible person at least ten (10) calendar days before the date of the adverse benefit determination, except in the following circumstances:

   a. The period of advance notice is shortened to five (5) business days if probable Enrollee fraud has been verified; and

   b. The notice may be given on the date of the adverse benefit determination for the following:

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

3. PIHP may give notice on the date of the adverse benefit determination when the adverse benefit determination is a denial of payment.

G. **Appeal Process**

1. PIHP shall define appeal as the request for review of an adverse benefit determination as defined by 42 CFR § 438.400. Pursuant to 42 CFR § 438.402(b), the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal.

2. The appeal must be filed within sixty (60) calendar days from the date on the adverse benefit determination notice.

3. The appeal may be filed either orally or in writing and, unless the Enrollee requested expedited resolution, the appeal must follow an oral filing with a written, signed appeal. PIHP shall:

a. Ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and confirm those inquiries in writing, unless the Enrollee requests expedited resolution;

b. Provide the Enrollee a reasonable opportunity to present evidence in person or in writing, present testimony, and make legal and factual arguments. PIHP shall inform the Enrollee of the limited time available to present the evidence;

c. Provide the Enrollee and his or her representative the Enrollee's case file, including medical records, other documents and records and any new or additional evidence considered, relied upon, or generated by PIHP in connection with the appeal of the adverse benefit determination. The information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal.

d. Consider the Enrollee, the Enrollee's representative, or estate representative of a deceased Enrollee as parties to the appeal;

e. Take into account all comments, documents, records and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

4. PIHP shall resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within thirty (30) calendar days from the day PIHP receives the appeal.

5. PIHP may extend the timeframe by up to fourteen (14) calendar days if:
   (i) The Enrollee requests the extension; or
   (ii) PIHP demonstrates (to the satisfaction of DMA, upon DMA's request) that there is need for additional information and how the delay is in the best interest of the Enrollee.

6. If PIHP extends the timeframes for a reason other than the request of the Enrollee, PIHP shall:
   i. Make reasonable effort to give the Enrollee prompt oral notice of the delay;
   ii. Within two (2) calendar days give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance, if he or she disagrees with the decision;
   iii. Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7. PIHP shall provide written notice of resolution in a format and language that at a minimum meets the standards described at 42 C.F.R. § 438.10. The written resolution notice must include:

a. The results and date of the appeal resolution;

b. For decisions not wholly in the Enrollee's favor:
   i. The right to request a State Fair Hearing;
   ii. How to request a State Fair Hearing;
   iii. The right to continue benefits pursuant to 42. C.F.R. § 438.420 pending a State Fair Hearing, if the appeal concerns the reduction, suspension or termination of currently authorized services.
   iv. How to request continuation of benefits; and
   v. If PIHP's adverse benefit determination is upheld in a State Fair Hearing, the Enrollee may be liable for the cost of any continued benefits.

8. PIHP shall continue the Enrollee's benefits pursuant to 42 CFR § 438.420 if all of the following criteria are met:

a. The Enrollee files the request for an appeal timely in accordance with 42 C.F.R. § 438.402 (c)(1)(ii) and (c)(2)(ii);

b. The appeal involves the termination, suspension or reduction of previously authorized services

c. The services were ordered by an authorized Provider;

d. The period covered by the original authorization has not yet expired; and

e. The Enrollee timely files for continuation of benefits. Timely files shall mean the Enrollee files for continuation of benefits on or before the later of the following:

   i. Within ten (10) calendar days of PIHP sending the adverse benefit determination; or
   ii. The intended effective date of PIHP's proposed adverse benefit determination

9. If, at the Enrollee's request, PIHP continues or reinstates the Enrollee's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs:

a. The Enrollee withdraws the appeal or request for State Fair Hearing; or

b. The Enrollee fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the PIHP sends the notice of an adverse resolution to the Enrollee's appeal under 438.408(d)(2); or

c. A State Fair Hearing office issues a hearing decision adverse to the Enrollee.

10. PIHP may recover the cost of the continuation of benefits furnished to the Enrollee while the appeal and State Fair Hearing was pending to the extent that the benefits were furnished solely because of the requirements of 42 C.F.R. § 438.420 if the final resolution of the appeal upholds PIHP's adverse benefit determination.

11. If PIHP or the State Fair Hearing Officer reverses an adverse benefit decision to deny, limit or delay services that were not furnished while the appeal was pending, PIHP shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date PIHP receives notice the adverse benefit determination was reversed.

12. If PIHP or the State Fair Hearing reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, PIHP or the State shall pay for those services, in accordance with State policy and regulations.

H. <u>Expedited Appeal Process:</u>

1. PIHP shall establish and implement an expedited review process for appeals for situations in which PIHP determines, based on a request from an Enrollee or from a Provider on behalf of an Enrollee, that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

2. PIHP is required to follow all standard appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

3. The Enrollee may file an expedited appeal either orally or in writing. No additional Enrollee follow-up is required.

4. PIHP shall inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

5. PIHP shall resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed three 72 hours after PIHP receives the appeal.

6. For any extension not requested by the Enrollee, PIHP shall give the member written notice of the reason for the delay.

7. In addition to written notice, PIHP shall also make reasonable efforts to provide oral notice.

8. PIHP shall ensure that punitive action is not taken against a Provider who either requests an expedited resolution or supports an Enrollee's appeal.

9. If PIHP denies a request for expedited resolution of an appeal, PIHP shall:

   a. Transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day PIHP received the appeal,

   b. Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.

I. <u>The State Fair Hearing:</u>

1. An Enrollee may request a State Fair Hearing (a) no later than one hundred twenty (120) calendar days from the date of PIHP's notice of resolution. and (b) only after receiving notice that PIHP is upholding the adverse benefit determination, unless PIHP fails to adhere to the notice and timing requirements in 42 CFR § 438.408 in which case the Enrollee shall be deemed to have exhausted PIHP's internal appeals process and may initiate a State Fair Hearing.

2. Pursuant to 42 CFR § 438.408(f)(3), the parties to the State Fair Hearing include PIHP as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

See the following page for Attachment N.

ATTACHMENT N

NETWORK PROVIDER ENROLLMENT AND RE-ENROLLMENT

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

A. TYPES OF PROVIDERS ENROLLED IN PIHP NETWORK

PIHP shall include the following types of Providers in its Provider Network:

1. **Agency-Based Providers:** An agency-based Provider is an entity organized as a corporation, limited liability company, partnership or other designation overseen by the NC Secretary of State, either for-profit or not-for-profit, engaged in the provision of Covered Services. Employees of the agency provide the services to the Enrollee, and agency management assures that the employees meet the qualifications to provide services and that all other requirements of the contract between PIHP and the agency-based Provider are met.

2. **Licensed Practitioners and Professional Practice Groups**: Licensed Practitioners in the areas of Psychiatry, Psychology, and Social Work are enrolled in PIHP Provider Network. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy. Practitioners may work for an Agency-based Provider (LP) or may directly contract with PIHP (LIP). Enrollees are offered a choice of LIPs or agency-based Providers when calling the Access line and requesting evaluation or outpatient treatment services.

3. **Hospitals and Psychiatric Residential Treatment Facilities:** Licensed in accordance with State law.

B. RE-ENROLLMENT OF PROVIDERS

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

1. Verification of information on the applicant, including;
2. Insurance requirements;
3. Current valid license to practice in each state where the Practitioner will treat Enrollees;
4. Valid DEA certificate; and/or CDS certificate;
5. Board certification if claimed by the applicant;
6. Malpractice claims since the previous credentialing event;
7. Practitioner attestation statement;
8. Re-query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners (for the specific discipline); and
9. Re-query for state sanctions and/or license limitations.

See the following page for Attachment O.

ATTACHMENT O

CREDENTIALING AND RE-CREDENTIALING

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

1. Applicants must have a valid North Carolina license issued by the North Carolina Division of Health Service Regulation (if applicable for type of Provider) before applying to the network. Licensed Practitioners shall meet State licensure requirements and hold a valid license from the State in which the individual is furnishing services to PIHP Enrollees.

2. Applicants must disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five (5) years. Applicants shall also disclose loss of license and criminal convictions and names of hospitals where applicant currently has admitting privileges.

3. Applicants must disclose any actions listed in # 2, which are pending.

4. Applicants must furnish PIHP a history of names if the entity has done business under other names or is using a "doing business as" (d/b/a) name.

5. Applicants must identify (by name, social security number, date of birth and address) all persons with an ownership or control interest of the entity as defined at 42 CFR § 455.101. A list of all owners of more than five percent (5%) interest and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company shall be provided.

6. Applicants must furnish PIHP a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at 42 CFR § 455.101, including but not limited to members of the applicant's Board of Directors.

7. Applicants must disclose if it is affiliated, by contract or otherwise, with any other Provider.

8. Applicants must furnish evidence of all insurance coverage required by Section 7.7-Credentialing.

9. Licensed Practitioner applicants must also provide the following information:

    i. History of loss of license and/or criminal convictions; actions by licensing board;

    ii. Names of hospitals at which the practitioner currently has admitting privileges (physicians only);

    iii. History of loss or limitation of privileges or disciplinary activity (physicians only);

    iv. Languages spoken proficiently

    v. Areas of specialized practices; and

    vi. Identification of an on-call designee, who shall be a member of the PIHP Closed Provider Network or approved by PIHP, and must have the same credentials or higher.

See the following page for Attachment P.

ATTACHMENT P

CAPITATION RATES AND RATE SETTING METHODOLOGY

Rate Setting Methodology — Use of Managed Care Data

DMA shall employ a rate-setting methodology that complies with the actuarial soundness requirements outlined in 42 CFR 438. To develop PMPM capitation rates on an actuarially-sound basis for PIHP using actual managed care data, the following general steps are performed:

1. Analyze, Adjust and Summarize the Managed Care Data;
2. Combine the Multiple Years of Managed Care Data together;
3. Project the Managed Care Base Data forward;
4. Include the Effect of Program/Policy Changes; and
5. Add an appropriate Administration Load.

Analyze, Adjust and Summarize the Managed Care Data — DMA shall collect multiple years of encounter and claims data from PIHP. PIHP shall be responsive to data requests from DMA for rate-setting, and PIHP shall certify the accuracy and completeness of the submitted data in accordance with 42 CFR 438.606. This data will be analyzed and reviewed along with the State's Medicaid eligibility data to identify the Enrollees and services covered by PIHP. This data shall be summarized and analyzed, and adjustments (positive and negative) are applied, as needed. These adjustments can account for items such as Enrollee liability, incurred but unpaid claims, duplicate claims, payments made outside the claims system and considerations for Alternative Payment Arrangements or In-Lieu of Services/Alternative Services. After adjusting PIHP's data for these and any other considerations as required by CMS, PIHP's claims costs shall be aggregated together to arrive at a set of base data for each rate cell. The historical data summaries shall be provided to PIHP by DMA or DMA's vendor in the form of a databook.

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

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

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

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

Separate rates are established for State Plan and 1915(b)(3) services consistent with requirements in the 1915(b) waiver with CMS.

See the following page for Attachment Q.

ATTACHMENT Q

BUSINESS TRANSACTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A Provider must submit, within thirty-five (35) calendar days of the date on a request by the Department or Secretary of the Department of Health and Human Services, full and complete information about:

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

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

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

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

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

In accordance with 42 C.F.R. § 438.602(i), no claims paid by PIHP to a network Provider, out-of-network Provider, subcontractor, or financial institution located outside of the U.S. shall be considered in the development of actuarially sound capitation rates.

See the following page for Attachment R.

ATTACHMENT R

CLINICAL COVERAGE POLICIES, BULLETINS and MANUALS

PIHP shall comply with the requirements of NC DMA Clinical Coverage Policies promulgated in accordance with N.C.G.S. § 108A-54.2 and available at http://dma.ncdhhs.gov/providers/clinical-coverage-policies, including but not limited to the following, as applicable to Covered Services under this Contract:

Facility Services
- 2A-1 Acute Inpatient Hospital Services

Community Based Services
- 3A, Home Health Services
- 3B, PACE (Program of All-Inclusive Care for the Elderly)
- 3D, Hospice Services
- 3G, Private Duty Nursing
- 3H-1, Home Infusion Therapy
- 3K-1, Community Alternatives Program for Children (CAP/C)
- 3K-2, Community Alternatives Program for Disabled Adults and Choice Option (CAP/DA-Choice)
- 3L, State Plan Personal Care Services (PCS)

Medical Equipment
- 5A, Durable Medical Equipment
- 5B, Orthotics & Prosthetics

Behavioral Health
- 8A, Enhanced Mental Health and Substance Abuse Services
- 8A-1, Assertive Community Treatment (ACT) Program
- 8A-2, Facility-Based Crisis Service for Children and Adolescents
- 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
- 8E, Intermediate Care Facilities for Individuals with Intellectual Disabilities
- 8I, Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population
- 8J, Children's Developmental Service Agencies (CDSAs)
- 8L, Mental Health/Substance Abuse Targeted Case Management
- 8N, NC Health Choice – Intellectual and Developmental Disabilities Targeted Case Management
- 8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders
- 8-P, North Carolina Innovations

For clarification of Covered Services, PIHP shall refer to the following Bulletins and Manuals. Such Bulletins and Manuals are listed for reference purposes only and shall not be deemed to be incorporated into, or amend, this Contract by such reference.

- NCMMIS Provider Claims and Billing Assistance Guide available at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
- Medicaid Bulletins:General and specific available at https://dma.ncdhhs.gov/document/2016-medicaid-bulletins-and-index
- Joint DMA-DMH Communication Bulletins available at http://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins
- Transportation Policy available at https://www2.ncdhhs.gov/DMA/services/transportation.htm
- Medicaid Manual available at http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/

- Administrative Procedures Services Manual 30-1 available at https://www.ncdhhs.gov/divisions/mhddsas/reports/records-management-and-documentation-manual-rmdm

- Administrative Procedures Services Manual 45-2 available at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/rm%26dm-manual8-1-14.pdf

- Administrative Procedures Services Manual 95-1 available at https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/apsm_95-1total2004.pdf

Clinical Coverage Policy #3 – Community Based Services: Private Duty Nursing; CAP/C; CAP/DA; Prior Approval for MPW Recipients; Home Health; Personal Care Services; Personal Care Services-Plus; Hospice; Home Infusion Therapy (Available on DMA web site at: www2.ncdhhs.gov/dma/mp/index.htm)

Clinical Coverage Policy #5 – Medical Equipment: Durable Medical Equipment; Orthotics and Prosthetics Available on DMA web site at: www2.ncdhhs.gov/dma/mp/index.htm

Clinical Coverage Policies #8 – Behavioral Health: Enhanced Mental Health and Substance Abuse Services; Inpatient Behavioral Health Services; Outpatient Behavioral Health Services; Psychiatric Residential Treatment Facilities; Residential Treatment Services; Intermediate Care Facilities for Individuals with Mental Retardation; Psychological Services in Health Departments and School Based Health Centers; Children's Developmental Service Agencies. Available on DMA web site at: www2.ncdhhs.gov/dma/mp/index.htm

NCMMIS Provider Claims and Billing Assistance Guide
Available at: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

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

https://dma.ncdhhs.gov/document/2016-medicaid-bulletins-and-index

Transportation Policy
Available on DMA web site at:

https://www2.ncdhhs.gov/DMA/services/transportation.htm

Medicaid Manual:http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/

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

https://www.ncdhhs.gov/divisions/mhddsas

See the following page for Attachment S.

ATTACHMENT S
ACCESS AND AVAILABILITY STANDARDS

ACCESSIBILITY

A. Geographic Location: Network Providers for all Covered Services must be as geographically accessible to Medicaid Enrollees as to non-Medicaid Enrollees.

B. Distance/Travel Time: Medicaid Enrollees should have access to Network Providers within thirty (30) miles distance or thirty minutes' drive time, 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility based or specialty Providers.

C. Facility Accessibility: Contracted Network Provider facilities must be accommodating for persons with physical or mental disabilities. PIHP shall require reasonable accommodations, in accordance with 42 CFR § 438.206 contained in 42 CFR Parts 430 through 481, edition revised as of October 1, 2015, and consider the ability of Network Providers to communicated with limited English proficient Enrollees in their preferred language and the ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Enrollees with physical or mental disabilities.

D. New Enrollee Orientation: Enrollee materials and information shall be sent to each new Enrollee by PIHP within fourteen (14) calendar days of effective date of enrollment.

E. Enrollee Services: Medicaid Enrollees must have toll-free telephone access to a Customer Services department to provide assistance, information, and education to members.

F. Support Services:

Transportation: Assistance with arrangement for transportation to Medically Necessary Treatment services through public and private means must be made available and communicated to Medicaid Enrollees.

Interpreters: Language interpretation services must be made available by telephone and/or in person; enabling Medicaid Enrollees to effectively communicate with PIHP and Providers. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

AVAILABILITY

A. PIHP shall ensure that Network Providers meet the following Access Standards related to Appointment Availability:

1. Emergency Services – Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by Provider staff from the PIHP or directly from an Enrollee; the Provider must provide face-to-face emergency care immediately for life threatening emergencies;

2. Urgent Need Services -- Providers must provide initial face-to-face assessments and/or treatment within forty-eight hours after the date and time a request for urgent care is received by Provider staff from the PIHP or directly from an Enrollee;

3. Routine Need Services -- Providers must provide initial face-to-face assessments and/or treatment within fourteen (14) calendar days of the date a request for routine care is received by Provider staff from the PIHP or directly from an Enrollee;

B. PIHP shall ensure that Network Providers meet the following Access Standards related to Office Wait Time:

1. Scheduled Appointments – Sixty minutes after the appointed meeting time;

2. Walk-Ins – within two hours after the Enrollee's arrival. If that is not possible, staff must schedule an appointment for the next available day;

3. Emergencies - PIHP staff shall ensure that Enrollees are provided face-to-face emergency care within two hours after the request for care is initiated by PIHP or directly by the Enrollee; life threatening emergencies shall be managed immediately.

C. After Hours Emergency and Referral

1. PIHP will provide toll-free telephone emergency and referral line twenty-four (24) hours per day.

2. PIHP Return Calls to Enrollees: Telephone inquiries made by Enrollees after hours for access/information must be responded to within one (1) hour of receiving the call.

D. The Enrollee has a right to a second opinion from a qualified health care professional within or outside the network, at no cost to the Enrollee. Upon request, PIHP shall provide an Enrollee with one second opinion from a qualified health care professional selected by the PIHP, at no cost to the Enrollee. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. PIHP shall not be required to provide an Enrollee with a third or fourth opinion.

See the following page for Attachment T.

ATTACHMENT T

Mixed Services Payment Protocol

Services	Claim Processing and/or Financial Liability
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	PIHP in acute hospital or psychiatric unit of a hospital when DRG is psychiatric
Outpatient X-ray and Lab Work	DMA fee-for-service Medicaid, except when provided during emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary ICD-10 diagnosis code is one contained in Attachment CC
Prescribed by a PIHP Network Provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.	DMA fee-for-service Medicaid, except when provided during emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary diagnosis code is one contained in Attachment CC
Prescribed by PIHP Network Provider on an outpatient basis such as therapeutic drug levels.	DMA fee-for-service Medicaid except when provided during emergency room visits where the Revenue Code is one of the following (450-459, 900-919), and the primary diagnosis code is one contained in Attachment CC
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.	DMA fee-for-service Medicaid, except for emergency room visits where the primary ICD-10 diagnosis code is one specified in Attachment CC
Other tests ordered by non- PIHP physician	DMA fee-for-service Medicaid, except for emergency room visits where the primary ICD-10 diagnosis code is one specified in Attachment CC
Drugs	
Outpatient prescription drugs and take home drugs.	DMA fee-for-service Medicaid
Ambulance	
Transport to the hospital when the primary diagnosis is behavioral care	DMA fee-for-service Medicaid
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	DMA fee-for-service Medicaid
Transfers authorized by PIHP from non-network facility to a network facility	PIHP
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	PIHP
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	PIHP
Medical/Surgical on Mental Health/Substance Abuse Unit	DMA fee-for-service Medicaid
Emergency Room Charges – Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	PIHP

Services	Claim Processing and/or Financial Liability
Emergency room services where the primary diagnosis on the claim is in the following range: Revenue Codes 450-459, 900-919 and the ICD-10 codes contained in Attachment CC	PIHP
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DMA fee-for-service Medicaid
Emergency Room Facility Charge.	
Emergency room services where the primary diagnosis on the claim is in the following range: Revenue Codes 450-459, 900-919 and the ICD-10 codes contained in Attachment CC	PIHP
Emergency room services where the primary diagnosis on the claim is NOT in the following range: 290-319	DMA fee-for-service Medicaid
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning.	DMA fee-for-service Medicaid, except for emergency room visits where the primary ICD-10 diagnosis code is one specified in Attachment CC
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders.	DMA fee-for-service Medicaid, except for emergency room visits where the primary ICD-10 diagnosis code is one specified in Attachment CC
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	PIHP
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or PIHP authorized physician	PIHP
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by Elevated vital signs, agitation, perspiration, Anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by PIHP. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis is in the range specified in Attachment CC.	PIHP

See the following page for Attachment U.

ATTACHMENT U

Financial Reporting Requirements

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

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

If a due date falls on a weekend or State recognized holiday, reports will be due the next business day. Required statements shall include reports specific to the Medicaid contract.

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

Schedule	Report name	Frequency	Due date[1]	Format
M	Alternative Payment Arrangements	Monthly	20 days after end of month	Predetermined
N	Fund Balance	Monthly	20 days after end of month	Predetermined
O	Medical Loss Ratio	Monthly	20 days after end of month	Predetermined
P	Reinvestment	Monthly	20 days after end of month	Predetermined
AA	Cost allocation plan	Annually	60 days prior to start of fiscal year	Narrative
BB	Audited financial statements	Annually	30 days after certification	Narrative
CC	OMB circular A-133 audit	Annually	30 days after certification	Narrative
DD	Related party transactions and obligations	Annually	60 days after year end	Narrative
EE	Physician incentive arrangements	Annually	60 days after year end	Narrative

See the following page for Attachment V.

ATTACHMENT V
(RESERVED)

See the following page for Attachment W.

ATTACHMENT W
Contract Compliance

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

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

Compliance Issue	Resolution/Action
	PIHP's monthly capitation payment due shall be subject to financial sanctions. (Refundable upon receipt).
Failure to authorize Medically Necessary Treatment services; inappropriate charges to Enrollees; Physician Incentive Plan non-compliance; falsifying information to Enrollees, DMA or the Department discrimination due to health status/service needs of Enrollees.	Beginning after this Contract has been in effect for ninety (90) calendar days, financial sanctions may be imposed by reducing the monthly premium payment(s) by up to five percent (5%) of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of PIHP's monthly capitation payment due shall be subject to financial sanctions.

See the following page for Attachment X.

ATTACHMENT X
Criminal Convictions Disclosures

The Attachment X-Criminal Convictions Report is a running record of all cases from the beginning to end of this Contract. The preferred method is to have the current month at the top and the previous months thereafter. Each bulleted instruction corresponds with each field on the identified spreadsheet or report. Failure by PIHP to submit to DMA Program Integrity the Attachment X-Criminal Convictions Report by the tenth (10th) day of the month may result in a penalty of One Hundred Dollars ($100) per calendar day until submission.

- Designate the LME-MCO submitting the report
- Identify the unit that is completing the report
- Insert date the report is submitted to the State
- Insert person name that is submitting the report
- Insert the Provider name (organization)
- Insert the MCO case number
- Insert the NPI(s) of the Provider.
- Insert the involved parties full name and NPI, if applicable
- Insert the type of criminal conviction associated with Health Care Fraud, Wire Fraud, Conspiracy, etc.
- Insert the date of the criminal conviction
- Insert what health care program associated with the criminal conviction
- Indicate if there are sentencing conditions and/or a corporate agreement
- Insert the date referred to the State
- In the comments section, include in additional information about the person, convictions, or organizations.

The preferred format for the Attachment X-Criminal Convictions Report follows on the next page:

PROGRAM INTEGRITY ACTIVITIES: Criminal Convictions Disclosures (Attachment X)
LME-MCO:
Unit:
Date Report Submitted:
Submitted by:

Provider Name	MCO Case #	NPI #	Involved parties/staff	Type of criminal conviction (e.g. Healthcare Fraud, Wire Fraud, Conspiracy, etc.)	Date of Criminal Conviction	Federal Health Care Program (e.g. Health Choice, Medicaid, Medicare, Tricare, etc.)	Sentence Conditions/Corporate Agreement	Date referred	Comments

See the following page for Attachment Y.

ATTACHMENT Y
Audits/Self-Audits/Investigations

The Attachment Y Report is a running record of all cases from the beginning to end of this Contract. The preferred method is to have the current month in **bold**, at the top and the previous months thereafter. Updates for previous months shall be highlighted. Each bulleted instruction corresponds with each field on the identified spreadsheet or report. Failure by PIHP to submit to DMA Program Integrity the Attachment Y Report by the tenth (10th) day of the month may result in a penalty against PIHP of One Hundred Dollars ($100) per calendar day until submission.

- Designate the LME-MCO submitting the report
- Identify the unit that is completing the report
- Insert date that is submitted to the State
- Insert person name that is submitting the report
- Insert the Provider name (organization)
- Insert the MCO case number
- Insert the NPI(s) of the Provider.
- Insert the date of when the desk audit and/or onsite started
- Insert the audit type to identify Audit, Self-Audit, Investigation. Audit is defined as Provider monitoring (PPR) or audit of a group of Providers (example: PRTF Providers, Residential Providers, etc.). Self-Audit is defined as a Provider conducting its own QA and identifying/self-disclosing billing anomalies, discrepancies, or overpayments. Investigations is defined as a case initiated by a lead, referral, complaint and/or FAMS data analytics reports. Remember to identify those cases that originate by a FAMS data analytics report
- Insert a brief statement about the allegation or complaint
- Describe self-audit issues or concerns, or audit and Investigation findings associated with the allegation or complaint. Please reframe from using 'substantiated' or 'unsubstantiated' as you only finding statement.
- Identify the payback amount/overpayment amount (example: amount identified in the TNO)
- Identify the overpayment amount after appeal (Local or OAH).
- Identify the amount recouped by the MCO
- Identify the remaining amount owed to MCO
- Insert the date received the allegation or complaint as the Open date
- Insert the date the all action on the case has been exhausted and or final determinations has been rendered with the exception of PI Referrals sent to DMA PI for the closed date
- Check the box if referred to DMA for potential fraud.
- Insert the date the Provider was referred to DMA Program Integrity
- Use the comments/ Review Updates for any additional information related to the case, Provider, or additional administrative actions taken. Also, include if the Audit or investigation was completed outside the SIU/PIU.

The preferred format for the Attachment Y Report follows on the next page:

PROGRAM INTEGRITY ACTIVITIES: Audits/Self-Audits/Investigations (Attachment Y)
LME-MCO:
Unit:
Date Report Submitted:
Submitted by:

Provider Name	MCO Case #	NPI #	Date of Audit	Audit Type	Allegation/ Complaint	Audit Issues/ Concerns/ Findings	Identified payback request (TNO amount requested)	Amount after Appeal	Amount Recouped	Outstanding Amount	Date Case Opened	Date Case Closed	Referred to DMA for Potential Fraud √	Date referred	Comments/ Review Updates

See the following page for Attachment Z.

ATTACHMENT Z
Terminations, Provider Enrollment Denials, Non-renewals, Other Actions

The Attachment Z Report is a running record of all cases from the beginning to end of this Contract. The preferred method is to have the current month at the top and the previous months thereafter. Each bulleted instruction corresponds with each field on the identified spreadsheet or report. Failure by PIHP to submit to DMA Program Integrity the Attachment Z Report by the tenth (10th) day of the following month may result in a penalty against PIHP of One Hundred Dollars ($100) per calendar day until submission.

- Designate the LME-MCO submitting the report
- Identify the unit that is completing the report
- Insert date that is submitted to the State
- Insert person name that is submitting the report
- Insert the Provider name (organization)
- Insert the MCO case number
- Insert the NPI(s) of the Provider.
- Insert the date of termination (involuntary), denial of enrollment, non-renewal or other actions
- Briefly describe the reason for termination
- Insert the date the Provider is eligible to reapply
- Insert date the Provider requested an appeal and the level of appeal (Local reconsideration or Office of Administrative Hearing)
- Insert date of the appeal decision and the level of appeal (Local reconsideration or OAH)
- Briefly describe the appeal decision and the level of appeal (Local reconsideration or OAH)
- Use the comments section to identify or briefly describe any other pertinent information related to the termination, denial of enrollment, non-renewal or other action.

The preferred format for the Attachment Z Report follows on the next page:

PROGRAM INTEGRITY ACTIVITIES: Terminations, Provider Enrollment Denials, Non-renewals or other Actions (Attachment Z)
LME-MCO:
Unit:
Date Report Submitted:
Submitted by:

Provider Name	MCO Case #	NPI #	Date of Termination (Involuntary), Denial of Enrollment, Non-renewal or Other Action	Reason (s)	Date eligible to reapply	Provider Appeal: Date Requested	Provider Appeal: Decision Date	Provider Appeal: Status/Decision	Comments

See the following page for Attachment AA.

ATTACHMENT AA
(RESERVED)

See the following page for Attachment BB.

Attachment BB
In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the State Plan or otherwise covered by this Contract but are more medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.
PIHP may cover for Enrollees, services or settings that are in lieu of services or settings covered under the State Plan as follows:

1. DMA determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to DMA by PIHP demonstrating such cost effectiveness and clinical effectiveness;
2. Enrollee shall not be required by PIHP to use the alternative service or setting;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Enrollees at the option of PIHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a Federal or State statute or regulation explicitly requires otherwise. In the event services do not meet cost neutrality, excess expenses will be excluded from the rate development process.

IMD Alternative Service Definition:
PIHP shall be eligible for a monthly capitation payment on behalf of an Enrollee aged twenty-one (21) to sixty-four (64) who is a patient in an IMD for part of that month in cases in which:

1. The Enrollee elects such services in an IMD as an alternative to otherwise covered settings for such services;
2. The IMD is a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services; and
3. The stay in the IMD is for no more than fifteen (15) calendar days in that month.

If a facility that would be considered an IMD under the statue is providing psychiatric or substance abuse care to an adult ages 21 to 64 for a Medicaid-covered individual in a managed care plan, the facility can treat that patient for fifteen (15) calendar days per month.

The following summaries briefly describe the In Lieu of Services that PIHP shall provide under this Contract. PIHP shall comply with and implement all of the terms and conditions of each of the full In Lieu of Service Definitions that were approved by DMA on the dates shown in the below summaries and that are on file with DMA and PIHP.

Service Name: Assertive Community Treatment Step-Down (ACT-SD)
Procedure Code: H0040-TS; H0040-22
Approved: 8/5/16
In lieu of: ACT
Description: ACT Step-Down (ACT-SD) will be the next lower level of care under ACT. The service will be provided by organizations that meet all of the provider requirements for Assertive Community Treatment (ACT) Team in DMA Clinical Policy 8A-1; ACT-SD will be provided by identified ACT team members within the provider organization. Only ACT Teams who have achieved full certification status, as measured by a rating of at least 3.7 on the Tool for Measurement of ACT (TMACT), will be permitted to offer ACT-SD services. An ACT Team is permitted to serve up to 20 individuals through their ACT-SD program.

ACT-SD is an intensive clinical case management model with a foundation in wellness management and recovery practices. Unlike ACT, where multiple services are bundled together in a single program thereby requiring a multidisciplinary team, ACT-SD staff will be limited to psychiatry, nursing, clinical case management, and peer supports. However, if an immediate need arises the specialists on the primary ACT team would be utilized as a first responder to help assess and stabilize. It would then be determined whether the consumer needs transition back to the full ACT service.

Service Name: Behavioral Health Urgent Care (BHUC)
Procedure Code: T2016 U5
Approved: 2/20/17
In lieu of: Community Hospital Emergency Department
Description: A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral. The behavioral health urgent care location must include the ability to initiate the Involuntary Commitment petition via first-level evaluations (Clinician Petition), medical screening, case management, and referrals.

Service Name and Description:
Service Name: Family Centered Treatment®
Procedure Code: H2022-22-ZI; H2022-U3-HE; H2022-22-Z2
Definitions:

□ **Therapist:** Associate or licensed therapist responsible for providing treatment to the child and family

□ **Team:** Multi-disciplinary team of therapists charged with guiding treatment and fidelity to the FCT model

□ **FCT Certification:** All FCT Clinicians undertake and successfully complete a competency-based, standardized training/certification process. Certification given by FCT Foundation and renewed every two years.

Approved: 5/29/15
In lieu of: Intensive In-Home
Description: Family Centered Treatment® (FCT©) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions. Children and adolescents eligible for FCT may be facing involvement in the juvenile justice system, out-of-home placements, and/or reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse), and/or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of recidivism. FCT is delivered by an assigned therapist with a caseload of 4-6 individuals/families. FCT is supervised by a trained FCT supervisor.

Service Name: Outpatient Plus (OPT Plus)
Procedure Code: 90837-22-PL; 90834-22-PL; H0036-22
Approved: 6/27/16
In lieu of: Outpatient Therapy and Intensive In-Home and Community Support Team
Description: Outpatient Plus (OPT Plus) is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals with complex clinical needs that traditional outpatient cannot adequately address. OPT Plus is a level of care between OPT and IIH/CST.
OPT Plus is a home and community-based treatment service focused on decreasing psychiatric and behavioral symptoms in order to reduce the need for higher levels of care or increase the likelihood of a successful transition to Outpatient Therapy from higher levels of care. OPT Plus will improve the beneficiary's ability to navigate systems and improve functioning in familial, social, educational, or occupational life domains. OPT Plus services often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Service Name: Rapid Response Crisis Services for Children and Youth
Procedure Code: S5145-22-Z3
License: 131D Licensed Therapeutic Foster Homes
Approved: 7/12/16
In lieu of: Therapeutic Foster Care Homes
Description: Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment and prevent or minimize the need for out-of-home placements.

See the following page for Attachment CC.

ATTACHMENT CC

ICD-10 CODES

Please see the Table beginning on the following page for the ICD-10 Codes which shall apply to this Contract. Codes with an Effective Date of 10/1/2015 are current as of 5/18/2017, and the updated codes that CMS communicated in 2016 are highlighted:

ICD-10 Codes			
Effective date	End date in NCTracks	2016 ICD-10 code	Description
10/1/2015	12/31/9999	F04	Amnestic disorder due to known physiological condition
10/1/2015	12/31/9999	F05	Delirium due to known physiological condition
10/1/2015	12/31/9999	F060	Psychotic disorder with hallucinations due to known physiological condition
10/1/2015	12/31/9999	F061	Catatonic disorder due to known physiological condition
10/1/2015	12/31/9999	F062	Psychotic disorder with delusions due to known physiological condition
10/1/2015	12/31/9999	F0630	Mood disorder due to known physiological condition, unspecified
10/1/2015	12/31/9999	F0631	Mood disorder due to known physiological condition with depressive features
10/1/2015	12/31/9999	F0632	Mood disorder due to known physiological condition with major depressive-like episode
10/1/2015	12/31/9999	F0633	Mood disorder due to known physiological condition with manic features
10/1/2015	12/31/9999	F0634	Mood disorder due to known physiological condition with mixed features
10/1/2015	12/31/9999	F064	Anxiety disorder due to known physiological condition
10/1/2015	12/31/9999	F068	Other specified mental disorders due to known physiological condition
10/1/2015	12/31/9999	F070	Personality change due to known physiological condition
10/1/2015	12/31/9999	F0781	Postconcussional syndrome
10/1/2015	12/31/9999	F0789	Other personality and behavioral disorders due to known physiological condition
10/1/2015	12/31/9999	F079	Unspecified personality and behavioral disorder due to known physiological condition
10/1/2015	12/31/9999	F09	Unspecified mental disorder due to known physiological condition
10/1/2015	12/31/9999	F1010	Alcohol abuse, uncomplicated
10/1/2015	12/31/9999	F10120	Alcohol abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F10121	Alcohol abuse with intoxication delirium
10/1/2015	12/31/9999	F10129	Alcohol abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1014	Alcohol abuse with alcohol-induced mood disorder
10/1/2015	12/31/9999	F10150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F10151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F10159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F10180	Alcohol abuse with alcohol-induced anxiety disorder
10/1/2015	12/31/9999	F10181	Alcohol abuse with alcohol-induced sexual dysfunction
10/1/2015	12/31/9999	F10182	Alcohol abuse with alcohol-induced sleep disorder
10/1/2015	12/31/9999	F10188	Alcohol abuse with other alcohol-induced disorder

10/1/2015	12/31/9999	F1019	Alcohol abuse with unspecified alcohol-induced disorder
10/1/2015	12/31/9999	F1020	Alcohol dependence, uncomplicated
10/1/2015	12/31/9999	F1021	Alcohol dependence, in remission
10/1/2015	12/31/9999	F10220	Alcohol dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F10221	Alcohol dependence with intoxication delirium
10/1/2015	12/31/9999	F10229	Alcohol dependence with intoxication, unspecified
10/1/2015	12/31/9999	F10230	Alcohol dependence with withdrawal, uncomplicated
10/1/2015	12/31/9999	F10231	Alcohol dependence with withdrawal delirium
10/1/2015	12/31/9999	F10232	Alcohol dependence with withdrawal with perceptual disturbance
10/1/2015	12/31/9999	F10239	Alcohol dependence with withdrawal, unspecified
10/1/2015	12/31/9999	F1024	Alcohol dependence with alcohol-induced mood disorder
10/1/2015	12/31/9999	F10250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F10251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F10259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1026	Alcohol dependence with alcohol-induced persisting amnestic disorder
10/1/2015	12/31/9999	F1027	Alcohol dependence with alcohol-induced persisting dementia
10/1/2015	12/31/9999	F10280	Alcohol dependence with alcohol-induced anxiety disorder
10/1/2015	12/31/9999	F10281	Alcohol dependence with alcohol-induced sexual dysfunction
10/1/2015	12/31/9999	F10282	Alcohol dependence with alcohol-induced sleep disorder
10/1/2015	12/31/9999	F10288	Alcohol dependence with other alcohol-induced disorder
10/1/2015	12/31/9999	F1029	Alcohol dependence with unspecified alcohol-induced disorder
10/1/2015	12/31/9999	F10920	Alcohol use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F10921	Alcohol use, unspecified with intoxication delirium
10/1/2015	12/31/9999	F10929	Alcohol use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F1094	Alcohol use, unspecified with alcohol-induced mood disorder
10/1/2015	12/31/9999	F10950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F10951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F10959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1096	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
10/1/2015	12/31/9999	F1097	Alcohol use, unspecified with alcohol-induced persisting dementia
10/1/2015	12/31/9999	F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder
10/1/2015	12/31/9999	F10981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
10/1/2015	12/31/9999	F10982	Alcohol use, unspecified with alcohol-induced sleep disorder

10/1/2015	12/31/9999	F10988	Alcohol use, unspecified with other alcohol-induced disorder
10/1/2015	12/31/9999	F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder
10/1/2015	12/31/9999	F1110	Opioid abuse, uncomplicated
10/1/2015	12/31/9999	F11120	Opioid abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F11121	Opioid abuse with intoxication delirium
10/1/2015	12/31/9999	F11122	Opioid abuse with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F11129	Opioid abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1114	Opioid abuse with opioid-induced mood disorder
10/1/2015	12/31/9999	F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F11181	Opioid abuse with opioid-induced sexual dysfunction
10/1/2015	12/31/9999	F11182	Opioid abuse with opioid-induced sleep disorder
10/1/2015	12/31/9999	F11188	Opioid abuse with other opioid-induced disorder
10/1/2015	12/31/9999	F1119	Opioid abuse with unspecified opioid-induced disorder
10/1/2015	12/31/9999	F1120	Opioid dependence, uncomplicated
10/1/2015	12/31/9999	F1121	Opioid dependence, in remission
10/1/2015	12/31/9999	F11220	Opioid dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F11221	Opioid dependence with intoxication delirium
10/1/2015	12/31/9999	F11222	Opioid dependence with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F11229	Opioid dependence with intoxication, unspecified
10/1/2015	12/31/9999	F1123	Opioid dependence with withdrawal
10/1/2015	12/31/9999	F1124	Opioid dependence with opioid-induced mood disorder
10/1/2015	12/31/9999	F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F11281	Opioid dependence with opioid-induced sexual dysfunction
10/1/2015	12/31/9999	F11282	Opioid dependence with opioid-induced sleep disorder
10/1/2015	12/31/9999	F11288	Opioid dependence with other opioid-induced disorder
10/1/2015	12/31/9999	F1129	Opioid dependence with unspecified opioid-induced disorder
10/1/2015	12/31/9999	F1190	Opioid use, unspecified, uncomplicated
10/1/2015	12/31/9999	F11920	Opioid use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F11921	Opioid use, unspecified with intoxication delirium

10/1/2015	12/31/9999	F11922	Opioid use, unspecified with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F11929	Opioid use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F1193	Opioid use, unspecified with withdrawal
10/1/2015	12/31/9999	F1194	Opioid use, unspecified with opioid-induced mood disorder
10/1/2015	12/31/9999	F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
10/1/2015	12/31/9999	F11982	Opioid use, unspecified with opioid-induced sleep disorder
10/1/2015	12/31/9999	F11988	Opioid use, unspecified with other opioid-induced disorder
10/1/2015	12/31/9999	F1199	Opioid use, unspecified with unspecified opioid-induced disorder
10/1/2015	12/31/9999	F1210	Cannabis abuse, uncomplicated
10/1/2015	12/31/9999	F12120	Cannabis abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F12121	Cannabis abuse with intoxication delirium
10/1/2015	12/31/9999	F12122	Cannabis abuse with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F12129	Cannabis abuse with intoxication, unspecified
10/1/2015	12/31/9999	F12150	Cannabis abuse with psychotic disorder with delusions
10/1/2015	12/31/9999	F12151	Cannabis abuse with psychotic disorder with hallucinations
10/1/2015	12/31/9999	F12159	Cannabis abuse with psychotic disorder, unspecified
10/1/2015	12/31/9999	F12180	Cannabis abuse with cannabis-induced anxiety disorder
10/1/2015	12/31/9999	F12188	Cannabis abuse with other cannabis-induced disorder
10/1/2015	12/31/9999	F1219	Cannabis abuse with unspecified cannabis-induced disorder
10/1/2015	12/31/9999	F1220	Cannabis dependence, uncomplicated
10/1/2015	12/31/9999	F1221	Cannabis dependence, in remission
10/1/2015	12/31/9999	F12220	Cannabis dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F12221	Cannabis dependence with intoxication delirium
10/1/2015	12/31/9999	F12222	Cannabis dependence with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F12229	Cannabis dependence with intoxication, unspecified
10/1/2015	12/31/9999	F12250	Cannabis dependence with psychotic disorder with delusions
10/1/2015	12/31/9999	F12251	Cannabis dependence with psychotic disorder with hallucinations
10/1/2015	12/31/9999	F12259	Cannabis dependence with psychotic disorder, unspecified
10/1/2015	12/31/9999	F12280	Cannabis dependence with cannabis-induced anxiety disorder
10/1/2015	12/31/9999	F12288	Cannabis dependence with other cannabis-induced disorder

10/1/2015	12/31/9999	F1229	Cannabis dependence with unspecified cannabis-induced disorder
10/1/2015	12/31/9999	F1290	Cannabis use, unspecified, uncomplicated
10/1/2015	12/31/9999	F12920	Cannabis use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F12921	Cannabis use, unspecified with intoxication delirium
10/1/2015	12/31/9999	F12922	Cannabis use, unspecified with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F12929	Cannabis use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F12950	Cannabis use, unspecified with psychotic disorder with delusions
10/1/2015	12/31/9999	F12951	Cannabis use, unspecified with psychotic disorder with hallucinations
10/1/2015	12/31/9999	F12959	Cannabis use, unspecified with psychotic disorder, unspecified
10/1/2015	12/31/9999	F12980	Cannabis use, unspecified with anxiety disorder
10/1/2015	12/31/9999	F12988	Cannabis use, unspecified with other cannabis-induced disorder
10/1/2015	12/31/9999	F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder
10/1/2015	12/31/9999	F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
10/1/2015	12/31/9999	F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F13121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
10/1/2015	12/31/9999	F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1314	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
10/1/2015	12/31/9999	F13150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F13151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F13159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F13180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
10/1/2015	12/31/9999	F13181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
10/1/2015	12/31/9999	F13182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
10/1/2015	12/31/9999	F13188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1319	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
10/1/2015	12/31/9999	F1321	Sedative, hypnotic or anxiolytic dependence, in remission
10/1/2015	12/31/9999	F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
10/1/2015	12/31/9999	F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
10/1/2015	12/31/9999	F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
10/1/2015	12/31/9999	F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
10/1/2015	12/31/9999	F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance

10/1/2015	12/31/9999	F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
10/1/2015	12/31/9999	F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
10/1/2015	12/31/9999	F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucination:
10/1/2015	12/31/9999	F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1326	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
10/1/2015	12/31/9999	F1327	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
10/1/2015	12/31/9999	F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
10/1/2015	12/31/9999	F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
10/1/2015	12/31/9999	F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
10/1/2015	12/31/9999	F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
10/1/2015	12/31/9999	F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
10/1/2015	12/31/9999	F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
10/1/2015	12/31/9999	F13931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
10/1/2015	12/31/9999	F13932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
10/1/2015	12/31/9999	F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
10/1/2015	12/31/9999	F1394	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
10/1/2015	12/31/9999	F13950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F13951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinat
10/1/2015	12/31/9999	F13959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1396	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amenstic disorder
10/1/2015	12/31/9999	F1397	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
10/1/2015	12/31/9999	F13980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
10/1/2015	12/31/9999	F13981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
10/1/2015	12/31/9999	F13982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
10/1/2015	12/31/9999	F13988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1399	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
10/1/2015	12/31/9999	F1410	Cocaine abuse, uncomplicated
10/1/2015	12/31/9999	F14120	Cocaine abuse with intoxication, uncomplicated

10/1/2015	12/31/9999	F14121	Cocaine abuse with intoxication with delirium
10/1/2015	12/31/9999	F14122	Cocaine abuse with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F14129	Cocaine abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1414	Cocaine abuse with cocaine-induced mood disorder
10/1/2015	12/31/9999	F14150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F14151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F14159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F14180	Cocaine abuse with cocaine-induced anxiety disorder
10/1/2015	12/31/9999	F14181	Cocaine abuse with cocaine-induced sexual dysfunction
10/1/2015	12/31/9999	F14182	Cocaine abuse with cocaine-induced sleep disorder
10/1/2015	12/31/9999	F14188	Cocaine abuse with other cocaine-induced disorder
10/1/2015	12/31/9999	F1419	Cocaine abuse with unspecified cocaine-induced disorder
10/1/2015	12/31/9999	F1420	Cocaine dependence, uncomplicated
10/1/2015	12/31/9999	F1421	Cocaine dependence, in remission
10/1/2015	12/31/9999	F14220	Cocaine dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F14221	Cocaine dependence with intoxication delirium
10/1/2015	12/31/9999	F14222	Cocaine dependence with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F14229	Cocaine dependence with intoxication, unspecified
10/1/2015	12/31/9999	F1423	Cocaine dependence with withdrawal
10/1/2015	12/31/9999	F1424	Cocaine dependence with cocaine-induced mood disorder
10/1/2015	12/31/9999	F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F14280	Cocaine dependence with cocaine-induced anxiety disorder
10/1/2015	12/31/9999	F14281	Cocaine dependence with cocaine-induced sexual dysfunction
10/1/2015	12/31/9999	F14282	Cocaine dependence with cocaine-induced sleep disorder
10/1/2015	12/31/9999	F14288	Cocaine dependence with other cocaine-induced disorder
10/1/2015	12/31/9999	F1429	Cocaine dependence with unspecified cocaine-induced disorder
10/1/2015	12/31/9999	F1490	Cocaine use, unspecified, uncomplicated
10/1/2015	12/31/9999	F14920	Cocaine use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F14921	Cocaine use, unspecified with intoxication delirium
10/1/2015	12/31/9999	F14922	Cocaine use, unspecified with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F14929	Cocaine use, unspecified with intoxication, unspecified

10/1/2015	12/31/9999	F1494	Cocaine use, unspecified with cocaine-induced mood disorder
10/1/2015	12/31/9999	F14950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F14951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F14959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F14980	Cocaine use, unspecified with cocaine-induced anxiety disorder
10/1/2015	12/31/9999	F14981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
10/1/2015	12/31/9999	F14982	Cocaine use, unspecified with cocaine-induced sleep disorder
10/1/2015	12/31/9999	F14988	Cocaine use, unspecified with other cocaine-induced disorder
10/1/2015	12/31/9999	F1499	Cocaine use, unspecified with unspecified cocaine-induced disorder
10/1/2015	12/31/9999	F1510	Other stimulant abuse, uncomplicated
10/1/2015	12/31/9999	F15120	Other stimulant abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F15121	Other stimulant abuse with intoxication delirium
10/1/2015	12/31/9999	F15122	Other stimulant abuse with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F15129	Other stimulant abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1514	Other stimulant abuse with stimulant-induced mood disorder
10/1/2015	12/31/9999	F15150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F15151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F15159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F15180	Other stimulant abuse with stimulant-induced anxiety disorder
10/1/2015	12/31/9999	F15181	Other stimulant abuse with stimulant-induced sexual dysfunction
10/1/2015	12/31/9999	F15182	Other stimulant abuse with stimulant-induced sleep disorder
10/1/2015	12/31/9999	F15188	Other stimulant abuse with other stimulant-induced disorder
10/1/2015	12/31/9999	F1519	Other stimulant abuse with unspecified stimulant-induced disorder
10/1/2015	12/31/9999	F1520	Other stimulant dependence, uncomplicated
10/1/2015	12/31/9999	F1521	Other stimulant dependence, in remission
10/1/2015	12/31/9999	F15220	Other stimulant dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F15221	Other stimulant dependence with intoxication delirium
10/1/2015	12/31/9999	F15222	Other stimulant dependence with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F15229	Other stimulant dependence with intoxication, unspecified
10/1/2015	12/31/9999	F1523	Other stimulant dependence with withdrawal
10/1/2015	12/31/9999	F1524	Other stimulant dependence with stimulant-induced mood disorder
10/1/2015	12/31/9999	F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F15251	Other stimulant dependence with stimulant-induced psychotic disorder w/hallucinations

10/1/2015	12/31/9999	F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F15280	Other stimulant dependence with stimulant-induced anxiety disorder
10/1/2015	12/31/9999	F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
10/1/2015	12/31/9999	F15282	Other stimulant dependence with stimulant-induced sleep disorder
10/1/2015	12/31/9999	F15288	Other stimulant dependence with other stimulant-induced disorder
10/1/2015	12/31/9999	F1529	Other stimulant dependence with unspecified stimulant-induced disorder
10/1/2015	12/31/9999	F1590	Other stimulant use, unspecified, uncomplicated
10/1/2015	12/31/9999	F15920	Other stimulant use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F15921	Other stimulant use, unspecified with intoxication delirium
10/1/2015	12/31/9999	F15922	Other stimulant use, unspecified with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F15929	Other stimulant use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F1593	Other stimulant use, unspecified with withdrawal
10/1/2015	12/31/9999	F1594	Other stimulant use, unspecified with stimulant-induced mood disorder
10/1/2015	12/31/9999	F15950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F15951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F15959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F15980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
10/1/2015	12/31/9999	F15981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
10/1/2015	12/31/9999	F15982	Other stimulant use, unspecified with stimulant-induced sleep disorder
10/1/2015	12/31/9999	F15988	Other stimulant use, unspecified with other stimulant-induced disorder
10/1/2015	12/31/9999	F1599	Other stimulant use, unspecified with unspecified stimulant-induced disorder
10/1/2015	12/31/9999	F1610	Hallucinogen abuse, uncomplicated
10/1/2015	12/31/9999	F16120	Hallucinogen abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F16121	Hallucinogen abuse with intoxication with delirium
10/1/2015	12/31/9999	F16122	Hallucinogen abuse with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F16129	Hallucinogen abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1614	Hallucinogen abuse with hallucinogen-induced mood disorder
10/1/2015	12/31/9999	F16150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F16151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F16159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F16180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
10/1/2015	12/31/9999	F16183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
10/1/2015	12/31/9999	F16188	Hallucinogen abuse with other hallucinogen-induced disorder

10/1/2015	12/31/9999	F1619	Hallucinogen abuse with unspecified hallucinogen-induced disorder
10/1/2015	12/31/9999	F1620	Hallucinogen dependence, uncomplicated
10/1/2015	12/31/9999	F1621	Hallucinogen dependence, in remission
10/1/2015	12/31/9999	F16220	Hallucinogen dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F16221	Hallucinogen dependence with intoxication with delirium
10/1/2015	12/31/9999	F16229	Hallucinogen dependence with intoxication, unspecified
10/1/2015	12/31/9999	F1624	Hallucinogen dependence with hallucinogen-induced mood disorder
10/1/2015	12/31/9999	F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
10/1/2015	12/31/9999	F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
10/1/2015	12/31/9999	F16288	Hallucinogen dependence with other hallucinogen-induced disorder
10/1/2015	12/31/9999	F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
10/1/2015	12/31/9999	F1690	Hallucinogen use, unspecified, uncomplicated
10/1/2015	12/31/9999	F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F16921	Hallucinogen use, unspecified with intoxication with delirium
10/1/2015	12/31/9999	F16929	Hallucinogen use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F1694	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
10/1/2015	12/31/9999	F16950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F16951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F16959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F16980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
10/1/2015	12/31/9999	F16983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
10/1/2015	12/31/9999	F16988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
10/1/2015	12/31/9999	F1699	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
10/1/2015	12/31/9999	F17200	Nicotine dependence, unspecified, uncomplicated
10/1/2015	12/31/9999	F17201	Nicotine dependence, unspecified, in remission
10/1/2015	12/31/9999	F17203	Nicotine dependence unspecified, with withdrawal
10/1/2015	12/31/9999	F17208	Nicotine dependence, unspecified, with other nicotine-induced disorders
10/1/2015	12/31/9999	F17209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
10/1/2015	12/31/9999	F17210	Nicotine dependence, cigarettes, uncomplicated
10/1/2015	12/31/9999	F17211	Nicotine dependence, cigarettes, in remission

10/1/2015	12/31/9999	F17213	Nicotine dependence, cigarettes, with withdrawal
10/1/2015	12/31/9999	F17218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
10/1/2015	12/31/9999	F17219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
10/1/2015	12/31/9999	F17220	Nicotine dependence, chewing tobacco, uncomplicated
10/1/2015	12/31/9999	F17221	Nicotine dependence, chewing tobacco, in remission
10/1/2015	12/31/9999	F17223	Nicotine dependence, chewing tobacco, with withdrawal
10/1/2015	12/31/9999	F17228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
10/1/2015	12/31/9999	F17229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
10/1/2015	12/31/9999	F17290	Nicotine dependence, other tobacco product, uncomplicated
10/1/2015	12/31/9999	F17291	Nicotine dependence, other tobacco product, in remission
10/1/2015	12/31/9999	F17293	Nicotine dependence, other tobacco product, with withdrawal
10/1/2015	12/31/9999	F17298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
10/1/2015	12/31/9999	F17299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
10/1/2015	12/31/9999	F1810	Inhalant abuse, uncomplicated
10/1/2015	12/31/9999	F18120	Inhalant abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F18121	Inhalant abuse with intoxication delirium
10/1/2015	12/31/9999	F18129	Inhalant abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1814	Inhalant abuse with inhalant-induced mood disorder
10/1/2015	12/31/9999	F18150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F18151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F18159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1817	Inhalant abuse with inhalant-induced dementia
10/1/2015	12/31/9999	F18180	Inhalant abuse with inhalant-induced anxiety disorder
10/1/2015	12/31/9999	F18188	Inhalant abuse with other inhalant-induced disorder
10/1/2015	12/31/9999	F1819	Inhalant abuse with unspecified inhalant-induced disorder
10/1/2015	12/31/9999	F1820	Inhalant dependence, uncomplicated
10/1/2015	12/31/9999	F1821	Inhalant dependence, in remission
10/1/2015	12/31/9999	F18220	Inhalant dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F18221	Inhalant dependence with intoxication delirium
10/1/2015	12/31/9999	F18229	Inhalant dependence with intoxication, unspecified
10/1/2015	12/31/9999	F1824	Inhalant dependence with inhalant-induced mood disorder
10/1/2015	12/31/9999	F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations

10/1/2015	12/31/9999	F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1827	Inhalant dependence with inhalant-induced dementia
10/1/2015	12/31/9999	F18280	Inhalant dependence with inhalant-induced anxiety disorder
10/1/2015	12/31/9999	F18288	Inhalant dependence with other inhalant-induced disorder
10/1/2015	12/31/9999	F1829	Inhalant dependence with unspecified inhalant-induced disorder
10/1/2015	12/31/9999	F1890	Inhalant use, unspecified, uncomplicated
10/1/2015	12/31/9999	F18920	Inhalant use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F18921	Inhalant use, unspecified with intoxication with delirium
10/1/2015	12/31/9999	F18929	Inhalant use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F1894	Inhalant use, unspecified with inhalant-induced mood disorder
10/1/2015	12/31/9999	F18950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F18951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F18959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1897	Inhalant use, unspecified with inhalant-induced persisting dementia
10/1/2015	12/31/9999	F18980	Inhalant use, unspecified with inhalant-induced anxiety disorder
10/1/2015	12/31/9999	F18988	Inhalant use, unspecified with other inhalant-induced disorder
10/1/2015	12/31/9999	F1899	Inhalant use, unspecified with unspecified inhalant-induced disorder
10/1/2015	12/31/9999	F1910	Other psychoactive substance abuse, uncomplicated
10/1/2015	12/31/9999	F19120	Other psychoactive substance abuse with intoxication, uncomplicated
10/1/2015	12/31/9999	F19121	Other psychoactive substance abuse with intoxication delirium
10/1/2015	12/31/9999	F19122	Other psychoactive substance abuse with intoxication with perceptual disturbances
10/1/2015	12/31/9999	F19129	Other psychoactive substance abuse with intoxication, unspecified
10/1/2015	12/31/9999	F1914	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
10/1/2015	12/31/9999	F19150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F19151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F19159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1916	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
10/1/2015	12/31/9999	F1917	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
10/1/2015	12/31/9999	F19180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
10/1/2015	12/31/9999	F19181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
10/1/2015	12/31/9999	F19182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
10/1/2015	12/31/9999	F19188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
10/1/2015	12/31/9999	F1919	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder

10/1/2015	12/31/9999	F1920	Other psychoactive substance dependence, uncomplicated
10/1/2015	12/31/9999	F1921	Other psychoactive substance dependence, in remission
10/1/2015	12/31/9999	F19220	Other psychoactive substance dependence with intoxication, uncomplicated
10/1/2015	12/31/9999	F19221	Other psychoactive substance dependence with intoxication delirium
10/1/2015	12/31/9999	F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F19229	Other psychoactive substance dependence with intoxication, unspecified
10/1/2015	12/31/9999	F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
10/1/2015	12/31/9999	F19231	Other psychoactive substance dependence with withdrawal delirium
10/1/2015	12/31/9999	F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
10/1/2015	12/31/9999	F19239	Other psychoactive substance dependence with withdrawal, unspecified
10/1/2015	12/31/9999	F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
10/1/2015	12/31/9999	F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
10/1/2015	12/31/9999	F19259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1926	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
10/1/2015	12/31/9999	F1927	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
10/1/2015	12/31/9999	F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
10/1/2015	12/31/9999	F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
10/1/2015	12/31/9999	F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
10/1/2015	12/31/9999	F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
10/1/2015	12/31/9999	F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
10/1/2015	12/31/9999	F1990	Other psychoactive substance use, unspecified, uncomplicated
10/1/2015	12/31/9999	F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
10/1/2015	12/31/9999	F19921	Other psychoactive substance use, unspecified with intoxication with delirium
10/1/2015	12/31/9999	F19922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
10/1/2015	12/31/9999	F19929	Other psychoactive substance use, unspecified with intoxication, unspecified
10/1/2015	12/31/9999	F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
10/1/2015	12/31/9999	F19931	Other psychoactive substance use, unspecified with withdrawal delirium
10/1/2015	12/31/9999	F19932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
10/1/2015	12/31/9999	F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified
10/1/2015	12/31/9999	F1994	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
10/1/2015	12/31/9999	F19950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
10/1/2015	12/31/9999	F19951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations

10/1/2015	12/31/9999	F19959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
10/1/2015	12/31/9999	F1996	Other psychoactive substance use, unspecified with psychoactive substance-induced persist
10/1/2015	12/31/9999	F1997	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
10/1/2015	12/31/9999	F19980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
10/1/2015	12/31/9999	F19981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
10/1/2015	12/31/9999	F19982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
10/1/2015	12/31/9999	F19988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
10/1/2015	12/31/9999	F1999	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
10/1/2015	12/31/9999	F200	Paranoid schizophrenia
10/1/2015	12/31/9999	F201	Disorganized schizophrenia
10/1/2015	12/31/9999	F202	Catatonic schizophrenia
10/1/2015	12/31/9999	F203	Undifferentiated schizophrenia
10/1/2015	12/31/9999	F205	Residual schizophrenia
10/1/2015	12/31/9999	F2081	Schizophreniform disorder
10/1/2015	12/31/9999	F2089	Other schizophrenia
10/1/2015	12/31/9999	F209	Schizophrenia, unspecified
10/1/2015	12/31/9999	F21	Schizotypal disorder
10/1/2015	12/31/9999	F22	Delusional disorders
10/1/2015	12/31/9999	F23	Brief psychotic disorder
10/1/2015	12/31/9999	F24	Shared psychotic disorder
10/1/2015	12/31/9999	F250	Schizoaffective disorder, bipolar type
10/1/2015	12/31/9999	F251	Schizoaffective disorder, depressive type
10/1/2015	12/31/9999	F258	Other schizoaffective disorders
10/1/2015	12/31/9999	F259	Schizoaffective disorder, unspecified
10/1/2015	12/31/9999	F28	Other psychotic disorder not due to a substance or known physiological condition
10/1/2015	12/31/9999	F29	Unspecified psychosis not due to a substance or known physiological condition
10/1/2015	12/31/9999	F3010	Manic episode without psychotic symptoms, unspecified
10/1/2015	12/31/9999	F3011	Manic episode without psychotic symptoms, mild
10/1/2015	12/31/9999	F3012	Manic episode without psychotic symptoms, moderate
10/1/2015	12/31/9999	F3013	Manic episode, severe, without psychotic symptoms
10/1/2015	12/31/9999	F302	Manic episode, severe with psychotic symptoms
10/1/2015	12/31/9999	F303	Manic episode in partial remission
10/1/2015	12/31/9999	F304	Manic episode in full remission

10/1/2015	12/31/9999	F308	Other manic episodes
10/1/2015	12/31/9999	F309	Manic episode, unspecified
10/1/2015	12/31/9999	F310	Bipolar disorder, current episode hypomanic
10/1/2015	12/31/9999	F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
10/1/2015	12/31/9999	F3111	Bipolar disorder, current episode manic without psychotic features, mild
10/1/2015	12/31/9999	F3112	Bipolar disorder, current episode manic without psychotic features, moderate
10/1/2015	12/31/9999	F3113	Bipolar disorder, current episode manic without psychotic features, severe
10/1/2015	12/31/9999	F312	Bipolar disorder, current episode manic severe with psychotic features
10/1/2015	12/31/9999	F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
10/1/2015	12/31/9999	F3131	Bipolar disorder, current episode depressed, mild
10/1/2015	12/31/9999	F3132	Bipolar disorder, current episode depressed, moderate
10/1/2015	12/31/9999	F314	Bipolar disorder, current episode depressed, severe, without psychotic features
10/1/2015	12/31/9999	F315	Bipolar disorder, current episode depressed, severe, with psychotic features
10/1/2015	12/31/9999	F3160	Bipolar disorder, current episode mixed, unspecified
10/1/2015	12/31/9999	F3161	Bipolar disorder, current episode mixed, mild
10/1/2015	12/31/9999	F3162	Bipolar disorder, current episode mixed, moderate
10/1/2015	12/31/9999	F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
10/1/2015	12/31/9999	F3164	Bipolar disorder, current episode mixed, severe, with psychotic features
10/1/2015	12/31/9999	F3170	Bipolar disorder, currently in remission, most recent episode unspecified
10/1/2015	12/31/9999	F3171	Bipolar disorder, in partial remission, most recent episode hypomanic
10/1/2015	12/31/9999	F3172	Bipolar disorder, in full remission, most recent episode hypomanic
10/1/2015	12/31/9999	F3173	Bipolar disorder, in partial remission, most recent episode manic
10/1/2015	12/31/9999	F3174	Bipolar disorder, in full remission, most recent episode manic
10/1/2015	12/31/9999	F3175	Bipolar disorder, in partial remission, most recent episode depressed
10/1/2015	12/31/9999	F3176	Bipolar disorder, in full remission, most recent episode depressed
10/1/2015	12/31/9999	F3177	Bipolar disorder, in partial remission, most recent episode mixed
10/1/2015	12/31/9999	F3178	Bipolar disorder, in full remission, most recent episode mixed
10/1/2015	12/31/9999	F3181	Bipolar II disorder
10/1/2015	12/31/9999	F3189	Other bipolar disorder
10/1/2015	12/31/9999	F319	Bipolar disorder, unspecified
10/1/2015	12/31/9999	F320	Major depressive disorder, single episode, mild
10/1/2015	12/31/9999	F321	Major depressive disorder, single episode, moderate
10/1/2015	12/31/9999	F322	Major depressive disorder, single episode, severe without psychotic features

10/1/2015	12/31/9999	F323	Major depressive disorder, single episode, severe with psychotic features
10/1/2015	12/31/9999	F324	Major depressive disorder, single episode, in partial remission
10/1/2015	12/31/9999	F325	Major depressive disorder, single episode, in full remission
10/1/2016	12/31/9999	F3289	Other depressive episodes
10/1/2015	12/31/9999	F329	Major depressive disorder, single episode, unspecified
10/1/2015	12/31/9999	F330	Major depressive disorder, recurrent, mild
10/1/2015	12/31/9999	F331	Major depressive disorder, recurrent, moderate
10/1/2015	12/31/9999	F332	Major depressive disorder, recurrent severe without psychotic features
10/1/2015	12/31/9999	F333	Major depressive disorder, recurrent, severe with psychotic symptoms
10/1/2015	12/31/9999	F3340	Major depressive disorder, recurrent, in remission, unspecified
10/1/2015	12/31/9999	F3341	Major depressive disorder, recurrent, in partial remission
10/1/2015	12/31/9999	F3342	Major depressive disorder, recurrent, in full remission
10/1/2015	12/31/9999	F338	Other recurrent depressive disorders
10/1/2015	12/31/9999	F339	Major depressive disorder, recurrent, unspecified
10/1/2015	12/31/9999	F340	Cyclothymic disorder
10/1/2015	12/31/9999	F341	Dysthymic disorder
10/1/2016	12/31/9999	F3481	Disruptive Mood Dysregulation Disorder
10/1/2015	12/31/9999	F349	Persistent mood [affective] disorder, unspecified
10/1/2015	12/31/9999	F39	Unspecified mood [affective] disorder
10/1/2015	12/31/9999	F4000	Agoraphobia, unspecified
10/1/2015	12/31/9999	F4001	Agoraphobia with panic disorder
10/1/2015	12/31/9999	F4002	Agoraphobia without panic disorder
10/1/2015	12/31/9999	F4010	Social phobia, unspecified
10/1/2015	12/31/9999	F4011	Social phobia, generalized
10/1/2015	12/31/9999	F40210	Arachnophobia
10/1/2015	12/31/9999	F40218	Other animal type phobia
10/1/2015	12/31/9999	F40220	Fear of thunderstorms
10/1/2015	12/31/9999	F40228	Other natural environment type phobia
10/1/2015	12/31/9999	F40230	Fear of blood
10/1/2015	12/31/9999	F40231	Fear of injections and transfusions
10/1/2015	12/31/9999	F40232	Fear of other medical care
10/1/2015	12/31/9999	F40233	Fear of injury
10/1/2015	12/31/9999	F40240	Claustrophobia

10/1/2015	12/31/9999	F40241	Acrophobia
10/1/2015	12/31/9999	F40242	Fear of bridges
10/1/2015	12/31/9999	F40243	Fear of flying
10/1/2015	12/31/9999	F40248	Other situational type phobia
10/1/2015	12/31/9999	F40290	Androphobia
10/1/2015	12/31/9999	F40291	Gynephobia
10/1/2015	12/31/9999	F40298	Other specified phobia
10/1/2015	12/31/9999	F408	Other phobic anxiety disorders
10/1/2015	12/31/9999	F409	Phobic anxiety disorder, unspecified
10/1/2015	12/31/9999	F410	Panic disorder [episodic paroxysmal anxiety] without agoraphobia
10/1/2015	12/31/9999	F411	Generalized anxiety disorder
10/1/2015	12/31/9999	F413	Other mixed anxiety disorders
10/1/2015	12/31/9999	F418	Other specified anxiety disorders
10/1/2015	12/31/9999	F419	Anxiety disorder, unspecified
10/1/2016	12/31/9999	F422	Obsessive-compulsive disorder
10/1/2016	12/31/9999	F423	Hoarding Disorder
10/1/2015	12/31/9999	F430	Acute stress reaction
10/1/2015	12/31/9999	F4310	Post-traumatic stress disorder, unspecified
10/1/2015	12/31/9999	F4311	Post-traumatic stress disorder, acute
10/1/2015	12/31/9999	F4312	Post-traumatic stress disorder, chronic
10/1/2015	12/31/9999	F4320	Adjustment disorder, unspecified
10/1/2015	12/31/9999	F4321	Adjustment disorder with depressed mood
10/1/2015	12/31/9999	F4322	Adjustment disorder with anxiety
10/1/2015	12/31/9999	F4323	Adjustment disorder with mixed anxiety and depressed mood
10/1/2015	12/31/9999	F4324	Adjustment disorder with disturbance of conduct
10/1/2015	12/31/9999	F4325	Adjustment disorder with mixed disturbance of emotions and conduct
10/1/2015	12/31/9999	F4329	Adjustment disorder with other symptoms
10/1/2015	12/31/9999	F438	Other reactions to severe stress
10/1/2015	12/31/9999	F439	Reaction to severe stress, unspecified
10/1/2015	12/31/9999	F440	Dissociative amnesia
10/1/2015	12/31/9999	F441	Dissociative fugue
10/1/2015	12/31/9999	F442	Dissociative stupor
10/1/2015	12/31/9999	F444	Conversion disorder with motor symptom or deficit

10/1/2015	12/31/9999	F445	Conversion disorder with seizures or convulsions
10/1/2015	12/31/9999	F446	Conversion disorder with sensory symptom or deficit
10/1/2015	12/31/9999	F447	Conversion disorder with mixed symptom presentation
10/1/2015	12/31/9999	F4481	Dissociative identity disorder
10/1/2015	12/31/9999	F4489	Other dissociative and conversion disorders
10/1/2015	12/31/9999	F449	Dissociative and conversion disorder, unspecified
10/1/2015	12/31/9999	F450	Somatization disorder
10/1/2015	12/31/9999	F451	Undifferentiated somatoform disorder
10/1/2015	12/31/9999	F4520	Hypochondriacal disorder, unspecified
10/1/2015	12/31/9999	F4521	Hypochondriasis
10/1/2015	12/31/9999	F4522	Body dysmorphic disorder
10/1/2015	12/31/9999	F4529	Other hypochondriacal disorders
10/1/2015	12/31/9999	F4541	Pain disorder exclusively related to psychological factors
10/1/2015	12/31/9999	F4542	Pain disorder with related psychological factors
10/1/2015	12/31/9999	F458	Other somatoform disorders
10/1/2015	12/31/9999	F459	Somatoform disorder, unspecified
10/1/2015	12/31/9999	F481	Depersonalization-derealization syndrome
10/1/2015	12/31/9999	F488	Other specified nonpsychotic mental disorders
10/1/2015	12/31/9999	F489	Nonpsychotic mental disorder, unspecified
10/1/2015	12/31/9999	F5000	Anorexia nervosa, unspecified
10/1/2015	12/31/9999	F5001	Anorexia nervosa, restricting type
10/1/2015	12/31/9999	F5002	Anorexia nervosa, binge eating/purging type
10/1/2015	12/31/9999	F502	Bulimia nervosa
10/1/2016	12/31/9999	F5081	Binge Eating Disorder
10/1/2016	12/31/9999	F5089	Avoidant/Restrictive Food Intake Disorder
10/1/2016	12/31/9999	F5089	Pica, in adults
10/1/2016	12/31/9999	F5089	Other Specified Feeding or Eating Disorder
10/1/2015	12/31/9999	F509	Eating disorder, unspecified
10/1/2015	12/31/9999	F5101	Primary insomnia
10/1/2015	12/31/9999	F5102	Adjustment insomnia
10/1/2015	12/31/9999	F5103	Paradoxical insomnia
10/1/2015	12/31/9999	F5104	Psychophysiologic insomnia
10/1/2015	12/31/9999	F5105	Insomnia due to other mental disorder

10/1/2015	12/31/9999	F5109	Other insomnia not due to a substance or known physiological condition
10/1/2015	12/31/9999	F5111	Primary hypersomnia
10/1/2015	12/31/9999	F5112	Insufficient sleep syndrome
10/1/2015	12/31/9999	F5113	Hypersomnia due to other mental disorder
10/1/2015	12/31/9999	F5119	Other hypersomnia not due to a substance or known physiological condition
10/1/2015	12/31/9999	F513	Sleepwalking [somnambulism]
10/1/2015	12/31/9999	F514	Sleep terrors [night terrors]
10/1/2015	12/31/9999	F515	Nightmare disorder
10/1/2015	12/31/9999	F518	Other sleep disorders not due to a substance or known physiological condition
10/1/2015	12/31/9999	F519	Sleep disorder not due to a substance or known physiological condition, unspecified
10/1/2015	12/31/9999	F520	Hypoactive sexual desire disorder
10/1/2015	12/31/9999	F521	Sexual aversion disorder
10/1/2015	12/31/9999	F5221	Male erectile disorder
10/1/2015	12/31/9999	F5222	Female sexual arousal disorder
10/1/2015	12/31/9999	F5231	Female orgasmic disorder
10/1/2015	12/31/9999	F5232	Male orgasmic disorder
10/1/2015	12/31/9999	F524	Premature ejaculation
10/1/2015	12/31/9999	F525	Vaginismus not due to a substance or known physiological condition
10/1/2015	12/31/9999	F526	Dyspareunia not due to a substance or known physiological condition
10/1/2015	12/31/9999	F528	Other sexual dysfunction not due to a substance or known physiological condition
10/1/2015	12/31/9999	F529	Unspecified sexual dysfunction not due to a substance or known physiological condition
10/1/2015	12/31/9999	F53	Puerperal psychosis
10/1/2015	12/31/9999	F54	Psychological and behavioral factors associated with disorders or diseases classified elsewhere
10/1/2015	12/31/9999	F550	Abuse of antacids
10/1/2015	12/31/9999	F551	Abuse of herbal or folk remedies
10/1/2015	12/31/9999	F552	Abuse of laxatives
10/1/2015	12/31/9999	F553	Abuse of steroids or hormones
10/1/2015	12/31/9999	F554	Abuse of vitamins
10/1/2015	12/31/9999	F558	Abuse of other non-psychoactive substances
10/1/2015	12/31/9999	F59	Unspecified behavioral syndromes associated with physiological disturbances and physical factors
10/1/2015	12/31/9999	F600	Paranoid personality disorder
10/1/2015	12/31/9999	F601	Schizoid personality disorder
10/1/2015	12/31/9999	F602	Antisocial personality disorder

10/1/2015	12/31/9999	F603	Borderline personality disorder
10/1/2015	12/31/9999	F604	Histrionic personality disorder
10/1/2015	12/31/9999	F605	Obsessive-compulsive personality disorder
10/1/2015	12/31/9999	F606	Avoidant personality disorder
10/1/2015	12/31/9999	F607	Dependent personality disorder
10/1/2015	12/31/9999	F6081	Narcissistic personality disorder
10/1/2015	12/31/9999	F6089	Other specific personality disorders
10/1/2015	12/31/9999	F609	Personality disorder, unspecified
10/1/2015	12/31/9999	F630	Pathological gambling
10/1/2015	12/31/9999	F631	Pyromania
10/1/2015	12/31/9999	F632	Kleptomania
10/1/2015	12/31/9999	F633	Trichotillomania
10/1/2015	12/31/9999	F6381	Intermittent explosive disorder
10/1/2015	12/31/9999	F6389	Other impulse disorders
10/1/2015	12/31/9999	F639	Impulse disorder, unspecified
10/1/2016	12/31/9999	F640	Gender Dysphoria in Adolescents and Adults
10/1/2015	12/31/9999	F642	Gender identity disorder of childhood
10/1/2015	12/31/9999	F648	Other gender identity disorders
10/1/2015	12/31/9999	F649	Gender identity disorder, unspecified
10/1/2015	12/31/9999	F650	Fetishism
10/1/2015	12/31/9999	F651	Transvestic fetishism
10/1/2015	12/31/9999	F652	Exhibitionism
10/1/2015	12/31/9999	F653	Voyeurism
10/1/2015	12/31/9999	F654	Pedophilia
10/1/2015	12/31/9999	F6550	Sadomasochism, unspecified
10/1/2015	12/31/9999	F6551	Sexual masochism
10/1/2015	12/31/9999	F6552	Sexual sadism
10/1/2015	12/31/9999	F6581	Frotteurism
10/1/2015	12/31/9999	F6589	Other paraphilias
10/1/2015	12/31/9999	F659	Paraphilia, unspecified
10/1/2015	12/31/9999	F66	Other sexual disorders
10/1/2015	12/31/9999	F6810	Factitious disorder, unspecified
10/1/2015	12/31/9999	F6811	Factitious disorder with predominantly psychological signs and symptoms

10/1/2015	12/31/9999	F6812	Factitious disorder with predominantly physical signs and symptoms
10/1/2015	12/31/9999	F6813	Factitious disorder with combined psychological and physical signs and symptoms
10/1/2015	12/31/9999	F688	Other specified disorders of adult personality and behavior
10/1/2015	12/31/9999	F69	Unspecified disorder of adult personality and behavior
10/1/2015	12/31/9999	F70	Mild intellectual disabilities
10/1/2015	12/31/9999	F71	Moderate intellectual disabilities
10/1/2015	12/31/9999	F72	Severe intellectual disabilities
10/1/2015	12/31/9999	F73	Profound intellectual disabilities
10/1/2015	12/31/9999	F78	Other intellectual disabilities
10/1/2015	12/31/9999	F79	Unspecified intellectual disabilities
10/1/2015	12/31/9999	F800	Phonological disorder
10/1/2015	12/31/9999	F801	Expressive language disorder
10/1/2015	12/31/9999	F802	Mixed receptive-expressive language disorder
10/1/2015	12/31/9999	F804	Speech and language development delay due to hearing loss
10/1/2015	12/31/9999	F8081	Childhood onset fluency disorder
10/1/2016	12/31/9999	F8082	Social (Pragmatic) Communication Disorder
10/1/2015	12/31/9999	F809	Developmental disorder of speech and language, unspecified
10/1/2015	12/31/9999	F810	Specific reading disorder
10/1/2015	12/31/9999	F812	Mathematics disorder
10/1/2015	12/31/9999	F8181	Disorder of written expression
10/1/2015	12/31/9999	F8189	Other developmental disorders of scholastic skills
10/1/2015	12/31/9999	F819	Developmental disorder of scholastic skills, unspecified
10/1/2015	12/31/9999	F82	Specific developmental disorder of motor function
10/1/2015	12/31/9999	F840	Autistic disorder
10/1/2015	12/31/9999	F842	Rett's syndrome
10/1/2015	12/31/9999	F843	Other childhood disintegrative disorder
10/1/2015	12/31/9999	F845	Asperger's syndrome
10/1/2015	12/31/9999	F848	Other pervasive developmental disorders
10/1/2015	12/31/9999	F849	Pervasive developmental disorder, unspecified
10/1/2015	12/31/9999	F88	Other disorders of psychological development
10/1/2015	12/31/9999	F89	Unspecified disorder of psychological development
10/1/2015	12/31/9999	F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
10/1/2015	12/31/9999	F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type

10/1/2015	12/31/9999	F902	Attention-deficit hyperactivity disorder, combined type
10/1/2015	12/31/9999	F908	Attention-deficit hyperactivity disorder, other type
10/1/2015	12/31/9999	F909	Attention-deficit hyperactivity disorder, unspecified type
10/1/2015	12/31/9999	F910	Conduct disorder confined to family context
10/1/2015	12/31/9999	F911	Conduct disorder, childhood-onset type
10/1/2015	12/31/9999	F912	Conduct disorder, adolescent-onset type
10/1/2015	12/31/9999	F913	Oppositional defiant disorder
10/1/2015	12/31/9999	F918	Other conduct disorders
10/1/2015	12/31/9999	F919	Conduct disorder, unspecified
10/1/2015	12/31/9999	F930	Separation anxiety disorder of childhood
10/1/2015	12/31/9999	F938	Other childhood emotional disorders
10/1/2015	12/31/9999	F939	Childhood emotional disorder, unspecified
10/1/2015	12/31/9999	F940	Selective mutism
10/1/2015	12/31/9999	F941	Reactive attachment disorder of childhood
10/1/2015	12/31/9999	F942	Disinhibited attachment disorder of childhood
10/1/2015	12/31/9999	F948	Other childhood disorders of social functioning
10/1/2015	12/31/9999	F949	Childhood disorder of social functioning, unspecified
10/1/2015	12/31/9999	F950	Transient tic disorder
10/1/2015	12/31/9999	F951	Chronic motor or vocal tic disorder
10/1/2015	12/31/9999	F952	Tourette's disorder
10/1/2015	12/31/9999	F958	Other tic disorders
10/1/2015	12/31/9999	F959	Tic disorder, unspecified
10/1/2015	12/31/9999	F980	Enuresis not due to a substance or known physiological condition
10/1/2015	12/31/9999	F981	Encopresis not due to a substance or known physiological condition
10/1/2015	12/31/9999	F9821	Rumination disorder of infancy
10/1/2015	12/31/9999	F9829	Other feeding disorders of infancy and early childhood
10/1/2015	12/31/9999	F983	Pica of infancy and childhood
10/1/2015	12/31/9999	F984	Stereotyped movement disorders
10/1/2015	12/31/9999	F985	Adult onset fluency disorder
10/1/2015	12/31/9999	F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
10/1/2015	12/31/9999	F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
10/1/2015	12/31/9999	F99	Mental disorder, not otherwise specified
10/1/2015	12/31/9999	G44209	Tension-type headache, unspecified, not intractable

10/1/2015	12/31/9999	G4720	Circadian rhythm sleep disorder, unspecified type
10/1/2015	12/31/9999	G4721	Circadian rhythm sleep disorder, delayed sleep phase type
10/1/2015	12/31/9999	G4722	Circadian rhythm sleep disorder, advanced sleep phase type
10/1/2015	12/31/9999	G4723	Circadian rhythm sleep disorder, irregular sleep wake type
10/1/2015	12/31/9999	G4724	Circadian rhythm sleep disorder, free running type
10/1/2015	12/31/9999	G4726	Circadian rhythm sleep disorder, shift work type
10/1/2015	12/31/9999	H9325	Central auditory processing disorder
10/1/2015	12/31/9999	R37	Sexual dysfunction, unspecified
10/1/2015	12/31/9999	R451	Restlessness and agitation
10/1/2015	12/31/9999	R452	Unhappiness
10/1/2015	12/31/9999	R455	Hostility
10/1/2015	12/31/9999	R456	Violent behavior
10/1/2015	12/31/9999	R4581	Low self-esteem
10/1/2015	12/31/9999	R4582	Worries
10/1/2015	12/31/9999	R480	Dyslexia and alexia
10/1/2015	12/31/9999	Z720	Tobacco use
10/1/2015	12/31/9999	Z87890	Personal history of sex reassignment

ICD-10 codes added on October 1, 2016

ATTACHMENT DD: TRAUMATIC BRAIN INJURY (TBI) WAIVER PROGRAM

BACKGROUND:

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid Enrollees to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to Enrollees through the Medicaid State plan and other Federal, State and local public programs as well as the supports that families and communities provide. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

The State of North Carolina applied for and was granted a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act) referred to herein as the "TBI Waiver". The TBI waiver is incorporated herein and made a part of this TBI Waiver Program Attachment DD ("this Attachment").

SCOPE OF WORK:

This Attachment is a part of Contract # DMA-MCO-2018-1 (the Contract) between Alliance Behavioral Health (PIHP) and the North Carolina Department of Health and Human Services – Division of Medical Assistance (DMA). PIHP and DMA shall follow all of the provisions of the Contract and of this Attachment. The TBI Waiver that was submitted to CMS in 2016 reflects the assumptions and contractual language of the 1915(c) NC Innovations Waiver with the exception of the information listed in this Attachment. In the event of a conflict among this Attachment, the Contract and the TBI Waiver related to the TBI Waiver, the TBI Waiver shall control first, then this Attachment, then the Contract.

DD Section 1. Effective Period

This Attachment shall be effective ninety (90) calendar days following the effective date set forth in the approved TBI Waiver and shall run concurrently with the Contract.

DD Section 2. Enrollment

2.1 The effective date of enrollment for TBI Waiver Enrollees shall be the date of eligibility for participation in the TBI Waiver.

2.2 PIHP may act to terminate an Enrollee from participation in the TBI Waiver based upon Enrollee's or Enrollee's personal representative's failure to comply with the requirements set forth in the TBI Waiver approved by CMS or for other reasons explicitly authorized in the TBI Waiver approved by CMS. Termination of an Enrollee from TBI Waiver participation is an adverse benefit determination subject to due process rights set forth in Attachment M – Enrollee Grievance and Appeal Procedures.

2.3 PIHP may act to terminate an Enrollee from participation in the TBI Waiver if s/he no longer meets the Level of Care criteria stipulated in the TBI Waiver.

DD Section 3. Covered Services

3.1 PIHP shall provide, arrange for, or otherwise bear responsibility for the provision of all Covered Services identified in the approved TBI Waiver to eligible Enrollees as defined therein, through contractual and/or payment arrangements with Network Providers, out-of-Network providers, if needed to ensure continuity of and access to care in accordance with 42 CFR § 438.206. All services shall be provided in a manner consistent with the TBI Waiver.

3.2 The amount, duration, and scope of TBI Waiver services must reasonably be expected to achieve the purpose for which the services are furnished. Covered Services shall be Medically Necessary and meet the Level of Care set forth in the Waiver. Services shall be available to individuals who are eligible for both Medicaid and Medicare.

3.3 This TBI Waiver is a three-year model waiver project to be implemented with Alliance and, if successful, to be modeled and rolled-out for other LME-MCOs in the State.

3.4 TBI Waiver Services Summary. A list of the services that shall be furnished under the TBI Waiver are as follows, and may be amended from time to time in cooperation with PIHP and upon approval of an amendment by CMS:

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Day Supports
Statutory Service	Personal Care
Statutory Service	Residential Supports
Statutory Service	Respite
Statutory Service	Supported Employment
Extended State Plan Service	OT
Extended State Plan Service	SLP
Extended State Plan Service	PT
Other Service	Assistive Technology
Other Service	Cognitive Rehabilitation (CR)
Other Service	Community Networking
Other Service	Community Transition
Other Service	Crisis Supports Services
Other Service	Home Modifications
Other Service	In Home Intensive Support
Other Service	Life Skills Training
Other Service	Natural Supports Education
Other Service	Resource Facilitation
Other Service	Specialized Consultation
Other Service	Vehicle Modifications

3.5 Accessibility of TBI Services - Unduplicated Number of Enrollees. The following table specifies the maximum number of unduplicated Enrollees who may be served in each year that the TBI Waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of Enrollees specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated Enrollees specified in this table is the basis for the cost neutrality calculations.

TBI Waiver YR	Total Unduplicated Number of TBI Enrollees	Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	49	5	44
Year 2	99	10	89
Year 3	107	12	95

3.6 TBI Quality Assurance and Quality Improvement shall be provided by PIHP in the manner prescribed in the TBI Waiver.

3.7 Utilization Management for TBI services shall be provided by PIHP in the manner prescribed in the TBI Waiver and accompanying policy.

3.8 TBI Clinical Records shall be maintained by PIHP and providers in the manner prescribed in the TBI Waiver.

3.9 Financial Integrity / Records shall be maintained by PIHP in the manner prescribed in the TBI Waiver.

3.10 PIHPs shall ensure that TBI Waiver Providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4).

DD Section 4. Duties and Responsibilities of PIHP

4.1 PIHP shall develop Enrollee written materials that describe all TBI Waiver services and supports.

4.2 PIHP shall provide TBI Education and Training for Enrollees and Families in the manner prescribed in the TBI Waiver.

4.3 PIHP shall develop stakeholder group(s) consisting of TBI Waiver Enrollees, families, advocates, and Providers to provide recommendations regarding implementation of TBI Waiver services and policies. PIHP shall keep meeting minutes and attendance records for each of these stakeholder meetings. PIHP shall make these records available for review by DMA and shall report on these efforts at IMT meetings.

4.4 Care Coordination. PIHP shall develop and implement policies and procedures that address the requirements of this section, including a process for identifying Enrollees who meet Special Healthcare Needs Population criteria as outlined in subsection 6.11.3(c) below, and for collaborating with the Department's Primary Care Case Management (PCCM) vendor as outlined in subsection 6.11.3(j) below. PIHP's coordination of care obligations shall apply to all Medicaid eligible for whom PIHP receives a capitation payment, including but not limited to Medicare/Medicaid dual eligible, Enrollees in the Innovations Waiver and Enrollees in the TBI Waiver.

4.5 In accordance with 42 CFR §438.208(c), PIHP shall perform coordination of care for Enrollees who are Enrollees participating in the TBI Waiver by performing applicable functions listed in subsections (b) and (d) above as well as the following functions, as clinically indicated:

a. Guiding the development and submission of the Individual Support Plan (ISP), based on assessed need and living arrangements, at least annually;
b. Explaining the individual budgeting tool, the service authorization process, and the mechanisms available to the Enrollee/ LRP to modify their budget;
c. Assisting the Enrollee/LRP in choosing a qualified provider to implement each service in the ISP including providing a list of available providers and arranging provider interviews;
d. Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal;
e. Maintaining close contact with Enrollee/ LRP (if applicable), providers, PCCM care manager (if applicable), 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;
f. Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the Enrollee;
g. Completing annual re-assessment of the Enrollee's level of care;
h. Ensuring that the Enrollee/ LRP completes the Freedom of Choice statement annually;
i. Completing the NC TBI Risk and Support Needs Assessment prior to the development of the ISP and updating at least annually or as significant changes occur with the Enrollee;
j. Providing timely notification to Utilization Management of necessary updates to the LOC and timely processing of updates needed to the ISP, based If an individual chooses not to participate in the TBI Waiver and may be eligible for Medicaid or other Medicaid funded services, the Care Coordinator shall inform the individual of the other services and supports that may be available in lieu of TBI Waiver services;
k. 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;
l. Monitoring of service delivery to verify that:
   (1) At least one service is utilized monthly, per NC TBI Waiver eligibility requirements,
   (2) Services are furnished in accordance with the ISP;
   (3) Enrollee is offered a choice of providers where required;
   (4) Enrollee has access to services and services meet the Enrollee's needs;
   (5) Issues of health and welfare (rights restrictions, abuse/neglect/exploitation, back-up staffing) and non-waiver service needs (medical care) are addressed and documented as appropriate;
   (6) Services utilized do not exceed authorization; and
   (7) Enrollee is satisfied with the services being rendered.

Monitoring shall take place in all service settings and shall include contacts with other members of the ISP team and review of service documentation using the standard TBI Waiver monitoring checklist. Monitoring must occur face to face on a monthly basis for Enrollees who live in residential programs, and Enrollees who are new to the NC TBI Waiver for the first six (6) months. All other monitoring visits shall occur on a schedule agreed to by the ISP team, no less than quarterly, to meet the Enrollee's health and safety needs.

In any month where no face to face monitoring occurs, the care coordinator shall contact the Enrollee/ LRP by telephone to ensure that there are no issues that need to be addressed.

4.6 Due Process. PIHP shall comply with the following due process principles as they relate to Enrollees who are participants in the NC TBI Waiver, including but not limited to development of the Enrollee's individual budget and ISP:

a. To the extent an employee of PIHP facilitates or assists in making a TBI Waiver Enrollee's request for authorization of services, PIHP shall ensure that an Enrollee's request for services is made in a manner consistent with the desires of the Enrollee and that those desires are reflected in the Enrollee's plan of care, including desires for the type, amount, and duration of services. Review of requests for authorization of services shall be made in accordance with 42 CFR § 438.210(d).
   (1) PIHP shall discuss the duration of the services expected by the Enrollee/ LRP and shall ensure that proposed plans of care request authorization for each service at the duration requested by the Enrollee during the plan year.
   (2) PIHP shall assist the Enrollee/ LRP in developing plans of care and shall explain options regarding the services available to the Enrollee.
   (3) PIHP shall inform TBI Waiver Enrollees that they may make a new request for services at any time by requesting an update or revision to the Enrollee's plan of care;

b. Care Coordinators may not exercise prior authorization authority over the Individual Support Plan;

c. If PIHP authorizes a requested service for a duration less than the duration requested in the plan of care, PIHP shall provide written notice with appeal rights and clinical reasons for the decision at the time of the limited authorization;

d. If PIHP denies a request for authorization of services by an Enrollee, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of service, PIHP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404.
   (1) An appeal filed by an Enrollee must not prevent any authorized services from being provided pending the outcome of the appeal. PIHP must not prevent the Enrollee from making a new request for services during a pending appeal.
   (2) PIHP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all Enrollees from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to appeal the denial, reduction, or termination of a service. PIHP shall not attempt to influence, limit, or interfere with an Enrollee's right or decision to file or pursue a grievance or request an appeal;

e. If PIHP reduces, suspends, or terminates an Enrollee's services during an existing authorization period, PIHP shall, upon request of the Enrollee, continue the Enrollee's benefits as set forth in 42 CFR § 438.420, if all the requirements of 42 CFR § 438.420 are met; and

f. 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 Waiver and other trainings relevant to due process procedures, whether related to the waiver or otherwise. PIHP shall train new employees within fifteen (15) business days of a new employee's start date and shall conduct due process training at least annually for all relevant staff. PIHP further agrees to update any materials publicly posted on PIHP's website that are inconsistent with the terms of subsection 6.11.3 (i) of the Contract or inconsistent with any trainings provided by the Department.

DD Section 5. Providers of TBI Waiver Services

5.1 DMA screens and determines TBI Provider enrollment into and disenrollment from the North Carolina Medicaid and medical assistance plan or program and from that pool of enrolled Providers, PIHP has full authority to create and manage its Closed Provider Network, including credentialing, contracting and termination, subject to applicable law, this attachment, and the DMA Contract.

5.2 Provider must be HCBS compliant prior to being enrolled by DMA and credentialed and contracted with by the PIHP.

5.3 National accreditation is required of providers of waiver services. Upon contracting with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of PIHP.

5.4 Provider agencies shall comply with the applicable provider Specifications for Services set forth in the TBI Waiver.

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

DD Section 6. Calculation of Rates/Payment

6.1 PIHP shall notify the local department of social services (DSS) that the individual has been approved to participate in the TBI Waiver. DSS then enters eligibility for waiver participation into the State's Eligibility Information System (NCFAST). NCFAST transmits eligibility to the MMIS, which pays a capitated payment to the PIHP monthly for each waiver beneficiary. Capitated payments continue until one of the following occurs:
- The individual loses Medicaid eligibility; or
- DSS, upon instruction from the PIHP, removes the individual from the Waiver.

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

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

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

6.5 Attachment P – Capitation Rates and Rate Setting Methodology describes the rate setting methodology for the capitated payments. Using the methodology in Attachment P, the rates shall be recalculated each year. DMA shall notify PIHP at least ninety (90) calendar days prior to the effective date of the new rates. PIHP shall have fourteen (14) business days to review the proposed rates. At the end of the fourteen (14) business day review period, PIHP may choose to accept the new rate, negotiate rate changes, or terminate the Contract with DMA in accordance with Section 12 of Attachment B - Default and Termination.

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

6.7 For TBI Waiver Enrollees who have deductibles (spend-downs), the MMIS pays prorated capitated payments based on the date the deductible is met.

6.8 The PIHP shall retain One Hundred percent (100%) of the monthly capitated payment for TBI Waiver Enrollees.

END OF ATTACHMENT DD

APPENDIX Y: MEDICAID PAYMENT AMOUNTS

Below are the rates for Alliance Behavioral HealthCare
July 1, 2017 – June 30, 2018

Alliance Behavioral HealthCare Medicaid Capitation Rates

CAPITATION RATES (State Plan Services)

Rating Group	Ages	SFY 2018 Contract Rate
AFDC	3+	$40.89
Foster Children	3+	$787.65
Aged	65+	$76.35
Blind/Disabled	3-20	$373.36
Blind/Disabled	21+	$316.11
Innovations	All Ages	$4,955.35
Subtotal (w/o Innovations)	All Ages	$104.56
Total (w/ Innovations)	**All Ages**	**$142.42**

TBI	22+	$5,684.07

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

Rating Group	Ages	SFY 2018 Contract Rate
AFDC	3+	$1.89
Foster Children	3+	$1.22
Aged	65+	$1.84
Blind/Disabled	3-20	$6.71
Blind/Disabled	21+	$21.08
Innovations	All Ages	$0.00
Subtotal (w/o Innovations)	All Ages	$4.65
Total (w/ Innovations)	All Ages	$4.62

TBI	22+	$0.00

CAPITATION RATES (TOTAL RATE)

Rating Group	Ages	SFY 2018 Contract Rate
AFDC	3+	$42.78
Foster Children	3+	$788.87
Aged	65+	$78.19
Blind/Disabled	3-20	$380.07
Blind/Disabled	21+	$337.19
Innovations	All Ages	$4,955.35
Subtotal (w/o Innovations)	All Ages	$109.21
Total (w/ Innovations)	All Ages	$147.04

TBI	22+	$5,684.07

Alliance Representative Approved/Accepted Date 3-28-17

DHHS Representative Approved/Accepted ____________________ Date ________

CMS Representative Approved/Accepted ____________________ Date ________