Amendment Number 2/3
Prepaid Health Plan Services
#30-190029-DHB – PHP

THIS Amendment to the Prepaid Health Plan Services Contract #30-190029-DHB – *PHP Name* (Contract) awarded February 4, 2019 and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and *PHP Name* (Contractor), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to make clarifications, technical corrections and updates to reflect legislative changes enacted by the General Assembly and other program changes in the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

1. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
2. Section V. Scope of Services;
3. Section VI. Contract Performance;
4. Section VII. Attachments A – N; and
5. Section VIII.O.7. Contractor's Contract Administrators.

The Parties agree as follows:

1. **Modifications to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections of the Contract.**

   Specific subsections are modified as stated herein.

   a. **Section III.A. Definitions, 112. – 130. are revised and restated as follows:**

      112. **Readily Accessible:** Has the same meaning as Readily Accessible as defined in 42 C.F.R. § 438.10(a).

      113. **Readiness Review**: Has the same meaning as described in 42 C.F.R. § 438.66(d).

      114. **Redeterminations:** The annual review of beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and NC Health Choice

      115. **Reprocess:** For the purposes of claims and encounters, the activities completed by a payer to reconsider the outcome of a previously adjudicated claim.

      116. **Rising Risk:** Population group that has not yet become high-risk but who may become high-risk if certain risk factors and behaviors are not addressed.

      117. **Security Assertion Markup Language (SAML):** This is the State's preferred standard for the implementation of identity and access management.

      118. **Significant Change:** Means any change in the services offered by PHPs, the benefits covered under the contract, the geographic service area, and the composition of or payments to the PHP's provider network, and the enrollment of a new population in the PHP.

      119. **Standard Plan:** A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most North Carolina Medicaid and

NC Health Choice beneficiaries and that are not BH IDD Tailored Plans as described in in Section 4.(10) of SL 2015-245, as amended by SL 2018-48.

120. **State:** The State of North Carolina, the NC Department of Health and Human Services as an agency or in its capacity as the Using Agency.

121. **State Business Day:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, except for North Carolina State holidays as defined by the Office of State Human Resources. https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays.

122. **State Fair Hearing:** The hearing or hearings conducted at the Office of Administrative Hearings (OAH) under N.C. Gen. Stat. § 108D-15 to resolve a dispute between a Member and a PHP about an Adverse Benefit Determination.

123. **Subcontractor:** An entity having an arrangement with the PHP, where the PHP uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the subcontractor and the Department, only the Contractor. Network providers are not considered Subcontractors for the Contract.

124. **Transitions of Care:** The Process of assisting a Member to transition between PHPs; between payment delivery systems; including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between providers upon a provider's termination from the PHP network.

125. **Value-Added Services:** Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the PHP's discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

126. **Value-Based Payment (VBP):** Payment arrangements between PHPs and providers that fall within Levels 2 and 4 of the multi-payer Health Care Payment (HCP) and Action Network (LAN) Alternative Payment Model (APM) framework.

127. **Vendor:** A companies, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.

128. **Video Remote Interpreting:** Has the same meaning as described in 28 C.F.R. § 35.104.

129. **Warm transfer:** Defined as a beneficiary or provider call is transferred directly from the original call center to the appropriate party without requiring the caller to make an additional call and without the PHP abandoning the call until the other party answers.

130. **X12 Transactions** – Any EDI transaction included in the x12.org standard. This includes but is not limited to the 834 Benefit Enrollment and Maintenance, the 837 Health Care Claim, and the 277 Health Care Information Status Notification. The entire transaction set can be found at http://www.x12.org.

b. Section III.B. Acronyms, 18. And 104. are revised and restated as follows:

18. Reserved.

104. Reserved.

c. Section III.D. Terms and Conditions is revised and restated as follows:

22. <u>Governmental Restrictions:</u>

a. In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.

b. Should the Department notify the PHP that any program or activity in the scope of work under this Contract is no longer authorized by law (e.g., vacated by a court of law, CMS withdraws federal authority, or subject of a legislative repeal), the PHP shall do no work on that part of the Contract after the effective date identified in the notice. The Department shall adjust capitation rates to remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the PHP works on a program or activity no longer authorized by law after the effective date identified in the notice, the PHP shall not be paid for that work. If the Department paid the PHP in advance to work on a program or activity no longer authorized by law and under the terms of this Contract the work was to be performed after the effective date identified in the notice, the payment for that work shall be returned to the Department. However, if the PHP worked on a program or activity no longer authorized by law prior to the effective date identified in the notice, and the Department included the cost of performing that work in its payments to the PHP, the PHP may keep the payment for that work even if the payment was made after the effective date identified in the notice.

2. Modifications to Section V. Scope of Services of the Contract.

Specific subsections are modified as stated herein.

a. Section V.A. Administration and Management 9. Staffing and Facilities h. Physical Presence in North Carolina is revised and restated as follows:

i. The PHP shall have a physical presence in North Carolina by having one or more offices located in the State.

a) The PHP shall establish an office in North Carolina at least ninety (90) days after Contract Award that shall be maintained for the duration of the contract.

b) The PHP shall establish call center(s) and staff in North Carolina at least ninety (90) days after Contract Award.

c) The Department requires the PHP establish an office in each of the six (6) Regions that is serves to support in care management functions and member, provider and stakeholder engagement requirements of the Contract by October 1, 2021 or a later date specified by the Department.

b. Section V.A. Administration and Management is revised to add the following:

10. Marketplace Participation

a. The PHP shall maintain the commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) as described in its PHP RFP response at *Attachment O. Offeror's Proposal and Response*.

b. The PHP shall deliver on its commitment to offer QHPs on the FFM by timely submitting all necessary NCDOI-related regulatory submissions (including premium rates and policy forms) and QHP application to the FFM in the Spring of 2021, and actively seeking all required state and federal approvals to offer QHPs during QHP Plan Year 2022.

c. Any references in *Attachment O. Offeror's Proposal and Response* to offer a QHP in North Carolina in QHP Plan Year 2021 or any references made by the PHP in its RFP response to *Attachment O. Offeror's Proposal and Response* to committing to offer a QHP in QHP Plan Year 2021 should be construed to mean a commitment to offer a QHP in QHP Plan Year 2022.

c. Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits e. Utilization Management xiv. is revised and restated as follows:

xiv. For behavioral health services, the PHP shall require providers to use the following behavioral health screening tools at part of the PHP's UM Program:

a) The PHP shall use the American Society for Addiction Medicine (ASAM) for substance abuse services for medical necessity reviews for all populations except children ages zero (0) through six (6). The PHP shall use EPSDT criteria when evaluation requests for service for children;

b) The PHP shall use either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers to determine medical necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.

f. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits, k. Electronic Visit Verification, iv. is revised and restated as follows:

iv. The PHP shall ensure that utilization of an EVV system for Personal Care Services (as part of the State Plan) is in effect no later than June 30, 2021 and by January 1, 2023 for Home Health Care Services.

g. Section V.C. Benefits and Care Management, 5. Non-Emergency Medical Transportation, b. is revised and restated as follows:

b. The PHP shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program and consistent with the Department's Medicaid Managed Care Policy Guidance for Non-Emergency Medical Transportation.

h. Section V.C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, c) Advanced Medical Home Data and Information Sharing, 1.vi.c) is revised and restated as follows:

c) The PHP shall provide encounter, provider and Member data at least monthly, or more frequently in order to support transitions of care requirements or as requested by the Department.

i. Section V.D. Providers, 1. Provider Network, e. Essential Providers (SL 2015-245, Section 5), i. is revised and restated as follows:

i. The PHP shall include all Essential Providers located in the PHP's Region(s) in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.

a) Except for a Veterans Home, a PHP must submit a request for an alternative arrangement relating to any Essential Provider with whom the PHP has failed to contract.

b) The PHP shall contract with newly identified Essential Providers within ninety (90) Calendar Days of notification from the Department of the addition of a new Essential Provider. If at the end of the ninety (90) Calendar Days a contract with the Essential Provider has not been established, the PHP shall submit a request for an alternative arrangement, in accordance with the Contract, relating to the Essential Provider.

j. Section V.D. Providers, 1. Provider Network, g. Assurances of Adequacy Capacity and Services (42 C.F.R. § 438.207), i.a), 3.ii. is revised and restated as follows:

ii. Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all Members on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a month.

k. Section V.D. Providers 1. Provider Network g. Assurances of Adequacy Capacity and Services (42 C.F.R. § 438.207) is revised to add the following:

iv. Ongoing Monitoring and Significant Changes in the Provider Network

a) At least once a month, the PHP shall monitor its Provider Network for a significant change that would affect the adequacy or capability or services and compliance with the time/distance and appointment wait time standards established by the Department as described in *Attachment F. First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards*.

b) Within five (5) Business Days of identifying a significant change that impacts network adequacy and the ability to provide services, the PHP shall provide notice to the Department in a format and manner as determined by the Department.

c) Within forty-five (45) Calendar Days of submission of the notice of a significant change, the PHP shall submit to the Department:

1. An updated Network Access Plan, including an updated attestation indicating compliance with or how the PHP will come into compliance with the time/ distance and appointment wait time standards established by the Department;
2. An updated Network data file as required under *Section V.D.1. Provider Network*; and

3. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.

l. Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, ii. c. is revised and restated as follows:

c. The PHP shall submit an unapproved contract template to the Department for approval at least sixty (60) Calendar Days before use with providers, including amended previously approved templates with significant changes.

m. Section V.D. Providers 2. Provider Network Management c. Provider Contracting is revised to add the following:

xxii. For any provider subject to a rate floor as outlined in *Section V.D.4., Provider Payments*, a PHP may include a provision in the provider's contract that the PHP will pay the lesser of billed charges or the rate floor only if the provider and the PHP have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. A PHP shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

xxiii. During contract negotiations with a provider, the PHP may, without the Department's prior approval, make amendments to a previously approved provider contract template.

a. Any change to a standard provision required by *Attachment G., First Revised and Restated Required Standard Provisions for PHP and Provider Contracts*, is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.u., 1.v., 1.w., or 1.x., which must be prior approved by the Department.

b. Any change to a standard provision required in *Section 2. of Attachment G., First Revised and Restated Required Standard Provisions for PHP and Provider Contracts*, must be prior approved by the Department.

c. Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirement of this Contract, or state or federal law.

d. The PHP may only make changes to the provisions required in *Section 3. of Attachment G., First Revised* and *Restated Required Standard Provisions for PHP and Provider Contracts*, when directed to do so by the Department.

n. Section V.D. Providers 2. Provider Network Management h. Network Provider System Requirements ii. is revised and restated as follows:

ii. Unless otherwise written in the contract, the PHP shall load newly contracted providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:

a. New Medicaid Enrolled provider attached to a new contract within ten (10) business days after completing contracting;

b. New Medicaid Enrolled hospital or facility provider attached to a new contract within fifteen (15) business days after completing contracting;

c. New Medicaid Enrolled provider attached to an existing contract within five (5) business days after completing contracting;
d. Changes for a re-enrolled Medicaid Enrolled provider, hospital, or facility attached to an existing contract within five (5) business days after receipt of notification of the change through the Medicaid Enrolled Provider data from the Department;
e. Change in existing contract terms within ten (10) business days of the effective date after the change; and
f. Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) Calendar Days after the PHP receives updated provider information.

o. Section V. D. Providers 2. Provider Network Management l. Provider Directory viii. is revised and restated as follows:

viii. The PHP shall provide the provider directory to NCTracks for inclusion in the Consolidated Provider Directory made available to the Enrollment Broker as described in *Section V. K. Technical Specifications*.

p. Section V.D. Providers 3. Relations and Engagement d. Provider Manual i.e) is revised and restated as follows:

e) Network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, and required availability;

q. Section V.D. Providers 4. Provider Payments e. Hospital Payment (Excluding Behavioral Health Claims) iv. is revised and restated as follows:

iv. The hospital rate floors shall apply for the following defined time periods, after which the PHP will have flexibility to negotiate reimbursement arrangements with the hospitals:
a) The first five (5) contract years for critical access hospitals and hospitals in economically depressed counties as defined as Tier 1 or Tier 2 counties as designated by the North Carolina Department of Commerce for 2019 (https://files.nc.gov/nccommerce/documents/files/2019-Tiers-memo_asPublished.pdf).
b) The first three (3) contract years for all other hospitals.

r. Section V.D. Providers 4. Provider Payments l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. §438.6(c)(1)(iii)(B)) v. is revised and restated as follows:

v. The PHP shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) Business Days of receiving the payment from the State.

s. Section V.D. Providers 4. Provider Payments r. Out of Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services) is revised and restated as follows:

i. With the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, the PHP shall be prohibited from

reimbursing an out of network provider more than ninety (90%) of the Medicaid Fee-for-Service rate if:

a) The PHP has made a good faith effort to contract with a provider but the provider has refused that contract.

ii. The PHP shall develop Good Faith Provider Contracting Policy that includes a description of how the PHP will conclude that a "good faith" contracting effort has been made and/or refused. The PHP shall submit the policy to the Department for review ninety (90) days after Contract Award.

a) The PHP shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.

iii. The PHP shall reimburse an out-of-network provider who is providing services to a Member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee-for-Service rate.

iv. Unless an agreement has been negotiated, the PHP shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee-for-Service rate when the PHP has not made a "good faith" effort to contract with the provider in accordance with the PHP's Good Faith Provider Contracting Policy.

v. The PHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee-for-Service rates specified in State Plan Amendments 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:

a) Are more reasonably available than can be provided by an enrolled in-state provider; or

b) The care and services are provided in any one of the following situations:

1. In response to an Emergency Medical Condition;
2. The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or
3. The health of the Member would be endangered if travel were undertaken to return to North Carolina.

vi. In accordance with 42 C.F.R. § 438.206(b)(5), the PHP shall coordinate payment with the out-of-network provider to ensure that the cost to the Member is no greater than it would be if services were provided within the network.

t. Section V.D. Providers 4. Provider Payments is revised to add the following:

w. The PHP shall monitor the Department website and other Department communication mechanisms daily for changes to the Medicaid Fee-for-Service rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Fee-for-Service rates:

i. The PHP shall make retroactive payment adjustments to the effective date of the Medicaid Fee-for-Service rate change as prescribed by the Department.

ii. The PHP shall implement applicable rate changes within timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable provider.

u. Section V.D. Providers 5. Provider Grievances and Appeals e. Appeals vi.b) is revised and restated as follows:

b) PHP shall include voluminous nature of required evidence/supporting documentation as good-cause reasons to extend the timeframe.

v. Section V.D. Providers 5. Provider Grievances and Appeals f. Resolution of Appeal, i. is revised and restated as follows:

i. The PHP shall establish a committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal.

w. Section V.D. Providers 5. Provider Grievances and Appeals is revised to add the following:

i. The PHP shall not discriminate against or retaliate against any provider based on any action taken by the provider under the Provider Grievances and Appeals Section of the Contract or based on any action taken by the provider on behalf of a Member under the Member Grievances and Appeals Section of the Contract.

x. Section V.E. Quality and Value 2. Value-Based Payments/Alternative Payment Models is revised to add the following:

l. The PHP shall re-submit contract templates to the Department for review at least ninety (90) Calendar Days before use in the market when any new VBP arrangements (excluding to AMHs, which is covered in *Section V.D.4. Provider Payments*), or changes to VBP arrangements, are added.

y. Section V.G. Program Operations 1. Service Lines, c. is revised and restated as follows:

c. PHP shall adhere to the Department's house of operation, location, staffing, Member ID requirements and service line activation date for each service line in accordance with *First Revised and Restated Section V.G. Table 1*.

z. Section V.G. Table 1: Member and Provider Support Call Center Operations is revised and restated stated as follows:

First Revised and Restated Section V.G. Table 1: Member and Provider Support Call Center Operations				
Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
i. Member Service Line	1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch) 2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment

	3. Open all State holidays			
ii. Provider Support Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
iii. Pharmacy Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Prescriber prior authorization services available to meet 24-hour review requirements as defined in Section V. C. 3. Pharmacy Benefits 3. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
iv. Nurse Line	1. Twenty-four (24) hours per day / seven (7) days per week / 365 days per year	No	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
v. Behavioral Health Crisis Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	Yes	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch

aa. Section V.G. Program Operations 5. Business Continuity b. is revised and restated as follows:

b. Within thirty (30) Calendar Days of the Contract Award, the PHP shall submit a detailed description of its Business Continuity Plan for all requirements specified in the Contract. See *Attachment N. Business Continuity Management Program*. The PHP shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following a natural or manmade disaster. The Plan shall meet recognized industry standards for security and disaster recovery requirements. The Plan shall identify disaster situations (e.g., fire, flood, terrorist event, hurricanes/tornadoes), which could result in a major failure. For each identified situation, the PHP shall explain in detail:

i. The preventive measures that would be instituted to minimize the likelihood of its occurrence;

ii. The back-up, off-site storage, and other pre-disaster safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:

a) Descriptions of the controls for back-up processing, including how frequently backups occur;
b) Documented back-up procedures;
c) The location of data that has been backed up (off-site and on-site, as applicable);
d) Identification and description of what is being backed up as part of the back-up plan;
e) Any change in back-up procedures in relation to the PHP's technology changes;
f) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated;

iii. Identify and review all federal or state disaster declarations made in North Carolina or affecting North Carolina in the last five (5) years as part of the PHP's business continuity planning;
iv. The tasks that would be involved, and identify by job description or title the PHP's staff and the Department's staff involvement;
v. Current contact information for all critical staff and relevant personnel and notification procedures (i.e. call tree);
vi. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternative worksite locations;
vii. The time-frame required to accomplish full recovery from the point of interruption;
viii. A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
ix. The procedures for coordinating with the Department in the event of a disaster;
x. Employee training and awareness detailing activation process;
xi. Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results;
xii. Incorporation of the Department best-practices from disaster response including:
    a) Increasing care management for medically fragile enrollees to include high risk enrollees (e.g., high risk pregnant women, dialysis patients, medically frail, hemophiliacs, long term care population) during an emergency/disaster
        1. Pre-Emergency:
            i. Incorporate disaster planning in the care planning process; and
            ii. Increase member outreach to ensure that adequate shelter, access to back-up equipment and/or caretaker training if equipment fails or arrange NEMT for evacuation if the member is unable to safely shelter in place.
        2. During an Emergency:
            i. Continue to check-in on high risk members to ensure safety;
            ii. Arrange for NEMT to evacuate if needed;
            iii. Offer extended service line hours with staff available and trained to answer and triage calls, including emergency-related queries; and
            iv. Reduce barriers to care during a disaster, as directed by the Department, to:
                a. Remove and/or reduce required prior authorizations,

b. All member access to out-of-network and telehealth providers, and
c. Increase member access to medications through maximum dosage limits and continued access to required medication including medication assisted treatment (MAT), anti-psychotics, and insulin.

3. Post-Emergency:
   i. Follow up with high risk members to ensure safety and identify additional needs; and
   ii. Offer extended service line hours with staff available and trained to answer and triage calls, including emergency-related queries.

b) Supporting the Department's priorities for state-wide and local disaster planning, including:
   1. Participation in the development of community disaster emergency response plans;
   2. Collaboration with the other Department vendors to align efforts, as needed;
   3. Appointment of at least one representative to the statewide disaster response panel; and
   4. Recruitment and training for in-network behavioral health providers to staff local disaster shelters; and

xiii. The procedures for notifying the Department, Enrollment Broker, Members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.

bb. Section V.l. Financial Requirements 3. Financial Management g. Financial accounting and audit i. is revised and restated as follows:

i. The PHP's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and this Contract. The Department will not recognize or pay services that cannot be properly substantiated by the PHP and verified by the Department. The PHP shall:
   a) Maintain accounting records for this Contract separate and apart from other corporate accounting records;
   b) Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
   c) Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the PHP. The PHP must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the PHP; and
   d) Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.

cc. Section V.J Compliance 1. Compliance Program c.iv.b) is revised and restated as follows:

b) In Contract Year 1, the report shall be submitted ninety (90) days prior to Medicaid Managed Care launch.

dd. Section V.J Compliance 3. Fraud, Waste, and Abuse Prevention, b.ii. is revised and restated as follows:

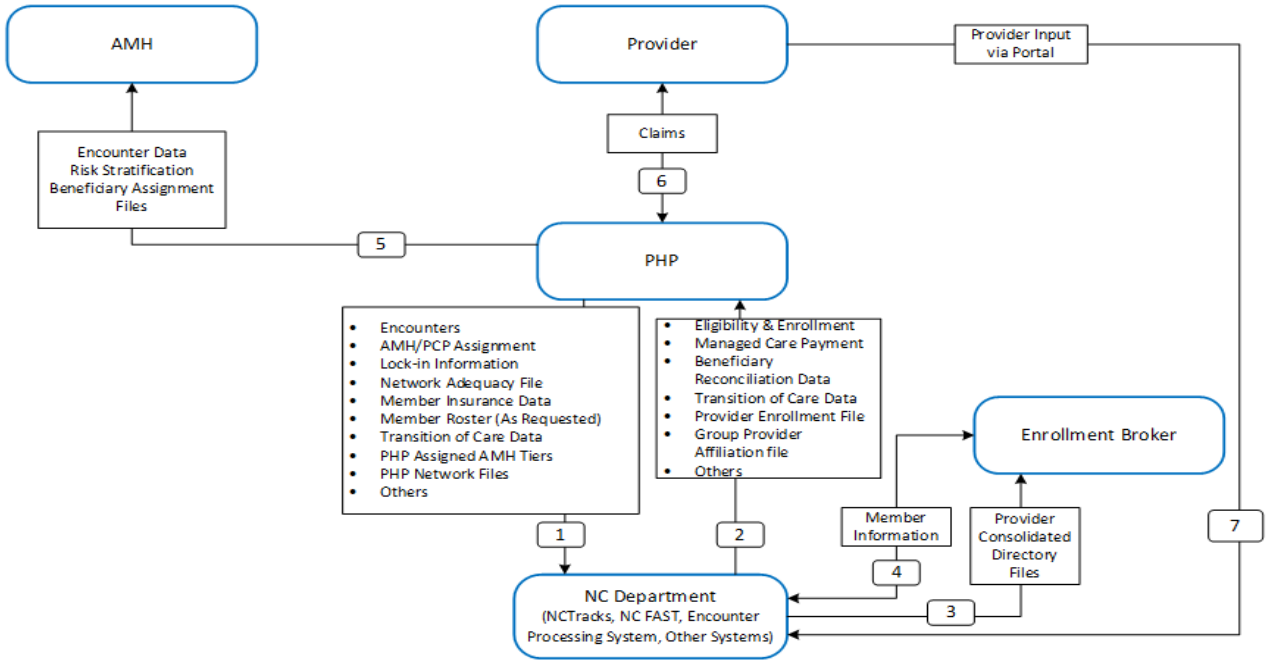
ii. The PHP shall establish a Special Investigations Unit (SIU) sixty (60) Calendar Days prior to Medicaid Managed Care launch, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan. The PHP shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.

a) The SIU will consist of at least one (1) dedicated staff member who is located in North Carolina.
b) The PHP's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
c) The PHP shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management or pre-law, or have at least three (3) years of relevant experience.
d) The PHP shall require that the members of its SIU, as well as its Chief Compliance Officer, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training.

ee. Section V. K. Technical Specifications 1. Data Exchange Model is revised and restated as follows:

a. The following First Revised and Restated Diagram and Accompanying Matrix provides a point in time, high-level view of the primary data exchanges associated with the PHP, the Department, and Department Vendors. As the program evolves and technical designs are finalized the data exchanges depicted below will change. The PHP will be responsible for implementing the data exchanges as defined by the Department.
b. The Department anticipates changes to its Information Technology Systems. The PHP will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file). The Department will provide test environments to allow adequate testing time.

First Revised and Restated Diagram and Accompanying Matrix



No.	First Revised and Restated Data Exchange Description – For Informational Purposes
1	The PHP will send the Department or its Vendors the following data: a) Encounter Data – Medical and pharmacy encounter data b) AMH/PCP Assignment – The PHP will submit to the Department the Member's assigned AMH/PCP c) Lock-in Data – Member lock-in data (including pharmacy and prescriber) d) Provider Network Data File e) PHP Network File f) Member Insurance Data g) Member Enrollment – On request the PHP will send the Department its current, complete roster of Medicaid Managed Care Members h) PHP Assigned AMH Tiers – The Provider and updated AMH Tier assignment anytime the PHP changes the Provider Attested AMH tier including the reason for the change
2	The Department will send the PHP the following data: a) Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records b) Managed Care Payments c) Member Reconciliation Date – The Department will send weekly 834 files to be used by the PHP for reconciliation purposes d) The Department will send a daily provider enrollment file e) The Department will send a daily affiliation file with provider data

3	The Department will send the Enrollment Broker the following data: a) The Department will send the Enrollment Broker a full list of all active and enrolled providers, including the Medicaid and Health Choice provider roster for inclusion in the Provider Directory. b) The Department will send the Enrollment Broker the provider affiliation file that includes all group practices and their affiliated doctors for a given location for the organization. c) The Department will send to the Enrollment Broker the PHP and Tribal Option network providers.
4	Real-time webservices between NC FAST and EB will be used to share beneficiary data from NC FAST to the EB and will also be used for the EB to send member PHP and PCP/AMH selections through that interface back to NC FAST.
5	The PHP will send the following data to the AMH's: a) Member Assignments; b) Encounter / Claims Data c) Member Risk Stratification Data
6	The PHP and the Provider will exchange the following data: a) Claims Data – the contracted Providers will send claims data for payment to the PHP. b) Payment Data – The PHP will send payments to the provider.
7	The Provider enrolls in Medicaid and maintains provider data via the NCTracks Provider Portal

ff. Section V. K. Technical Specifications 5. Provider Directory is revised and restated as follows:

a. The PHP shall develop a Provider Directory in accordance with *Section D. 2 Provider Network Management*. NCTracks is responsible for integrating the Provider Directory information to supply with a Consolidated Provider Directory to support PHP choice counseling and selection.
   i. The PHP should use the National Provider Identifier (NPI) issued by NPPES plus the NCTracks assigned Service Location Code as the unique provider identifier. For those providers who do not qualify for NPI's, the Atypical Provider ID issued by NC DHHS' NCTracks system should be used.

b. Consolidated Provider Directory Data Transmissions
   i. The Department has appointed NCTracks with the creation of a Consolidated Provider Directory which will include all Managed Care and Medicaid Fee for Service providers.
   ii. The PHP will, at a frequency defined by the Department, create a full provider directory file including data (as defined in the Contract) on all contracted providers in their network. The PHP will deliver the file to NCTracks based on technical process.
   iii. The final file format will be determined by NCTracks or the Department's PDM; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).
   iv. The transport will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).
   v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the selected Enrollment Broker or NCTracks.

3. Modifications to Section VI. Contract Performance.

Specific subsections are modified as stated herein.

a. Section VI.A. Contract Violations and Noncompliance e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages v. Liquidated Damages, Section VI.A. Table 1: PHP Liquidated Damages is revised and restated as follows:

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
Administration and Management		
1.	Failure to meet plan readiness review deadlines as set by the Department.	$5,000 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section V.A.9. Staffing and Facilities* and *Attachment O.10. Disclosure of Conflicts of Interest.*	$10,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by At*tachment O.9. Disclosure of Litigation and Criminal Conviction.*	$1,000 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Attachment O.11. Disclosure of Ownership Interest*.	$2,500 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
Members		
5.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section V.B.4. Marketing*	$5,000 per occurrence
6.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section V.B.2. Medicaid Managed Care Enrolment and Disenrollment.*	$500 per occurrence per Member

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
7.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section V.B.3. Member Engagement.*	$250 per occurrence per Member
8.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.6. Member Grievances and Appeals.*	$500 per occurrence
9.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$5,000 per occurrence
10.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND $500 per Calendar Day for each day the PHP fails to provide continuation or restoration as required by the Department.
11.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.6. Member Grievances and Appeals.*	$1,000 for each mediation or hearing that the PHP fails to attend as required
Benefits and Care Management		
12.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	$5,000 per occurrence per Member
13.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$5,000 per standard authorization request $7,500 per expedited authorization request
14.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified Section *V.D.1. Provider Network.*	$1,000 per occurrence

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
15.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$2,500 per occurrence
16.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.C.3. Pharmacy Benefits.*	$2,500 per Calendar Day per occurrence
17.	Failure to comply with Transition of Care requirements as specified *Section V.C.4. Transition of Care.*	$100 per Calendar Day, per Member AND The value of the services the PHP failed to cover during the applicable transition of care period, as determined by the Department.
18.	Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified *Section V.C.5. Non-Emergency Transportation.*	$500 per occurrence per Member
19.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	$1,500 per occurrence per driver
20.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	$250 per occurrence per Member
21.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	$1,500 per Calendar Day per vehicle
22.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	$250 per Calendar Day
23.	Failure to develop a Care Plan for a Member that includes all required elements as described in the *Section V.C.6. Care Management* (including a failure by a designated care management subcontractor to comply).	$500 per deficient/missing plan
24.	Failure to complete a Comprehensive Assessment, including reassessments, within the timeframes specified in *Section V.C.6. Care Management.*	$100 per Calendar Day per Member
		$500 per Calendar Day per High-Risk Pregnant woman
		$500 per Calendar Day per At-Risk child

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
25.	Failure to develop a Care Plan for each Member with LTSS needs in accordance with *Section V.C.6. Care Management.*	$1,000 per occurrence per Member
26.	Failure to comply with minimum Transitional Care Management requirements as described in *Section V.C.6. Care Management.*	$250 per occurrence per Member
27.	Failure to timely notify the Department that the PHP lowered a provider's AMH Tier status.	$500 per Calendar Day per occurrence
28.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with a LHD.	$500 per Calendar Day
29.	Failure to implement and maintain an Opioid Misuse Prevention Program and Member Lock-In Program as described in *Section V.C.7. Prevention and Population Health Management Program.*	$2,000 per Calendar Day for each day the Department determines the PHP is not in compliance
Providers		
30.	Failure to update online and printed provider directory as required by *Section V.D.2. Provider Network Management.*	$1,000 per occurrence
31.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by *Section V.D.2. Provider Network Management.*	$100 per Calendar Day per Member for failure to timely notify the affected Member
32.	Failure to follow the Quality Determination process established by the PHP's Credentialing and Re-Credentialing Policy.	$2,000 per occurrence per provider
33.	Failure to complete a decision to contract with a provider within forty-five (45) Calendar Days of receipt of complete Medicaid Enrolled Provider data from the Department or the Department's vendor by the Provider Network Participation Committee.	$50 per Calendar Day per provider

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
34.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in *Section V.D.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$2,500 per month for failure to meet any of the listed standards, either individually or in combination
35.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	$250 per Calendar Day
36.	Failure to maintain accurate provider directory information as required by *Section V.D.2. Provider Network Management.*	$100 per confirmed incident
37.	Failure to timely provide notice to the Department of capacity to serve the PHP's expected enrollment as described in *Section V.D.1. Provider Network.*	$2,500 per Calendar Day
Quality and Value		
38.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.E.1. Quality Management and Quality Improvement.*	$5,000 per Calendar Day
39.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per Calendar Day
40.	Failure to timely submit QAPI to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per Calendar Day
41.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.3. National Committee for Quality Assurance (NCQA) Association.*	$100,000 per month for every month beyond the month NCQA accreditation must be obtained
Claims and Encounter Management		
42.	Failure to timely submit monthly encounter data set certification.	$1,000 per Calendar Day

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
Financial Requirements		
43.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Attachment J: Reporting Requirements.*	$2,000 per Calendar Day
44.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section V.I.2 Medical Loss Ratio* and *Attachment J. Reporting Requirements.*	$2,000 per Calendar Day
45.	Failure to timely and accurately submit financial reports in accordance with *Attachment J: Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per Calendar Day
Compliance		
46.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.J.3. Fraud, Waste and Abuse Prevention.*	$5,000 per Calendar Day that the Department determines the PHP is not in compliance
47.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.J.1. Compliance Program* and *Attachment J: Reporting Requirements.*	$1,000 per Calendar Day
48.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.J.4. Third Party Liability* and *Attachment J: Reporting Requirements*	$250 per Calendar Day
49.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$2,500 per incident for failure to fully cooperate during an investigation
50.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	$250 per Calendar Day

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
51.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.J.3. Fraud, Waste and Abuse Prevention* and *Attachment J: Reporting Requirements.*	$2,000 per Calendar Day
Technical Specifications		
52.	Failure by the PHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$500 per Member per occurrence per AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PHP's failure to comply with the terms of this Contract, the PHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
53.	Failure by the PHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$500 per Member per occurrence
54.	Failure by the PHP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500 per Member per occurrence, not to exceed $10,000,000
Directives and Deliverables		
55.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$500 per Calendar Day that the Department determines the PHP is not in compliance
56.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$1,000 per occurrence per committee that the Department determines the PHP is not in compliance

First Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
57.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$500 per Calendar Day the unapproved agreement or materials are in use
58.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$1,500 per occurrence per plan/program that the Department determines the PHP is not in compliance
59.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	$500 per Calendar Day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action

The Remainder of this page is intentionally left blank.

b. Section VI.A. Table 2: PHP Service Level Agreement is revised and restated as follows:

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Daily	$1,000 per occurrence
Member Grievances and Appeals					
2.	Member Appeals Resolution - Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
3.	Member Appeals Resolution - Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$5,000 per month
Pharmacy Benefits					
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
Service Lines					
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
7.	Call Response Time/Call Answer Timeliness - Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
8.	Call Wait/Hold Times - Member Services line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
9.	Call Abandonment Rate – Member Services line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
10.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-eight percent (98%) of all incoming calls.	The time after the initial answer to an incoming call and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$15,000 per month

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
12.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
13.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$10,000 per month
14.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
16.	Call Response Time/Call Answer Timeliness - Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$5,000 per month
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month
19.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
20.	Call Wait/Hold Times - Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
21.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
Encounters					
22.	Encounter Data Timeliness/ Completeness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per claim per Calendar Day
23.	Encounter Data Timeliness/ Completeness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	$100 per claim per Calendar Day

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$50,000 per week
26.	Encounter Data Reconciliation - Pharmacy	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Daily	$1,000 per day
27.	Encounter Data Reconciliation - Medical	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Daily	$1,000 per day

First Revised and Restated Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
Website Functionality					
28.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	$2,500 per occurrence
29.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month
30.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence (each communication outside of the standard for the month)

c. Section VI.C. Withholds, paragraph 3. is revised and restated as follows:

3. The withhold program will be effective eighteen (18) months following the date of Medicaid Managed Care launch, or at a later date as determined by the Department.

4. **Modifications to Section VII. Attachments A - N**

   Specific attachments and subsections are modified as stated herein.

   a. **Section VII. Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards is revised and restated in its entirety as set forth in** Attachment 1: *Attachment F. First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards,* to this Amendment.

   b. **Section VII. Attachment H. First Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers is revised and restated in its entirety as set forth in** Attachment 2: *Attachment H. Second Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers*. Medicaid Managed Care Addendum for Indian Health Care Providers, to this Amendment.

   c. **Section VII. Attachment I. Provider Appeals is revised and restated in its entirety as set forth in** Attachment 3**:** *Attachment I. First Revised and Restated Provider Appeals*, to this Amendment.

   d. **Section VII. Attachment K. Risk-Level Matrix is revised and restated in its entirety as set forth in** Attachment 4**:** *Attachment K. First Revised and Restated Risk-Level Matrix*, to this Amendment.

5. **Modifications Section VIII. Attachment O.7. Contractor's Contract Administrators**
   Section VIII. Attachment O.7. Contractor's Contract Administrators is revised and restated in its entirety as set forth in Attachment 5: *Attachment O.7. First Revised and Restated Contractor's Contract Administrators*, to this Amendment.

6. **Effective Date:** This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

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

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Execution:

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

PHP Name

_____ Date: _____

PHP Authorized Signature

Department of Health and Human Services

_____ Date: _____

Dave Richard
Deputy Secretary
NC Medicaid

Attachments

Attachment 1: *Attachment F. First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards*

Attachment 2: *Attachment H. Second Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers*

Attachment 3: *Attachment I. First Revised and Restated Provider Appeals*

Attachment 4: *Attachment K. First Revised and Restated Risk-Level Matrix*

Attachment 5: *Attachment O.7. First Revised and Restated Contractor's Contract Administrators*

Attachment 1:

Attachment F: First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards

At a minimum, Offeror's network shall consist of hospitals, physicians, advanced practice nurses, SUD and behavioral health treatment providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in Section V.D.1. Provider Network.

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

More information is available at: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf. The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all members have timely access to all covered health care services, Offeror shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Certain service types are not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

For purposes of network adequacy standards, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.

Section VII. Attachment F. First Revised and Restated Table 1: PHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members

Section VII. Attachment F. First Revised and Restated Table 1: PHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
5	Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
7	Outpatient Behavioral Health Services	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members
8	Location-Based Services (Behavioral Health)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
9	Crisis Services (Behavioral Health)	≥ 1 provider of each crisis service within each PHP Region	
10	Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP Region	
11	Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of Members

[1] *Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included to satisfy OB access requirements.*

Section VII. Attachment F. First Revised and Restated Table 1: PHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
12	All State Plan LTSS (except nursing facilities)*	PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
13	Nursing Facilities*	PHP must have at least 1 nursing facility accepting new patients in every county.	PHP must have at least 1 nursing facility accepting new patients in every county.

The PHP is required to use the definitions of service categories for Behavioral Health time/distance standards found in behavioral health service types in *Section VII. Attachment F. First Revised and Restated Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. First Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards*.

Section VII. Attachment F. First Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children)
2.	Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (adult)

Section VII. F. Table 2: Definition of Service Category for Behavioral Health Time and Distance Standards		
Reference Number	**Service Type**	**Definition**
3.	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based program (adult • Facility-based crisis services for children and adolescents • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center(ADATC) detoxification crisis stabilization (adult)
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

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

Section VII. Attachment F. First Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) Calendar days for Member less than six (6) months of age Within thirty (30) Calendar days for Members six (6) months or age and older.
2	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar days

4	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. Attachment F. First Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar days
Specialty Care			
6	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar days
8	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Behavioral Health Care			
9	Mobile Crisis Management Services	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within two (2) hours
10	Urgent Care Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours

Section VII. Attachment F. First Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
11	Urgent Care Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
13	Routine Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
14	Emergency Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
15	Emergency Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

The PHP is required to use the following provider types as "specialty care" providers for purposes of *Section VII. Attachment F. Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. First Revised and Restated Table 3: PHP Appointment Wait Time Standards* as found in this attachment:

Section VII. Attachment F. First Revised and Restated Table 4: Specialty Care Providers	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery

Section VII. Attachment F. First Revised and Restated Table 4: Specialty Care Providers	
Reference Number	**Service Type**
8a.	Gynecology[1]
9.	Infectious Disease
10.	Hematology
11.	Nephrology
12.	Neurology
13.	Oncology

[1] Measured on members who are female and age 14 or older

14.	Ophthalmology
15.	Optometry
16.	Orthopedic Surgery
17.	Pain Management (Board Certified)
18.	Psychiatry
19.	Pulmonology
20.	Radiology
21.	Rheumatology
22.	Urology

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Attachment 2:

Attachment H. Second Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Plan") and_____(herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.[2]

2. Definitions.

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

(a) "Indian" means any individual defined at 25 U.S.C. § 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. §136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

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

(b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

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

(c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. § 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

(f) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

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

- ☐ *IHS.*
- ☐ *An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.*
- ☐ *A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§450 et seq.*
- ☐ *A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).*
- ☐ *An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.*

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

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

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. § 1396o-(j)), 42 C.F.R. §§ 447.56 and 457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR §§ 438.14((b)(3) and 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR §§ 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

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

9. Non-Taxable Entity.

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

10. Insurance and Indemnification.

(a) **Indian Health Service.** The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) **Indian Tribes and Tribal Organizations.** A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) **Urban Indian Organizations.** A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

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

a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

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

13. Governing Law.
The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.
Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.
To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).

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

16. Payment of Claims.
The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. §§ 438.14(c)(2) and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

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

APPROVALS

For the Managed Care Plan:	**For the IHCP:**
Date: _____	*Date:* _____
_____	_____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS that is an IHCP:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

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

(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

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

Attachment 3:

Attachment I. First Revised and Restated Provider Appeals

The following are the reasons for which the PHP must allow a provider to appeal an adverse decision made by the PHP. The PHP shall provide an appeals process to providers in accordance with *Section V.D.5. Provider Grievances and Appeals*.

Section VII. Attachment I. First Revised and Restated Table 1: Provider Appeals	
Reference Number	**Appeal Criteria**
For Network Providers	
1	A network provider has the right to appeal certain actions taken by the PHP. Appeals to the PHP shall be available to a network provider for the following reasons: a) Program Integrity related findings or activities; b) Finding of fraud, waste, or abuse by the PHP; c) Finding of or recovery of an overpayment by the PHP; d) Withhold or suspension of a payment related to fraud, waste, or abuse concerns; e) Termination of, or determination not to renew, an existing contract for LHD care/case management services; f) Determination to lower an AMH provider's Tier Status; and g) Violation of terms between the PHP and provider.
For Out-of-network Providers	
2	An out-of-network provider may appeal certain actions taken by the PHP. Appeals to the PHP shall be available to an out-of-network provider for the following reasons: a) An out-of-network payment arrangement; b) Finding of waste or abuse by the PHP; and c) Finding of or recovery of an overpayment by the PHP.

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Attachment 4:

Attachment K. First Revised and Restated Risk Level Matrix

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

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

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

Section VII. Attachment K. First Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or the integrity of Medicaid Managed Care	Failure to substantially provide medically necessary covered services Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract Imposing on Members premiums or cost-sharing that are in excess of that permitted by the Department Failure to substantially meet minimum care management and care coordination requirements Failure to substantially meet minimum Transition of Care Policy requirements Failure to substantially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception) Denying coverage for out-of-network care when no reasonable access to an in-network provider is available Continuing failure to resolve Member and provider appeals and grievances within specified timeframes

Section VII. Attachment K. First Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to maintain PHP license in good standing with DOI Failure to timely submit accurate and/or complete encounter data in the required file format Misrepresenting or falsifying information that it furnishes to CMS or to the Department Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation Failure to substantially comply with the claims processing requirements and standards Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) Failure to substantially comply with the Preferred Drug List requirements Failure to timely fulfil commitment to participate as a Qualified Health Plan (QHP) on the Federally Facilitated Marketplace in the individual health insurance market in North Carolina in QHP Plan Year 2022 as specified in *Section V.A.10. Marketplace Participation*. Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation One or more Level 2 violations within a Contract year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize Member(s) health, safety, and welfare or access to care	Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract Failure to comply with established rate floors and fee schedules as required under the Contract Failure to make additional directed payments to certain providers as required under the Contract EQRO or other program audit reports with substantial findings Failure to comply with Member services requirements (including hours of operation, call center, and online portal)

Section VII. Attachment K. First Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to maintain the privacy and/or security of data containing protected health information (PII) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PII Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation Two or more Level 3 violations within a Contract year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program	Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) Failure to notify the Department and Members of terminated network providers within required timeframes Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) Using unapproved Member notices, educational materials, and handbooks and marketing materials Engaging in prohibited marketing activities and practices Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation Three or more Level 4 violations within a Contract year
LEVEL 4	Submission of a late, incorrect, or incomplete report or Deliverable (excludes encounter data and other financial reports)

Section VII. Attachment K. First Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
Action(s) or inaction(s) that inhibit the efficient operation the managed care program	Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation Failure to comply with time frames for distributing (or providing access to) Member handbooks, identification cards, provider directories, and educational materials to Members (or potential Members) Failure to meet minimum requirements requiring coordination and cooperation with external entities EQRO or other program audit reports with non-substantia findings Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements) Failure to timely furnish a policy, handbook, directory, or manual upon request by a Member or potential Member as required under the Contract

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Attachment 5:

Attachment O. 7. First Revised and Restated Contractor's Contract Administrators

7. First Revised and Restated Contractor's Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

Contract Administrator regarding day to day activities herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	