Amendment Number 11 (12)
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 X. Third Revised and Restated Summary of Contractual Payments and Risk Sharing Terms.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

a. Section III.A. Definitions is revised to add newly defined terms:

i. **Indian Health Care Plan (IHCP)** - An IHCP is a provider of service which includes all services that Cherokee Indian Hospital Authority or the Eastern Band of Cherokee Indians offer under Medicaid. They can be any Federally Recognized Tribal or Indian Health Services provider in or out of state.

ii. **Indian Managed Care Entity (IMCE)** - The IMCE is referred to as the Tribal Option in North Carolina. It provides care management for all members enrolled in Tribal Option and is separate from the Indian Health Care Plans.

b. Section III. B. Acronyms is revised to add the following new acronyms:

i. CMARC: Care Management for At-Risk Children
ii. CME: Child Medical Evaluation
iii. CMEP: Child Medical Evaluation Program
iv. CMHRP: Care Management for High-Risk Pregnancies

c. Section III.C. Terms and Conditions 11. Contract Administrators for the Department are revised and restated as follows:

For the Department

Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick Associate Director, Managed Care Contracting
Address 1 Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7015
Fax Number	919-832-0225
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

Contract Administrator regarding day to day activities herein:

Name & Title	Cassandra McFadden Deputy Director of Standard Plans
Address 1 Physical Address	820 S. Boylan Avenue McBryde Building Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7040
Fax Number	919-832-0225
Email Address	Cassandra.McFadden@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

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

Name & Title	Pyreddy Reddy DHHS CISO
Address 1	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

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

Name & Title	Ryan Eppenberger Privacy Officer
Physical Address	1700 Umstead Drive Raleigh, NC 27603
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7700
Email Address	Ryan.Eppenberger@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

d. Section III.D. Terms and Conditions 32. PAYMENT AND REIMBURSEMENT, l. COVID-19 Vaccination Incentive Program is revised and restated as follows:

l. COVID-19 Vaccination Incentive Program:

i. **Incentive Program for Members**

a. The Department will make payments to the Contractor for fifty percent (50%) of expenditures on the COVID-19 Vaccination Member Incentive Program up to one million dollars ($1,000,000) through December 31, 2022.

1. The PHP shall limit Member Incentives to no more than two hundred dollars ($200) per Member through December 31, 2022.
2. The Department will provide reimbursement for the administration and payment of incentives in the Contractor's COVID-19 Vaccination Member Incentive Program. The Department will limit reimbursement to the Contractor for the administration of the COVID-19 Vaccination Member Incentive Program to no more than twenty percent (20%) of the total payments to the Contractor.

b. The Department will make payment to the Contractor sixty (60) Calendar Days after receipt of a complete COVID-19 Member Incentive Program Expenditure Report for the duration of the program through December 31, 2022.

ii. **Incentive Program for PHPs**

a. The Department will establish a COVID-19 Vaccination Incentive Program.

b. As provided in *Section V.I.7. COVID-19 Vaccination Incentive Program Payments*, the Contractor will be eligible to receive a separate incentive payment for each Member over the age of five (5) who becomes fully vaccinated for COVID-19 after the Gating Target is met. Fully vaccinated shall be defined as receiving one (1) Johnson & Johnson shot; two (2) Moderna, or two (2) Pfizer shots. Payment will be made after the Contractor meets the Department's defined Gating Target.

1. In order to be eligible for the COVID-19 Vaccination Incentive Program, all Prepaid Health Plans awarded a Standard Plan Contract, must meet a Gating Target, 30% of all Standard Plan Members over five (5) years old must be fully vaccinated based on the North Carolina Immunization Registry (NCIR).

e. Section III. D. Terms and Conditions is revised to add the following:

51. Substance Use Data (42 C.F.R. Part 2): Contractor is fully bound by the provisions of 42 C.F.R. Part 2 upon receipt of data from DHB that includes Patient Identifying Information (PII) regarding substance use disorder, as those terms are defined by 42 C.F.R. § 2.11. Contractor shall implement appropriate safeguards to prevent the unauthorized uses and disclosures of data protected under 42 C.F.R. Part 2. Contractor shall report any unauthorized uses, disclosures, or breaches of data subject to this term and condition, to the Contract Administrators for DHB within three (3) Business Days of the unauthorized use, disclosure, or breach. This notice is in addition to any other notice requirement regarding unauthorized disclosure of PII or PHI required by the Contract. Information disclosed to Contractor is limited to that which is necessary for the Contractor to perform its duties under the Contract. Contractor shall not re-disclose information to a third party unless that third party is a contract agent of the Contractor or Subcontractor,

helping to provide services described in the contract and only if the subcontractor only further discloses the information back to the contractor or lawful holder from which the information originated.

2. <u>Modifications to Section V. Scope of Services</u>

Specific subsections are modified as stated herein.

a. Section V.A. Administration and Management, 1. Program Administration, h. is revised and restated as follows:

h. Compliance with Department Policies
   i. The PHP shall comply with Department policies as identified and required by the Department, including the following:
      a) Medicaid Managed Care Enrollment Policy
      b) Department Clinical Coverage Policies;
      c) Transition of Care Policy;
      d) Care Management Policy;
      e) Advanced Medical Home Program Policy;
      f) Care Management for High-Risk Pregnancy Policy;
      g) Care Management for At-Risk Children Policy;
      h) Management of Inborn Errors of Metabolism Policy;
      i) Uniform Credentialing and Recredentialing Policy;
      j) NC Non-Emergency Medical Transportation Managed Care Policy;
      k) Advanced Medical Home Provider Manual;
      l) Healthy Opportunities Pilot Care Management Protocol;
      m) Healthy Opportunities Pilot Payment Protocol;
      n) Healthy Opportunities Pilot Transitions of Care Protocol;
      o) Healthy Opportunities Standard Plan Implementation Period Incentive Payments Milestone Guide, and
      p) Managed Care Clinical Supplemental Guidance.

b. Section V.A. Administration and Management, 3. National Committee for Quality Assurance (NCQA) Accreditation, a-b. is revised and restated as follows:

a. The PHP shall achieve accreditation by NCQA by the end of Contract Year 4.
b. The PHP shall achieve NCQA LTSS Distinction by the end of Contract year 4.

c. Section V.A. Administration and Management, 8. Advance Directives, f. is revised and restated as follows:

f. The PHP shall provide adult Members with written information on advance directives policies, and include a description of applicable state law. 42 C.F.R. § 438.3(j)(3). Written information shall include the following:
   i. Member's rights under State law;
   ii. PHP policies with respect to the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives;
   iii. Information on the advance directive policies of the PHP;

iv. Each Member's right to file a grievance with the State Certification and Survey Agency for fully licensed services and the PHP for unlicensed services concerning any alleged noncompliance with laws pertaining to advance directives.
v. Each Member has the right to file a grievance with other applicable agencies such as advocacy agencies, licensing boards, etc; and
vi. Option to register his or her advance directive with the North Carolina Secretary of State's Office so the advance directive can be retrievable by medical professionals.

d. Section V.B. Members, 6. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements, ii. is revised and restated as follows:

ii. The PHP shall, while adhering to the Utilization Management Program, employ strategies to resolve grievance and appeals at the lowest level of escalation that meets a Member's needs and in a manner that does not discourage Members from exercising their rights.

e. Section V.B. Members, 6. Member Grievance and Appeals, c. Member Grievance Process, v. is revised and restated as follows:

v. The PHP shall use the Department developed Notice of Acknowledgment of Receipt of Grievance template to notify the Member of receipt of the grievance.

f. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, ii. is revised and restated as follows:

ii. Each Notice of Adverse Benefit Determination shall conform with 42 C.F.R. § 431.210, contain and explain:
a) The Adverse Benefit Determination the PHP has made or intends to make. 42 C.F.R. § 438.404(b)(1);
b) The reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);
c) The Member's right to file an Appeal, including information on exhausting the PHP's one (1) level of appeal and the right to request a State Fair Hearing if the Adverse Benefit Determination is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);
d) Procedures for exercising Member's rights to file a grievance or appeal. 42 C.F.R. § 438.404(b)(4);
e) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
f) The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).

g. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, iii. is revised and restated as follows:

iii. The PHP shall use the Department developed template for the Notice of Adverse Benefit Determination.

h. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, v. Timing of the Notice of Adverse Benefit Determination, b) is revised and restated as follows:

b) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PHP shall provide written notice as expeditiously as possible and no later than five (5) calendar days before the date of the Adverse Benefit Determination takes effect if:

1. The PHP has facts indicating that action should be taken because of probable fraud by the Member; and
2. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).

i. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, vii. Expedited Resolution of Plan Appeals, d) is revised and restated as follows:

d) In accordance with N.C. Gen. Stat. § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited requests made by a network provider acting as an authorized representative of a Member on behalf of a Member, the PHP shall presume an expedited appeal resolution is necessary. The PHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).

j. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, b. is revised to add the following:

viii. Not impose aggregate lifetime dollar limits or annual dollar limits, as defined in 42 C.F.R. § 438.900, on the total amount of benefits that may be paid under the PHP.

k. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered Services is revised to add the following:

v. The PHP shall adhere to the Department's Managed Care Clinical Supplemental Guidance, which references requirements for clinical coverage which supplement NC Medicaid and NC Health Choice clinical coverage policies.

l. Section V.C. Table 4: Required Clinical Coverage Policies is revised and restated as follows:

Second Revised and Restated Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	**SCOPE**
Obstetrics and Gynecology	1E-7: Family Planning Services
Physician	1A-23: Physician Fluoride Varnish Services 1A-36: Implantable Bone Conduction Hearing Aids (BAHA) 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair 13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	As defined in *Section V.C.3. Pharmacy Benefits*

m. Section V.C. Table 5: Medicaid Managed Care Cost Sharing is revised and restated as follows:

First Revised and Restated Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	**ANNUAL ENROLLMENT FEE**	**SERVICE**	**COPAY**
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency Visit in Hospital ER	$4/visit $4/visit $4/visit $4/prescription $4/visit $4/visit $4/visit $4/visit
North Carolina Health Choice (NCHC)			
NCHC beneficiaries with family income is less than 159% FPL	None	Office visits Generic Prescription Brand Prescription when no generic available Brand prescription when generic available Over-the-counter medications Non-emergency emergency room visits	$0/visit $1/script $1/prescription $3/prescription $1/prescription $10/visit

First Revised and Restated Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	**ANNUAL ENROLLMENT FEE**	**SERVICE**	**COPAY**
NCHC beneficiaries with family income greater than 159% and less than 211% FPL	$50 per child or $100 maximum for two or more children	Office visit Outpatient hospital Generic Prescription copay Brand Prescription (when no generic available) Brand prescription (when generic available) Over-the-counter medications Non-emergency emergency room visits	$5/visit $5/visit $1/prescription $1/prescription $10/prescription $1/prescription $25/visit

n. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, is revised to add the following:

n. Hysterectomy Statement and Sterilization Consent

i. The PHP shall provide hospitals the ability to check the status of the hysterectomy statement and sterilization consent forms online.

ii. The PHP shall provide the capability to capture the NPI of the facility where a sterilization procedure was performed and to display that information in the consent form record for the Member.

iii. The PHP shall provide the web-based capability for the rendering provider and service facility provider, including providers associated with the facility, to inquire on the status of the consent by searching with the NPI and Member Medicaid ID.

iv. The PHP shall provide an operational timeline to the Department for review and approval on how the PHP will meet the requirements of this section no later than September 1, 2022.

o. Section. V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs is revised and restated as follows:

ii. Ingredient Costs

a) The PHP shall reimburse pharmacies ingredient costs at the same rate at the Medicaid and NC Health Choice Fee-for-Service rate.

b) The PHP shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.

c) Beginning in 2026 and subject to Department review and approval, the PHP may develop its own pharmacy contracting for ingredient reimbursement if the PHP can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the PHP must also submit a pharmacy network access monitoring plan.

d) The PHP shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the PHP.

e) Reimbursement Inquiries. The PHP shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.

f) Ingredient Costs for Non-340B

1. The PHP shall reimburse pharmacy ingredient costs using the same reimbursement methodologies as defined in the State Plan and applied to Medicaid and NC Health Choice Fee-for-Service programs.
    i. Fee-for-Service rates are based on the National Average Drug Acquisition Cost (NADAC). If there is no NADAC, the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), or other financial arrangements established by the Department, as defined in the State Plan.
    ii. For traditional ingredient costs, reimbursement is based on the lesser of logic methodology, such that the pharmacy is reimbursed at the lesser of usual and customary (U&C), gross amount due (GAD) or the calculated allowed amount derived from NADAC, plus a professional dispensing fee. If not NADAC, then the lesser of WAC or SMAC (plus a professional dispensing fee), U&C or GAD.
2. Non-340B hemophilia drugs shall be reimbursed by the PHP based on the Hemophilia reimbursement methodology defined in the State Plan.
    i. Under the State Plan non-340B hemophilia drugs are reimbursed at the lesser of the following:
        a. Non-340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee;
        b. Providers' usual and customary charge reported in the usual and customary Charge (U&C) field, plus a per unit professional dispensing fee; or
        c. Providers' Gross Amount Due (GAD).
    ii. Under the State Plan, the dispensing fee is paid based on the quantity of units dispensed. The per unit professional dispensing fee is $0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is $0.025/unit for all other non-hemophilia treatment center pharmacies.

g) Ingredient Costs for 340B

1. Traditional 340B drugs purchased through the 340B program shall be reimbursed by the PHP based on the Fee for Service reimbursement methodology for 340B drugs as defined in the State Plan and applied to Medicaid and NC Health Choice Fee-for-Service programs.
    i. Under the State Plan, reimbursement rates are based on the provider's actual acquisition cost (purchase price) plus a professional dispensing fee. Reimbursement is based on actual acquisition cost when it is the lesser of National Average Drug Acquisition Cost (NADAC) or the gross amount due; if there is no NADAC, the lesser of the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), usual and customary, gross amount due, or other financial arrangements established by the Department.
    ii. The PHP shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B

program. The PHP shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission clarification field 420-DK at the POS.

2. Hemophilia drugs purchased through the 340B program shall be reimbursed by the PHP based on the Hemophilia reimbursement methodology as defined in the State Plan.
    i. Under the State Plan, 340B hemophilia drugs are reimbursed at the lesser of the following:
        a. 340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee. SMAC rates are based on the providers' acquisition cost (purchase price);
        b. Provider's acquisition cost (purchase price) reported in the usual and customary charge (U&C) field, plus a per unit professional dispensing fee;
        c. or Provider's Gross Amount Due (GAD).
    ii. Under the State Plan, the dispensing fee is paid based on the quantity of units dispensed, reimbursement is applicable to pharmacy. The per unit professional dispensing fee is $0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is $0.025/unit for all other non-hemophilia treatment center pharmacies.
    iii. The PHP shall require the provider to only bill acquisition costs or purchase price in the U&C field.

h) Reimbursement for Drugs in Indian Health Services

1. The PHP shall reimburse the Indian Health Services, or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of Indian Health Care Improvement Act (25 U.S.C § 1603 and authorized by Public Law 93-638 Agreement).
    i. For drugs with calculated allowable amounts of less than $1,000 utilizing the Office of Management and Budget (OMB) encounter reimbursement methodology, which will pay a maximum of two (2) prescription drugs per Member, per day, per pharmacy provider under the OMB encounter payments, and for any additional prescription drugs (3 and up) same Member, same day, same pharmacy provider, the PHP shall reimburse at zero.
    ii. For drugs with a calculated allowable amount equal to or greater than $1,000, the PHP shall reimburse the I/T/U utilizing the current Fee-for-Services reimbursement methodology as defined by the State Plan. The following is a list of exclusions to the I/T/U OMB encounter/ All Inclusive Rate (AIR):
        a. Drugs and vaccines procured free of charge,
        b. Emergency supply dispensation,
        c. Eyeglasses,
        d. Prosthetic devices and hearing aids,
        e. Diabetic testing supplies and continuous glucose monitors,
        f. Drug counseling or medication therapy management,
        g. 340B drugs,
        h. Medicare Part-B drugs,
        i. Medication assisted treatment (MAT) drugs,

j. Professional dispensing fees,
k. Collection of rebates,
l. Drug delivery or mailing, and
m. Drugs dispensed to Members assigned to Health Choice and Family Planning Waiver benefit plans.

i) Blood Glucose Diabetes Testing Supplies (BGDTS) and Continuous Glucose Monitors (CGM)
1. The PHP shall reimburse BGDTS and CGMs at the lesser of State Maximum Allowable Cost (SMAC) rates or the provider's billable charges reported by the provider in the Usual and Customary Charge field.
2. The PHP shall reimburse BGDTS based on the per unit basis (Example: one (1) box contains hundred (100) strips and only forty (40) will be dispensed; provider should bill the PHP for forty (40) units).
3. The PHP shall not pay professional dispensing fees (PDF) for pharmacy BGDTS or CGM.
4. The PHP shall only cover BGDTS listed on the PDL at pharmacy point-of-sale (POS).
5. The PHP shall only cover therapeutic CGMs listed on the PDL at pharmacy POS.
6. The PHP shall only cover BGDTS and CGMs within the quantity limits defined in the NC Medicaid Pharmacy DTS CMG Fee Schedule
7. The PHP shall require PA for a therapeutic CGM dispensed through pharmacy POS.
8. The PHP shall cover non-therapeutic CGMs under DME. The PHP shall ensure the provider submits a non-therapeutic CGM as a medical claim.
9. The PHP shall not cover therapeutic CGMs under the DME program.

j) Medical Professional Drug Claims
1. Hospital Outpatient Drug Claims
i. The PHP shall ensure drugs utilized in the Outpatient Hospital setting are billed to the PHP at their usual and customary charge, including those drugs used from the 340B inventory (rebates are collected on non 340B drugs in this setting).
ii. The PHP shall ensure providers bill transactions of outpatient hospital services to the PHP on a UB-04 or 837i transaction. The drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp RCC).
iii. The requirements in this section apply to physician practices that are part of a hospital-based clinic (e.g., the clinic is a department of a hospital). Drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp) RCC).
2. Hospital Inpatient Drug Claims
i. The PHP shall reimburse the cost of drugs in the inpatient hospital setting utilizing the inpatient hospital reimbursement methodology, based on diagnosis-related group (DRG) (rebates are not collected for 340B drugs in this setting).
3. Physician Administered Drug Program (PADP)
i. The PHP shall reimburse procedure coded drugs covered under the PADP and shall require providers to bill the PHP utilizing the CMS form 1500/837p.
ii. The PHP shall require claims to be billed by providers utilizing the HCPCS and NDC combination per the NDC: HCPS Crosswalk file.

iii. The PHP shall ensure drugs used in the PADP program are eligible for rebate (rebates are collected for drugs under this program, except for 340B drugs, radiopharmaceuticals, vaccines, and Crofab).
iv. The PHP shall ensure 340B Drugs listed under the PADP are billed by the provider to the PHP at Acquisition Cost.
v. The PHP shall ensure the provider bills 340B drugs under CMS form 1500/837p with UD Modifiers, at 340B acquisition cost (purchase price) in the usual and customary Charge (U&C) field (rebates are not collected for 340B claims in this setting).

4. Federally Qualified Health Centers/Rural Health Centers
   i. The PHP shall reimburse FQHC/RHC facilities for medical professional drugs at no less than one hundred percent (100%) of the NC Medicaid Federally Qualified Health Center Fee Schedule and NC Medicaid Rural Health Center Fee Schedule.
   ii. The PHP shall require FQHC/RHC facilities to bill 340B drugs at 340B actual acquisition cost.
   iii. The PHP shall reimburse FQHC/RHC facilities for 340B drugs at the 340B acquisition cost plus a professional dispensing fee for point of sale (POS) claims. The PHP shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B program. The PHP shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission clarification field 420-DK at the POS.
   iv. The PHP shall reimburse FQHC/RHC facilities for 340B drugs submitted as professional claims at the 340B acquisition cost. The PHP shall require the FQHC/RHC to submit professional claims utilizing the UD modifiers.
   v. The PHP shall reimburse FQHC/RHC facilities in compliance with ingredient costs as prescribed in *Section V.C.3.h.ii,* a) – c).

p. Section V.C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Provision of Care Management for High-Need Members, b) InCK Consent and Development of Shared Action Plan (SAP), 1. is revised and restated as follows:

1. The PHP shall ensure that every InCK attributed Member assigned to SIL 2 and 3 is informed of their eligibility for InCK and shall complete the InCK consent process. The PHP shall enable care team collaboration supported by the InCK model in accordance with the InCK consent process set out in the AMH Provider Manual.

q. Section V.C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Provision of Care Management for High-Need Members, b) InCK Consent and Development of Shared Action Plan (SAP), 5. is revised and restated as follows:

5. The PHP shall ensure that the SAPs are completed using the standardized format provided by NC InCK, as set out in the AMH Provider Manual.

r. Section V.C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Provision of Care Management for High-Need Members, c) Care Management Services, 11., ii., f), 3) is revised and restated as follows:

3) Access to InCK's platform and Member's profile and adhering to the InCK consent process set out in the AMH Provider Manual.

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

1. In cases where the Department establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department in the latest version of the Advanced Medical Home data specifications guidance documents found at https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance.

t. Section V.C. Benefits and Care Management, 8. Opportunities for Health, f. PHP Contributions to Health-Related Resources, ii. is revised and restated as follows:

ii. The PHP that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Department defined Medical Loss Ratio (MLR), as described in *Section V. I. 2. Medical Loss Ratio*, subject to Department review and approval.

u. Section V.C. Benefits and Care Management, 8. Opportunities for Health, g. Enhanced Case Management Pilot to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxv. Pilot Enrollment is revised to add the following:

e. Beginning no sooner than September 1, 2022, or a later date defined by the Department, the PHP shall begin providing a written Healthy Opportunities Pilot Enrollee Rights and Responsibilities Form, using the Department-developed template, to Members within fourteen (14) Calendar Days of a Member's enrollment in the Healthy Opportunities Pilot. The information in this form must be mailed to the Member and be made available online. The Member may choose to receive an electronic copy of this form rather than a mailed hard copy.

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

xxiv. Tobacco-free Policy

a. The PHP shall require contracted facilities, with the exception of the residential provider facilities noted below, implement a tobacco-free policy covering any portion of the property on which the participating provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting participating providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve. However contracted facilities that are owned or controlled by the provider

and which provide ICF-ID services or residential services that are subject to the HCBS final rule are exempt from this requirement, in these settings:

1. Indoor use of tobacco products shall be prohibited in all provider owned/operated contracted settings.
2. For outdoor areas of campus, providers shall ensure access to common outdoor space(s) that are free from exposure to tobacco products/use and prohibit staff/employees from using tobacco products anywhere on campus.

w. Section V.D. Providers, 2. Provider Network Management, h. Network Provider System Requirements, i. is revised and restated as follows:

i. Reserved.

x. 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 contracted providers into the claim adjudication and payment system within the following time frames 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. NC Medicaid provider attached to a new contract within ten (10) business days after completing contract execution.
b. NC Medicaid hospital or facility attached to a new contract within fifteen (15) business days after completing contract execution.
c. Reserved.
d. Reserved.
e. Change in existing contract terms within fifteen (15) Business Days of the effective date after the contract change.
f. Reserved.

y. Section V.D. Providers, 2. Provider Network Management, h. Network Provider System Requirements, iv. is revised and restated as follows:

iv. In no case shall a provider be used as a PCP or loaded into the provider directory during a timeframe in which the provider cannot receive payment on the health plan's current payment cycle. This provision does not apply to providers suspended by the Department.

z. Section V.D. Providers, 2. Provider Network Management, i. Network Provider Credentialing and Re-credentialing Policy, iv. is revised and restated as follows:

iv. The PHP shall make updates outside of the annual review, if there are substantive updates or revisions that impact provider or PHP business, as determined by the Department or PHP. Updates outside of the annual review are not counted towards the annual review. Only those specific substantive updates or revisions will be reviewed by the Department outside of the annual review. The PHP shall submit any significant changes to the PHP's Credentialing and Re-credentialing Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.

aa. Section V.D. Providers, 2. Provider Network Management, l. Provider Directory, vii. is revised and restated as follows:

vii. In no case shall a provider be loaded into the provider directory which cannot receive payment on the PHP's current payment cycle. This provision does not apply to providers suspended by the Department. If the PHP is made aware of providers included in their network file that are not actively enrolled in NC Medicaid, the PHP shall remove the provider from the PHP consumer-facing electronic directory within one (1) Business Day of notification from the Department.

bb. Section V.D. Providers, 4. Provider Payments, e. Hospital Payments (Excluding Behavioral Health Claims), iii. is revised and restated as follows:

iii. The applicable rate floor and methodology for outpatient hospital services (excluding hospital outpatient laboratory services), including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

a) The applicable rate floor and methodology for in-network hospital outpatient laboratory services shall be 146.38% of the Medicaid Fee-for-Service Laboratory fee schedule rate in effect on February 28, 2020, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology.

b) The PHP shall apply the following exceptions to the rate floor and methodology for in-network hospital outpatient laboratory services:

1. If the services are not part of the NC Medicaid Laboratory Fee schedule, outpatient hospital reimbursement shall be one hundred percent (100%) of billed charges multiplied by the Ratio of Cost to Charges (RCC) when calculating the reimbursement rate.
2. COVID-19 Vaccine Administration and COVID-19 Testing reimbursement shall be based on the NC Medicaid published state-wide rate.

cc. Section V.D. Providers, 4. Provider Payments, e. Hospital Payments (Excluding Behavioral Health Claims) is revised to add the following:

viii. The PHP shall not use the Outpatient Prospective Payment System (OPPS) to reimburse institutional hospital outpatient claims including lab and drug claims.

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

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) Calendar Days after Contract Award and at any time a significant change is made to the policy.

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.

b) The PHP shall include in its Good Faith Provider Contracting Policy a description of the outreach program to providers that the PHP, and its subcontractors as applicable, will

utilize when leveraging one of the PHP's existing Medicaid program's Networks to build a new program's Network.

ee. Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards iv. a) is revised and restated as follows:

a) The PHP shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225 and within this Contract.

ff. Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, vi. is revised and restated as follows:

vi. Remittance Advice

a) The PHP shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.

b) The PHP shall provide a remittance advice to every Local Health Department each month explaining their CMARC and CMHRP payments including number of members, rates, and total payment for each program individually.

c) The PHP shall provide a remittance advice to every Advanced Medical Home Tier 3 or its payment delegate each month explaining their medical home and care management fees, number of members, rates, and total payment for each component (medical home and care management payment) individually.

gg. Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards is revised to add the following:

vii. The PHP shall process and pay claims based on the codes submitted by the provider. The PHP shall not change any data elements submitted by the provider on a claim.

viii. Claims Processing for Child Medical Evaluation (CME)

a) When a Member is referred for an exam for suspected maltreatment by Child Welfare Services or DSS, the PHP shall require the rostered CMEP providers to follow the Child Medical Evaluation and Medical Team Conference for Child Maltreatment Policy (Clinical Coverage Policy 1A-5) and bill according to Clinical Coverage Policy 1A-5 Attachment A, requiring the CME claim to be submitted with the Child Medical Evaluation Checklist (Attachment B).

b) When processing CME claims referred through law enforcement, the PHP shall process these claims as any other claim for services rendered and not follow Clinical Coverage Policy 1A-5.

ix. Claims Provider Validation

a) The PHP shall validate the taxonomy code submitted on the claim against the Taxonomy Code field(s) sent for the provider on the provider enrollment file. The additional taxonomy level information provided for information purposes only on the provider enrollment file should not be used during the claim submission process.

b) The PHP shall validate the claim's date of service against the enrolled provider's taxonomy effective dates. In the case of inpatient stays, if a provider's taxonomy status changes during a Member's stay, taxonomy effective date validation should be based on

the date of discharge for DRG based claims and should be based on the date of service for per diem claims.

c) Once validated, the PHP shall price claims based on the taxonomy code submitted on the claim.

x. The PHP shall use the same grouper version as the Department. Grouper updates at the Department occur annually in October, and the PHP shall use the PHP Billing Guide to identify the current grouper version number.

hh. Section V.H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i. is revised to add the following:

d) The PHP shall pay medical home fees and care management fees, that includes AMH, CMARC, CMHRP and Healthy Opportunities payments, by no later than the last day of each month however, payment for each month shall be based upon Member's enrollment with the PHP at the beginning of the same month.

ii. Section V.H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. revised and restated as follows:

iii. Pursuant to N.C. Gen. Stat. § 58-3-225(f), the PHP may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. The PHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member for pharmacy point of sale claims. However, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

jj. Section V.H. Claims and Encounter Management, 1. Claims, g. System Standards is revised to add the following:

iii. The PHP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must, at a minimum, allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard HIPAA transaction (ASC X12, 275 claim attachment format or attachment indication in an 837 with the attachment sent separately). The PHP shall implement this capability for provider use no later than January 1, 2023. If an extension is needed, the PHP may submit a request to the Contract Administrator for Day-to-Day

Activities. Extension requests shall include documentation of how providers submitting child medical exam checklists and sterilization consent forms will be impacted.

kk. Section V.H. Claims and Encounter Management, 1. Claims, i. National Correct Coding Initiative (NCCI) is revised to add the following:

iii. The PHP shall only apply Outpatient Hospital NCCI edits to outpatient lab, drugs, and radiology claims.

ll. Section V.H. Claims and Encounter Management, 1. Claims, is revised to add the following:

j. Known System Issues

i. The PHP shall develop, maintain, and share a Known System Issues Tracker with providers through newsletters, provider portal, and/or health plan website on a weekly basis to keep providers informed on all known health plan system issues with provider impact.

ii. The Known System Issues tracker shall include the following information, at a minimum:

a) Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);

b) Number of Impacted Providers: number of known providers impacted by the system issue;

c) Category: type of system issue (e.g., claims, eligibility, provider, prior approval);

d) Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;

e) Date Issue Found: month, day, and year the PHP identified the system issue;

f) Number of Days Outstanding: number of days this issue has been open;

g) Estimated Fix Date: month, day, and year the PHP plans to have this system issue resolved;

h) Status: status of the issue (open, ongoing, or closed);

i) Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;

j) Interest/Penalties Owed: whether interest and penalties will be applied (Yes or No); and

k) Date Resolved: month, day, and year the PHP resolved this system issue.

iii. The PHP shall maintain each item on the Known Issues Tracker for at least ninety (90) Calendar Days after resolution of the issue.

iv. The PHP shall include the link to the Known Issues Tracker in the Provider Manual and submit the updated deliverable to the Department no later than September 1, 2022.

mm. Section V.H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, vii. Specifications, b) is revised and restated as follows:

b) The PHP shall follow the detailed process outlined in the Encounter Data Submission Guide. Encounters are defined in the two (2) groups below:

1. Medical, including ILOS, value added services, and Healthy Opportunities pilot services. In addition, medical includes pharmacy claims billed as professional or institutional claims.
2. Pharmacy includes outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.

nn. Section V.H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix. is revised and restated as follows:

ix. The PHP shall submit all claims processed as encounters, as defined in this Section, and each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

a) Timeliness

1. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim payment date
2. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the claim payment date.
3. The PHP encounter data submissions shall meet or exceed a timely submission standard of ninety-eight percent (98%) within thirty (30) Calendar Days after payment whether paid or denied for medical claims and within seven (7) Calendar Days after payment whether paid or denied for pharmacy claims.
    i. Medical: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters
    ii. Pharmacy: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters will be counted by the Department as pharmacy encounters.
4. Encounter data timeliness shall be defined as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.

b) Reserved.

c) Accuracy

1. PHP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
    i. Medical: for purposes of determining if the PHP has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters.
    ii. Pharmacy: for purposes of determining if the PHP has met the accuracy encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.

iii. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.

d) Reconciliation

1. PHP encounter submissions shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.
   i. Medical: For purposes of determining if the PHP has met the reconciliation encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters.
   ii. Pharmacy: For purposes of determining if the PHP has met the reconciliation encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.
2. Encounter data reconciliation shall be defined as 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.

oo. Section V.I. Financial Requirements, 4. Risk Corridor, a. is revised and restated as follows:

a. A risk corridor arrangement between the PHP and the Department will apply to share in gains and losses of the PHP as defined in this section. The Risk Corridor payments to and recoupments from the PHP will be based on a comparison of the PHP's reported Risk Corridor Services Ratio ("Reported Serves Ratio") for each Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Standard Plan Rate Book ("Target Services Ratio").
   i. The Risk Corridor Measurement Period for rating year one is defined as July 1, 2021 to June 30, 2022.
   ii. The Risk Corridor Measurement Period for rating year two is defined as July 1, 2022 to June 30, 2023.
   iii. The risk corridor payments and recoupments will be based on a comparison of the PHP's Reported Services Ratio for each measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the Standard Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
   iv. The PHP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments).
   v. The Reported Services Ratio numerator shall be the PHP's expenses for the applicable Risk Corridor Measurement Period specific to the North Carolina Medicaid and NC Health Choice managed care programs. The numerator shall be defined as the sum of:
      a) Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments and COVID-19 vaccine and testing costs.

b) Advanced Medical Home Fees as defined in Section 4. Provider Payments including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department.
c) Performance Incentive Payments to Advanced Medical Homes as defined in Section 4. Provider Payments.
d) Other quality-related incentive payments to NC Medicaid providers.
e) Non-claims-based provider stabilization payments to support provider sustainability and beneficiary access.
f) Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.
g) The final Risk Corridor Services Ratio report should also include any payments required by the Minimum Primary Care Provider Expenditure requirement for the applicable risk corridor measurement period.

vi. The PHP is prohibited from including in the Reported Services Ratio numerator the following expenditures:
a) Payments to providers for delegated Care Management.
b) Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department.
c) Interest or penalty payments to providers for failure to meet prompt payment standards.
d) Payments to related providers that violate the Payment Limitations as required in the Contract.
e) COVID-19 vaccine administration and testing costs included in a non-risk arrangement.
f) Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

vii. The Reported Services Ratio denominator represents the Medicaid managed care revenue received by the PHP for enrollments effective during the applicable Risk Corridor Measurement Period. The denominator shall be equal to the Department-defined MLR denominator.

viii. PHP shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the applicable Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

ix. The PHP must provide an attestation of the accuracy of the Information provided in its submitted risk corridor calculations, including minimum PCP Expenditure requirement calculation, as specified in 42 C.F.R. § 438.606.

x. Terms of the Risk Corridor
a) If the Reported Services Ratio is less than the Target Services Ratio minus 3%, the PHP shall pay the Department 50% of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus 3% and the Reported Services Ratio.
b) If the Reported Services Ratio is greater than the Target Services Ratio plus 3%, the Department shall pay the PHP 50% of the Reported Services Ratio denominator

multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus 3%.

xi. Risk Corridor Settlement and Payments

a) The Department will complete a settlement determination for each Risk Corridor Measurement Period.

b) The PHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

c) The PHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department. The risk corridor settlement will consider the outcome of the Minimum Primary Care Expenditure requirement evaluation. As such, the final Risk Corridor settlement will include the following two iterations of the Risk Corridor Services Ratio report.

1. Preliminary Risk Corridor Services Ratio report will exclude from the numerator any payments required from the Minimum Primary Care Provider Expenditure requirement.
2. Final Risk Corridor Services Ratio report will consider the final outcome and any payments required from the Minimum Primary Care Provider Expenditure requirement for the applicable risk corridor measurement period.

d) The PHP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.

e) The Department may choose to review or audit any information submitted by the PHP.

f) The Department will complete a Risk Corridor Settlement determination for each Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.

g) The Department will provide the PHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section VI.A.e.vii*. of the Contract within fifteen (15) Calendar Days of the notice by the Department to the PHP.

h) If the final Risk Corridor Settlement requires the PHP to remit funds to the Department, the PHP must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.

i) At the sole discretion of the Department, the Department may allow the PHP to contribute all or a part of the amount otherwise to be remitted to:

1. Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
2. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.

j) To be considered for the in lieu of remittance option, the PHP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the PHP's interim Risk Corridor Services Ratio report.

k) If the PHP has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the PHP by offsetting a subsequent monthly capitation payment.

l) If the final Risk Corridor Settlement requires the Department to make additional payment to the PHP, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the PHP initiates a dispute as described in *Section VI.A.e.vii.* the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

pp. Section V.I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, b. is revised and restated as follows:

b. The PHP shall calculate and report the Reported PCP Expenditure Percentage as the ratio of the Reported PCP Expenditures to the Department-defined MLR denominator for ~~the~~ each Risk Corridor Measurement Period as part of the interim and final Risk Corridor Service Ratio reports.

qq. Section V.I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, e. is revised and restated as follows:

e. The Minimum PCP Expenditure Percentage shall be calculated as follows:

i. For the Risk Corridor Measurement Period for rating year one: ninety percent (90%) of the PCP Target Expenditure Percentage for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization based payments).

ii. For the Risk Corridor Measurement Period for rating year two: ninety-two and one-half percent (92.5%) of the PCP Target Expenditure Percentage for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization based payments).

rr. Section V.I. Financial Requirements, 7. COVID-19 Vaccination Incentive Program Payments, b. is revised and restated as follows:

b. The COVID-19 Vaccination Incentive Program will run from when the Gating Target is reached through December 31, 2022.

ss. Section V.I. Financial Requirements, 7. COVID-19 Vaccination Incentive Program Payments, c. is revised and restated as follows:

c. Once the Gating Target is reached, the PHP will be eligible for the following incentive payments for Members over age five (5) that become fully vaccinated after the Gating Target was met:

i. One hundred dollars ($100) for each Member who is from a county where the average vaccination rate for Standard Plan Members is above the state average for Standard Plan Members.

ii. One hundred and twenty dollars ($120) for each Member who is from a county where the average vaccination rate for Standard Plan Members is below the state average for Standard Plan Members.

tt. Section V.I. Financial Requirements, 7. COVID-19 Vaccination Incentive Program Payments, d., v. is revised and restated as follows:

v. The Department shall make one (1) payment to the PHP in FY23Q3 for performance through December 31, 2022.

uu. Section V. J. Compliance, 4. Third Party Liability, i. Identification of Other Forms of Insurance, ii. is revised and restated as follows:

ii. The PHP shall load and submit to the Department updates and additions on other forms of insurance into its system within five (5) Business Days of matching and verification and the PHP is required to review State TPL data prior to denying any claim for TPL or other insurance.

vv. Section V. J. Compliance, 4. Third Party Liability (TPL) is revised to add the following:

l. The PHP shall pay and then chase for the following services:

i. Medical Support Enforcement: The PHP shall pay and chase if the claim is for a service provided to a Member on whose behalf child support enforcement is being carried out if:

a) The third party coverage is through an absent parent; and

b) The provider certifies that, if the provider has billed a third party, the provider has waited one hundred (100) Calendar Days from the date of service without receiving payment before billing the PHP.

ii. Preventive Pediatric Services: The PHP shall pay and chase for claims for preventive pediatric services, including EPSDT.

iii. In addition to medical support enforcement and preventative pediatric services, *Section V. J. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits* lists programs and services that are an exception to the general rule that NC Medicaid is the payer of last resort. As applicable, when a Member of the PHP is entitled to one or more of the following programs or services covered by the PHP, the PHP shall pay and chase the claim.

Section V.J. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program or Service	**Federal**	**State**
1. Crime Victims Compensation Fund	X	
2. Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
3. Ryan White Program	X	
4. Indian Health Services	X	
5. Veteran's Benefits for state nursing home per diem payments	X	
6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	

7. Women, Infants and Children Program	X	
8. Older American Act Programs	X	
9. World Trade Center Health Program	X	
10. Grantees under the Title V of the Social Security Act	X	
11. Division of Service for the Blind		X
12. Division of Public Health "Purchase of Care" Program		X
13. Vocational Rehabilitation Services		X
14. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

The remainder of this page is intentionally left blank.

3. Modifications to Section VI. Contract Performance

Specific subsections are modified as stated herein.

a. Section VI.A. Contract Violations and Noncompliance, *Fourth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages* is revised and restated as follows:

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
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 *Attachment 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.9. 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.
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
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.	Reserved.	Reserved.
10.	Failure to comply with all orders and final decisions relating to claim disputes, appeals and/or State Fair Hearing as issued or as directed by the Department.	$5,000 per occurrence

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
11.	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.
12.	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
13.	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
14.	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 and V.C.3. Pharmacy Benefits.*	$5,000 per standard authorization request $7,500 per expedited authorization request
15.	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
16.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$2,500 per occurrence
17.	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
18.	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.
19.	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
20.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	$1,500 per occurrence per driver
21.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	$250 per occurrence per Member
22.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	$1,500 per Calendar Day per vehicle
23.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	$250 per Calendar Day

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
24.	Reserved.	Reserved.
25.	Reserved.	Reserved.
		Reserved.
		Reserved.
26.	Reserved.	Reserved.
27.	Reserved.	Reserved.
28.	Reserved.	Reserved.
29.	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
30.	Failure to implement and maintain an Opioid Misuse Prevention 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 with the Opioid Misuse Prevention Program requirements
31.	Failure to update online and printed provider directory as required by *Section V.D.2. Provider Network Management.*	$1,000 per provider, per Calendar Day
32.	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
33.	Reserved.	Reserved.
34.	Reserved.	Reserved.
35.	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
36.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	$250 per Calendar Day
37.	Failure to maintain accurate provider directory information as required by *Section V.D.2. Provider Network Management.*	$100 per confirmed incident
38.	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
39.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in *Section V.E.1. Quality Management and Quality Improvement.*	$5,000 per Calendar Day
40.	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
41.	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

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
42.	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
43.	Failure to timely submit monthly encounter data set certification.	$1,000 per Calendar Day
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Attachment J: Third Revised and Restated Reporting Requirements*.	$2,000 per Calendar Day
45.	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 and Attachment J. Reporting Requirements.*	$2,000 per Calendar Day
46.	Failure to timely and accurately submit monthly 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
47.	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
48.	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
49.	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
50.	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
51.	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
52.	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

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
53.	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.
54.	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
55.	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
56.	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
57.	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
58.	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
59.	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
60.	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
61.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$500 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
62.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$1,000 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)

Fifth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
63.	Failure to implement and maintain a Member Lock-In Program as described in *Section V.C.7. Prevention and Population Health Management Program.*	$500 per calendar day per member that the PHP is not meeting Lock-In Requirements outlined in *Section V.C.7 Prevention and Population Health Management Program* and N.C. Gen. Stat. § 108A-68.2.
64.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PHP Network File within one (1) Business Day as specified in *Section V.D.2. Provider Network Management.*	$1,000 per provider per Business Day
65.	Engaging in gross customer abuse of Members by PHP service line agents as prohibited by *Section V.G.1. Service Lines*.	$1,000 per occurrence
66.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.G.1. Service Lines.*	$250 per Business Day the PHP fails to timely report to the Department
67.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in *Section V.C.8. Opportunities for Health*.	$500 per Calendar Day that the Department determines the PHP is not in compliance beginning on or after August 1, 2022.
68.	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes as specified in *Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization*.	$500 per Calendar Day beginning on or after September 1, 2022
69.	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes as specified in *Section V.D.4. Provider Payments*.	$500 per Calendar Day beginning on or after September 1, 2022

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b. Section VI.B. Service Level Agreements, Section VI.A. Table 2: Third Revised and Restated PHP Service Level Agreement is revised and restated as follows:

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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.	Monthly	$1,000 per eligibility file that does not meet the submission guidelines of the eligibility file.
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
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
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

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 and the number of calls abandoned 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
8.	Call Wait/Hold Times - Member Services line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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 and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The PHP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$15,000 per month
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 and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
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 and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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 and the number of calls abandoned 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
20.	Call Wait/Hold Times - Pharmacy Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
22.	Encounter Data Timeliness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after payment whether paid or denied. *For purposes of this standard, medical encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x.*	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 – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after payment whether paid or denied. *For purposes of this standard, pharmacy encounters only include 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.*	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
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims. *For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters.*	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

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	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 within thirty (30) Calendar Days or at least ninety-nine percent (99.8%) of paid claim amounts reported on financial reports within sixty (60) Calendar Days. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	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.	Monthly	$100,000 per month
27.	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
28.	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
29.	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)

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
30.	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 within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. *For purposes of this standard, medical encounters only include 837-P encounters and 837-I encounters.*	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.	Monthly	$10,000 per month
31.	Call Response Time/Call Answer Timeliness – NEMT Member 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 and the number of calls abandoned 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
32.	Call Wait/Hold Times – NEMT Member Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
33.	Call Abandonment Rate – NEMT Member Line	The call abandonment 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

Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
34.	Call Response Time/Call Answer Timeliness – NEMT Provider 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 and the number of calls abandoned 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
35.	Call Wait/Hold Times – NEMT Provider Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
36.	Call Abandonment Rate – NEMT Provider Line	The call abandonment 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
37.	Non-Emergency Transportation – Hospital Discharge	The PHP shall ensure that at least ninety-eight percent (98%) of Medicaid Members discharged from hospitals or emergency departments are picked up within three (3) hours of receipt of the request from the Member, the Member's authorized representative, or hospital staff, or within (3) hours of the Member's scheduled discharge, whichever is later, as specified in the *NC Non-Emergency Medical Transportation Managed Care Policy*.	The number of trips per month that Contractor fails to pick up at least ninety-eight percent (98%) of Medicaid Members being discharged from a hospital or emergency department within the established timeframes after receipt of a request from the Member, the Member's authorized representative, or hospital staff for NEMT.	Monthly	$3,000 per trip for any delay beyond the three (3) hour pick-up requirement for any trip above the 2% threshold

4. Modifications to Section VII. Attachments A-N

Specific attachments and subsections are modified as stated herein.

1. *Section VII. Attachment E. First Revised and Restated Required PHP Quality Metrics* is revised and restated in its entirety as set forth in *Attachment 1: Attachment E. Second Revised and Restated Required PHP Quality Metrics*, to this Amendment.

2. *Section VII. Attachment F. Second Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* is revised and restated in its entirety to modify *Section VII. Attachment F. Second Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time and Distance Standards* as set forth in *Attachment 2: Attachment F. Third Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards*, to this Amendment.

3. *Section VII. Attachment G. Third Revised and Restated Required Standard Provisions for PHP and Provider Contracts* is revised and restated in its entirety as set forth in *Attachment 3: Attachment G. Fourth Revised and Restated Required Standard Provisions for PHP and Provider Contracts*, to this Amendment.

4. *Section VII. Attachment J. Third Revised and Restated Reporting Requirements* is revised and restated in its entirety as set forth in *Attachment 4: Attachment J. Fourth Revised and Restated Reporting Requirements*, to this Amendment.

5. *Section VII. Attachment M. Policies, 6. First Revised and Restated Uniform Credentialing and Re-credentialing Policy* is revised and restated in its entirety as set forth in *Attachment 5: Attachment M. 6. Second Revised and Restated Uniform Credentialing and Re-credentialing Policy*, to this Amendment.

5. Section X, Third Revised and Restated Summary of Contractual Payment and Risk Sharing Terms is revised and restated in its entirety as *Section X. Fourth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms* and attachment 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.

Execution:

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

Department of Health and Human Services

_____ Date: _____

Dave Richard, Deputy Secretary

PHP Name

_____ Date: _____

PHP Authorized Signature

Attachment 1

Attachment E. Second Revised and Restated Required PHP Quality Metrics

Section VII. Second Revised and Restated Attachment E. Table 1: Survey Measures and General Measures lists the Department's quality and administrative measures that are meant to provide the Department with a complete picture of the PHP's processes and performance as described in *Section V.E. Quality and Value*. These Measures include a select set of Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

1. The PHP shall track all measures listed in *Section VII. Second Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*. The Department will monitor other measures that are not included in the table below and may engage with the PHPs~~-~~ around these performance measures. An asterisk (*) indicates that the measure is calculated by the Department.

Section VII. Second Revised and Restated Attachment E. Table 1. Survey and General Measures			
Reference #	*NQF #*	*Measure Name*	*AMH Measure*
1.	N/A	Child and Adolescent Well-Care Visit (WCV)	x
2.	1516	Well-Child Visits in the First 30 Months of Life (W30)	x
3.	N/A	Total Eligibles Receiving at least One Initial or Periodic Screen (EPSDT)	
4.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
5.	0032	Cervical Cancer Screening (CSC)	x
6.	0038	Childhood Immunization Status (Combination 10) (CIS)	x
7.	0033	Chlamydia Screening in Women (Total Rate) (CHL)	x
8.	0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC).	x
9.	0018	Controlling High Blood Pressure (CBP)	x
10.	0039	Flu Vaccinations for Adults (FVA, FVO)*	
11.	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	
		7- Day Follow-up	
		30-Day Follow-up	
12.	1517	Prenatal and Postpartum Care (Both Rates) (PPC)	
		Timeliness of Prenatal Care	
		Postpartum Care	
13.	1407	Immunizations for Adolescents (Combination 2) (IMA)	x
14.	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	

15.	N/A	Low Birthweight[1]	
16.	2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	
17.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	
18.	N/A	Rate of Screening for Pregnancy Risk	
19.	N/A	Rate of Screening for Unmet Resource Needs	
20.	0418/04118e	Screening for Depression and Follow-Up Plan (DSF)	x
21.	2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	
22.	1768	Plan All-Cause Readmissions	x
23.	N/A	Total Cost of Care*	x

2. Updates to PHP Quality Metrics

   a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website and subsequently amend *Section VII. Second Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*, as necessary, to align with the annual January update.

   b. The PHP shall adopt the updated measures posted annually in January for the upcoming measurements years with reporting to be provided to the Department in June of the subsequent year.

   c. The PHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Section VII. Fourth Revised and Restated Attachment J. Table 1: Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the PHP would report the results in June 2024).

[1] The Department will work jointly with the plans to report this measure.

Attachment 2

Attachment F. Third 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 sufficientlyavailable 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 physical health providers/services, 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.

For purposes of network adequacy standards for behavioral health providers/services, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

Section VII. Attachment F. Second 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 atleast 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
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	Obstetrics1	≥ 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 ofresidence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles ofresidence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*

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 atleast 95% of Members
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 inevery 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 acceptingnew patients in every county.	PHP must have at least 1 nursing facility acceptingnew 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. Second Revised and Restated. Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. Third Revised and Restated. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards*.

Section VII. Attachment F. Third Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
ReferenceNumber	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers(adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (OTP) (adult)
3.	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult • Facility-based crisis services for children and adolescents • Ambulatory detoxification • 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 • Acute care hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

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

Section VII. Attachment F. Second 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 andolder	Care provided to prevent illness or injury; examples include, but are notlimited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar Days
1a	Preventive Care Services – child, birth through 20 yearsof 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 of age and older.
2	Urgent Care Services	Care provided for a non-emergent illnessor 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 withoutSymptoms	Non-symptomatic visits for routinehealth check-up.	Within thirty (30) Calendar Days
4	After-Hours Access – Emergent and Urgent	Care requested after normal businessoffice hours.	Immediately {available twenty-four (24) hours a day, threehundred sixty-five (365) days a year}

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, suchas 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 illnessor 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 withoutSymptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
8	After-Hours Access – Emergent and Urgent	Care requested after normal businessoffice 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.: BehavioralHealth Service Definition Policy*	Within two (2) hours

10	Urgent Care Services forMental Health	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Within twenty-four (24) hours
11	Urgent Care Services for SUDs	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Within twenty-four (24) hours
12	Routine Services for MentalHealth	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Within fourteen (14) Calendar Days
13	Routine Services for SUDs	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Within fourteen (14) Calendar Days
14	Emergency Services forMental Health	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Immediately {available twenty-four (24) hours a day, threehundred sixty-five (365) days a year}
15	Emergency Services for SUDs	Refer to *Attachment M. 8.: BehavioralHealth Service Definition Policy*	Immediately {available twenty-four (24) hours a day, threehundred 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. Second Revised and Restated Table 1: PHP Time/DistanceStandards* and *Section VII. Attachment F. Second Revised and Restated Table 3: PHP Appointment Wait Time Standards* as found in this attachment:

Section VII. Attachment F. Second 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
8a.	Gynecology[2]
9.	Infectious Disease
10.	Hematology
11.	Nephrology
12.	Neurology
13.	Oncology
14.	Ophthalmology
15.	Optometry
16.	Orthopedic Surgery
17.	Pain Management (Board Certified)
18.	Psychiatry
19.	Pulmonology
20.	Radiology
21.	Rheumatology
22.	Urology

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

Attachment 3

Attachment G. Fourth Revised and Restated Required Standard Provisions for PHP and Provider Contracts

The PHP shall develop and implement contracts with providers to meet the requirements of the Contract. The PHP's provider contracts shall at a minimum comply with the terms of the Contract, state and federal law, and include required applicable standard contracts clauses.

1. **Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following**:
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
    e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the PHP's insolvency the contract must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:

1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.

h. Member Billing: The contract must address the following:
   i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and
   ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

i. Provider Accessibility. The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.

j. Eligibility Verification. The contract must address the PHP's obligation to provide a mechanism that allows providers to verify Member eligibility, based on current information held by the PHP, before rendering health care services.

k. Medical Records. The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
   i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;
   ii. Maintain adequate medical and other health records according to industry and PHP standards; and
   iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Member Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.

m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).

n. Data to the Provider: The contract must address the PHP’s obligations to provide data and information to the provider, such as:
   i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
   ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.

iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.

o. Utilization Management: The contract must address the provider's obligations to comply with the PHP's utilization management programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

p. Provider Directory: The provider's authorization and the PHP's obligation to include the name of the provider or the provider group in the provider directory distributed to Members.

q. Dispute Resolution: Any process to be followed to resolve contractual differences between the PHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.D.5. Provider Grievances and Appeals*.

r. Assignment: Provisions on assignment of the contract must include that:

i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.

ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

s. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.

t. Interpreting and Translation Services: The contract must have provisions that indicate:

i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.

ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.

iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.

w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:

i. G. S. 58-3-200(c).
ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
iii. G.S. 58-50-270(1), (2), and (3a).
iv. G.S. 58-50-275 (a) and (b).
v. G.S. 58-50-280 (a) through (d).
vi. G.S. 58-50-285 (a) and (b).
vii. G.S. 58-51-37 (d) and (e).

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

z. Clinical Records Requests for Claims Processing: the contract shall indicate that the PHP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).

aa. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PHP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

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

cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:

i. The Designated Pilot Care Management Entity shall:

a) Utilize NCCARE360 for functions outlined in *PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.*
b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*
c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.
d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot*.
e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals, i. Provider Complaints related to the Healthy Opportunities Pilot.*
f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*

ii. The PHP shall:
a) Make fixed Per Member Per Month (PMPM) Pilot care management payments to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined *PHP Contract Section V.D.4 Provider Payments, w. Healthy Opportunities Pilot Payments, ii. Care Management Payments.*
b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.

iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.

dd. Healthy Opportunities Network Leads: The PHP must contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as noted in Section V.D.1.c.vi, using a Department-standardized PHP-Network Lead model contract, to access the Network Lead's network of Pilot providers, also referred to as Human Service Organizations (HSOs).

ee. Advanced Medical Home InCK: For all Advanced Medical Homes participating in the InCK program, a provision that outlines the InCK model and requirements that is consistent with the Advanced Medical Home Manual. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's InCK Program.

2. Additional contract requirements are identified in the following Attachments:

a. Attachment M. 2. First Revised and Restated Advanced Medical Home Program Policy

b. Attachment M. 3. Pregnancy Management Program Policy

c. Attachment M. 4. Care Management for High-Risk Pregnancy Policy

d. Attachment M. 5. Care Management for At-Risk Children Policy

e. Advanced Medical Home Manual

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

   a. Compliance with State and Federal Laws

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

   b. Hold Member Harmless

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

   c. Liability

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

   d. Non-discrimination Equitable Treatment of Members

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

   e. Department authority related to the Medicaid program

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

   f. Access to provider records

      The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [PHP and Provider Contract/Agreement] and

any records, books, documents, and papers that relate to the [PHP and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

i. *The United States Department of Health and Human Services or its designee;*
ii. *The Comptroller General of the United States or its designee;*
iii. *The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee*
iv. *The Office of Inspector General*
v. *North Carolina Department of Justice Medicaid Investigations Division*
vi. *Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;*
vii. *The North Carolina Office of State Auditor, or its designee*
viii. *A state or federal law enforcement agency.*
ix. *And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.*

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

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

g. G.S. 58-3-225, Prompt claim payments under health benefit plans.

Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, PHP shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later), except for pharmacy point of sale claims which shall be submitted within three hundred sixty-five (365) *Calendar Days of the date of the provision of care. However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.*

i. *For Medical claims (including behavioral health):*
    1. *The [Company] shall within eighteen (18) calendar days of receiving a Medical Claim notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to process the claim.*
    2. *The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.*

3. *A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.*

ii. *For Pharmacy Claims:*
   1. *The [Company] shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.*
   2. *A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.*

iii. *If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).*
   1. *The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).*

iv. *If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.*

v. *Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.*

vi. *The [Company] shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require the [Provider] to requests the interest or the penalty.*

h. Contract Effective Date.

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

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

i. Tobacco-Free Policy.

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

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

Contracts with facilities that are owned or controlled by the provider, and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required*:*

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

1. *Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].*
2. *For outdoor areas of campus, [PROVIDER] shall ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and prohibit staff/employees from using tobacco products anywhere on campus.*

Attachment 4

Attachment J. Fourth Revised and Restated Reporting Requirements

The following table details the Medicaid Managed Care Program reports that the PHP must submit to the Department. The PHP shall submit reports in the format, frequency and method that is defined in the NC PHP Report Guide. The NC PHP Report Guide provides guidance specific to each report. The Department shall maintain the NC PHP Report Guide, along with all applicable report templates, and publish to the PHP via the PHP Contract Data Utility (PCDU) with effective date. If a technical change is made to a template before the next NC PHP Report Guide version is published, a revised template will be posted to the PCDU with its new effective date. Each of the report templates contain specific data elements required, data definitions, and required formats.

Although the State has indicated the reports that are required, the PHP may suggest additional reports.

1. As part of Readiness Activities, the PHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
2. The Department reserves the right to require additional reports beyond what is included in this Attachment, which shall be added by Amendment. The PHP shall submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

Fourth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
1. ***Administration and Management***	
a. PHP Operating Report	Annual report of each entity identified under the PHP Operating Report, providing evidence of PHP oversight activities and entity performance (i.e. metrics, CAPs, sanctions)
2. ***Members***	
a. PHP Enrollment Extract	Weekly detail and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
b. Member Services Quality Assurance Report	Quarterly report of survey results which measures member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.

c. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.
d. Planned Marketing Procedures, Activities, and Methods	Annual report of planned marketing activities including number/types of events, locations, description of materials distributed, and number of Members reached.
e. Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs
g. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PHP including the total number of appeal and grievance requests filed with the PHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.
h. PHP Enrollment Summary Report	Monthly summary report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
i. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).
j. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report of non-verifiable Member addresses and returned mail.
k. Nursing Facility Admission Disenrollment Report	Ad hoc report on Member disenrollment from a PHP due to a Nursing Facility stay longer than 90 days.
l. Clearinghouse Daily Uploads Extract	Tracking file submitted for each daily or monthly upload to the PCG Clearinghouse of each initial Notice of Adverse Benefit Determination (NABD) and Resolution Notice of Adverse Benefit Determination sent to members.
m. Monthly PHP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems.

n. COVID-19 Vaccine Incentive Program Report	Monthly report to include cumulative Member level details on COVID-19 Vaccination Member Incentive Program, including Member information, vaccine provider data, incentives provided and expenditures.
3. ***Benefits and Care Management***	
a. Institute of Mental Disease (IMD) Report	Alternate-week report providing the prior two calendar weeks' summary of members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provide NPI, facility admission date and facility discharge date.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.
c. ProDUR Alert Report	Quarterly report highlighting prospective alerts and responses for pharmacy claims.
d. Top GSNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.
e. Ad Hoc and Trigger Report	Quarterly report containing activities and ad hoc report, summary of total paid claims, and trigger report with comparison of top 200 GC3s by claim count.
f. EPSDT Report	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.
g. Non-Emergency Medical Transportation (NEMT) Report	Monthly report highlighting the NEMT utilization, monthly requests received, processed, denied and open where the date of service falls within the reporting range.
h. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.
i. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs.
j. Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots.
k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management payments.
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. AMH Integration Contracting Report	Monthly AMH Tier 3 practices contracting and integration status report

p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. High Needs Members Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members.
s. Crossover-Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.
t. Quarterly Admission and Readmission Report	Quarterly summary report of admission and readmission trends.
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.
c. Network Adequacy Exceptions Narrative Report	Quarterly narrative report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with PRV001-J Network Adequacy Exceptions Report
d. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of

	approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy.
e. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Provider Contracting Determinations and Activities Narrative Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with PRV005-J: Provider Contracting Determinations and Activities Narrative Report.
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Essential Provider Alternate Arrangements Narrative Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy. To be submitted with the Essential Alternate Arrangements Report.
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. Reserved	Reserved

n. Provider Grievances, Appeals, and Litigated Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.
p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Suspended and Terminated Providers Report	Monthly report showing suspended claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business

	day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. PHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Referenced in Sections V.D.2.j.i.a / V.D.2.j.i.b.
y. UNC Vidant Hospital Directed Payment Report Data – Outpatient	Quarterly report to collect claims data to support outpatient directed payments to UNC / Vidant Hospitals.
z. UNC Vidant Hospital Directed Payment Report Data – Inpatient	Quarterly report to collect claims data to support inpatient directed payments to UNC / Vidant Hospitals.
5. ***Quality and Value***	
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved.	Reserved
d. Reserved.	Reserved
e. Reserved.	Reserved
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
6. ***Stakeholder engagement***	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.
b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. ***Program Administration***	
a. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.

b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
d. Secondary Call Center Service Line Report	Monthly secondary call center service line utilization and statistics.
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
g. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. (Section IV.4.d.)

9. ***Financial Requirements***	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template.
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.
d. NC PHP Claims Monitoring Report	Weekly summary of the volume and dollar amount of claims that were paid, denied, and rejected during the reporting period, and current inventory of pended claims by professional, institutional, and pharmacy. Top 10 denial reasons by volume and dollar amount.

Attachment 5

Attachment M. POLICIES

6. Second Revised and Restated Uniform Credentialing and Re-credentialing Policy

1. **Background**
   This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a Prepaid Health Plan (PHP) in determining whether to allow a provider to be included in the PHP's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled provider.

2. **Scope**
   This Policy applies to the PHP and covers credentialing and re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to acute, primary, behavioral health, Substance Use Disorders, and Long-Term Services and Support (LTSS) [42 C.F.R. § 438.214(b)(1)].

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

   a. **Centralized Provider Enrollment and Credentialing**

      i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

         a) The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid or NC Health Choice programs (or both).

            1. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
            2. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

         b) The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid or NC Health Choice services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

         c) The process and information requirements shall meet the most current applicable data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.

1. The applicable data and processing standards shall be consistent with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.

d) Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid Enrolled provider, with the application serving for enrollment as a Medicaid Fee-for-Service provider as well as a Medicaid managed care provider.
   1. The Department shall not mandate Medicaid managed care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

e) Providers will be reverified and recredentialed every three years, except as otherwise specifically permitted by the NC DHHS in the Contract.

f) A PHP shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the PHP will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.

g) The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers.
   1. A PHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

b. **Provider Credentialing and Re-credentialing Policy**

i. The PHP shall develop and implement, as part of its Credentialing and Re-credentialing Policy, through written policies and procedures for the selection and retention of network providers based upon the Department's Uniform Credentialing and Re-credentialing Policy. The PHP's Policy, at a minimum, must:

a) Meet the requirements specified in 42 C.F.R. § 438.214;

b) Meet the requirements specified in this Contract;

c) Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;

d) Establish that the PHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval;

e) Reserved.

f) Reserved.

g) Prohibit PHP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment;

h) Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

i) Prohibit PHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;

j) Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.
k) Reserved.
l) Reserved.
m) Reserved.
n) If PHP requires a provider to submit additional information as part of its contracting process, the PHP's policy shall include a description of all such information.
o) PHP shall evaluate a provider's continued eligibility as follows:
    1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
    2. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
p) Include a statement that the current policy and all previous versions will be published on the PHP's website and include the Policy effective dates of each version.

ii. PHP shall follow this Policy and its Provider Credentialing and Re-credentialing Policy when making a network contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state network providers.
iii. PHP shall have discretion to make network contracting decisions consistent with this Department Policy and the PHP's Provider Credentialing and Re-credentialing Policy.
iv. PHP shall publish its approved Provider Credentialing and Re-credentialing Policy, including all previous versions, on the PHP's website and include the effective date of each Policy. The PHP shall make the Credentialing/Recredentialing Policy available, within ten (10) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

SECTION X. FOURTH REVISED AND RESTATED SUMMARY OF CONTRACTUAL PAYMENT AND RISK SHARING TERMS

A. This Section summarizes SFY 2023 capitation payment and risk sharing terms and figures included in the Standard Plan Rate Book for State Fiscal Year 2023 dated May 26, 2022. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,682.70	$1,601.73	$1,858.52	$1,701.82	$1,536.52	$1,532.32
TANF, Newborns (<1)	$1,027.18	$831.15	$924.50	$865.21	$828.49	$866.10
TANF, Children (1–20)	$183.73	$162.03	$174.11	$160.48	$162.78	$157.99
TANF, Adults (21+)	$404.84	$412.59	$422.13	$407.58	$431.61	$406.60
Maternity Event	$11,515.44	$10,862.95	$12,417.16	$11,257.89	$10,782.66	$11,805.50

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	91.7%	91.0%	91.5%	90.9%	91.3%	91.3%
TANF, Newborns (<1)	91.1%	90.3%	90.8%	90.0%	90.5%	90.6%
TANF, Children (1–20)	88.2%	87.6%	87.8%	85.8%	87.2%	87.7%
TANF, Adults (21+)	89.9%	89.4%	89.7%	89.1%	89.5%	89.6%
Maternity Event	94.5%	94.0%	94.3%	94.0%	94.2%	94.2%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.5%	4.8%	4.7%	4.5%	5.4%	4.8%
TANF, Newborns (<1)	11.2%	15.2%	14.2%	13.7%	15.4%	13.3%
TANF, Children (1–20)	17.9%	19.1%	18.6%	17.9%	18.4%	17.6%
TANF, Adults (21+)	8.9%	8.9%	9.3%	9.2%	10.3%	9.0%
Maternity Event	15.3%	16.1%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.2%	88.8%	85.8%	88.1%	92.3%	88.0%