

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, “*Agreement*”) is made and entered into by and between Test Provider (“*Provider*”) and Carolina Complete Health, Inc. (“*Health Plan*”) (each a “*Party*” and collectively the “*Parties*”). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement (“*Effective Date*”).

WHEREAS, Provider desires to provide certain health care services to individuals enrolled in Products offered by or available from or through a Company or Payor (as defined herein), and Provider desires to participate in such Products as a “Participating Provider,” as set forth herein; and

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals enrolled in such Products, and Health Plan desires to have Provider participate in certain of such Products as a Participating Provider, as set forth herein.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE 1 - DEFINITIONS

When capitalized in this Agreement, the following terms have the meanings set forth below.

1.1 ***Affiliate*** means, at any time during the Term hereof, an entity directly or indirectly controlling, controlled by or under common control with the applicable Party.

1.2 ***Attachment*** means any attachment, addendum, schedule or exhibit that is attached to this Agreement as of the Effective Date or thereafter, each of which is incorporated in this Agreement by reference and may be amended from time to time as provided herein. References to this “Agreement” include references to all Attachments.

1.3 ***Clean Claim*** has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4 ***Company*** means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates that choose to participate in the rights and benefits of this Agreement.

1.5 ***Compensation Schedule*** means, at any given time, the then-effective schedule(s) of maximum rates payable to Provider or Contracted Providers for Covered Services provided to Covered Persons with respect to a particular Product, as set forth in an Attachment.

1.6 ***Contracted Provider*** means a physician, hospital, health care professional or any other provider of Covered Services that has a downstream relationship with Provider (i.e., is employed by or has a direct or indirect contractual relationship with Provider) and that was listed on the immediately preceding Roster Report (as such term is defined in Section 2.2.3). For the purposes of this Agreement, to the extent that Provider provides Covered Services under this Agreement, the term “Contracted Provider” also includes Provider.

1.7 ***Cost-Sharing Amounts*** means any amounts payable by a Covered Person, such as copayments, cost-sharing coinsurance, deductibles or other amounts that are the Covered Person’s financial responsibility under the applicable Coverage Agreement, if applicable.

1.8 ***Coverage Agreement*** means any agreement or program entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative or other services in support of a health care program for an individual or group of individuals, which may include or reference a list of benefits to which Covered

Persons are entitled and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.9 **Covered Person** means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.10 **Covered Services** means those services and items that Company determines are Medically Necessary, payable and covered under the applicable Coverage Agreement.

1.11 **Governmental Contract** means the Company's or Payor's contract with a governmental authority under which Company or Payor arranges for the provision of Covered Services to Covered Persons. For purposes of this Agreement, a Governmental Contract may function as a Coverage Agreement as well as a Payor Contract.

1.12 **Medically Necessary** shall, as to each particular Product, have the meaning defined in the applicable Coverage Agreement or Regulatory Requirements.

1.13 **Participating Provider** means, with respect to a particular Product, any physician, hospital, ancillary or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company and that is designated by Company as a "participating provider" in such Product.

1.14 **Payor** means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.15 **Payor Contract** means the contract with a Payor, pursuant to which Company furnishes administrative or other services in support of Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. For purposes of this Agreement, "Payor Contract" includes any applicable Governmental Contract.

1.16 **Product** means any program or health benefit arrangement designated as a "product" by Health Plan that is now or hereafter offered by or available from or through Company. Such designation shall be indicated by Health Plan's adoption of a separate Product Attachment specific to such Product.

1.17 **Product Attachment** means, as to each particular Product, the Attachment setting forth requirements, terms and conditions specific or applicable to such Product, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.18 **Provider Manual** means, as to each particular Product, the provider and billing manuals adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, submission and processing of claims, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time. References herein to the "Provider Manual" shall be understood to mean references to the specific Provider Manual(s) applicable under the circumstances.

1.19 **Regulatory Requirements** means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization including, but not limited to, the requirements set forth in a Product Attachment.

1.20 **State** is defined as the state where Company is licensed, except as otherwise identified in the applicable Attachment.

ARTICLE 2 - PRODUCTS AND SERVICES

2.1 **Contracted Providers.** Provider shall cause each Contracted Provider to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions that are applicable to a Contracted Provider under this Agreement and the Provider Manual and/or Policies (as defined in Section 2.4 herein), and to fulfill all of the duties, responsibilities and obligations imposed on Contracted Providers under this Agreement and such Provider Manual and/or Policies.

2.2 **Participation in Products.**

2.2.1 Provider shall, at all times during the Term (as defined in Section 7.1 herein), require each of its Contracted Providers to, subject to Company's approval as set forth in this Article 2, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2 A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider (i) will participate in all or a minimum number of provider panels or networks; (ii) will be used by a minimum number of Covered Persons; or (iii) will indefinitely remain a Participating Provider or member of a provider panel or network.

2.2.3 Provider shall provide Health Plan with the information listed on Schedule C, entitled "Contracted Provider Information," for itself and all Contracted Providers as of the Effective Date (the "**Initial Roster Report**"). Thereafter, if at any time during the Term the information in the Initial Roster Report or any subsequent Roster Report (as such term is defined herein) changes, Provider shall provide Health Plan with a list of such modifications at least 30 days prior to the effective date of such changes, subject to the requirements of Section 2.2.4 (the Initial Roster Report and each modified roster report thereafter to be referred to as a "**Roster Report**"). Each Roster Report shall be provided in a manner and format reasonably requested by Health Plan.

2.2.4 If Provider wishes to include a new employed or contracted provider in a Roster Report where such provider was not included in the immediately preceding Roster Report (i.e., in the event Provider wishes to add a "new Contracted Provider") to this Agreement, Provider shall provide written notice to Health Plan of the prospective addition(s). If the new provider is an individual practitioner for whom Covered Services will be billed under a tax identification number ("**TIN**") reported by Provider on the immediately preceding Roster Report (a "**New Practitioner Under An Existing TIN**"), such individual practitioner shall become a Contracted Provider under the Agreement within 60 days from the date of Provider's written notice, unless Health Plan notifies Provider that such individual practitioner is not accepted by Health Plan. If the new provider is not a New Practitioner Under An Existing TIN, such provider will become a Contracted Provider under this Agreement (i) within 60 days of the date of Health Plan's written acceptance of the Contracted Provider; or (ii) upon the amendment of this Agreement. Provider shall, through written agreements with each of its Contracted Providers (other than Provider) or otherwise, require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.3 **Covered Services.** With respect to those Products in which Contracted Provider is a Participating Provider, each Contracted Provider shall provide Covered Services to Covered Persons enrolled in such Products, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to individuals who are not Covered Persons, within the

scope of Contracted Provider's license, if applicable, and in accordance with generally accepted standards of Contracted Provider's practice and business and all applicable Regulatory Requirements.

2.4 Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times comply with the requirements, policies, programs and procedures established by Company or Payor (collectively, "**Policies**") which may be described in this Agreement, the Provider Manual or other communications from Company or Payor, and which include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; procedures relating to claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievances and appeals; submission, re-submission and processing of claims; risk adjustment and grouper submission; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. Provider acknowledges that the failure to comply with such Policies could result in a denial or reduction of payment to Provider or Contracted Provider, as determined by Company or Payor. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers through one or more designated websites or alternative means, or by providing a copy upon request. Health Plan will use reasonable efforts to notify Provider in advance of a material change to the Provider Manual. Such notice may be given by a periodic provider newsletter, an update to the on-line Provider Manual or any other written method (electronic or paper).

2.5 Credentialing Criteria. Provider and each Contracted Provider shall complete the credentialing and/or recredentialing process as required by Company's Policies and shall, at all times during the Term hereof, meet all of Company's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees (a) that it is currently, and for the duration of this Agreement shall remain, (i) in compliance with all applicable Regulatory Requirements, including licensing laws (ii), if applicable, accredited by The Joint Commission or the American Osteopathic Association and (iii), if applicable, a Medicare and/or Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6 Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company will make available to Provider and Contracted Providers a method whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. Company will use reasonable efforts to include or contractually require Payors to clearly display Payor's name, logo, mailing address or other identifier on each membership card.

2.7 Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide Covered Services. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8 Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that Company or Payor determinations that certain items or services are not Covered Services, or that Covered Services have not been provided or billed in accordance with the requirements of this Agreement, the Provider Manual and/or Policies, are administrative decisions only. Such decisions do not absolve the Contracted

Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement is intended to interfere with Contracted Provider's relationship with Covered Persons or prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality or medical treatment decisions or alternatives.

2.9 Carve-Out Vendors. Provider acknowledges that Company may, during the Term hereof, subcontract network responsibility or otherwise delegate responsibility for the provision of (i.e., "carve-out") certain Covered Services as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, use such carve-out vendors designated by Company for those Covered Services identified by Company.

2.10 Contractual Interference. Neither Provider nor Contracted Providers shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. During the Term and for one year thereafter, Provider and Contracted Providers shall not steer or otherwise directly or indirectly solicit any Covered Person to join a competing health plan or induce any Covered Person to cease doing business with Company. Provider (and each Contracted Provider) and Company shall not publicly disparage the other during the Term or in connection with any expiration, termination or non-renewal of this Agreement. Nothing in this Agreement should be construed as limiting the ability of Provider or Contracted Providers to promote Provider to the general public or to post information regarding other health plans consistent with Regulatory Requirements and Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. Except as may be otherwise required by Regulatory Requirements, Provider and Contracted Providers may not inform Covered Persons that this Agreement has been terminated or non-renewed sooner than 30 days prior to the effective date of such termination or non-renewal.

2.11 Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, identity or type of Payor, rate or source of payment (e.g., Medicaid or other State-specific health care program), physical or mental disability, or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to Provider's subcontractors, and Provider and each Contracted Provider agree to comply with such requirements.

2.12 Notice of Certain Events. Provider shall give written notice to Health Plan of (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any material change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days from the date it first obtains knowledge of the pending of the same.

2.13 Use of Name. Provider and each Contracted Provider hereby authorizes Company and Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any) and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14 Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement in accordance with all applicable Regulatory Requirements. If sanctions or penalties are imposed on Company due to Provider's or Contracted Provider's (or any of their respective subcontractors') noncompliance with applicable Regulatory Requirements or this Agreement,

Health Plan may hold Provider responsible for that portion of such sanctions or penalties that are the result of Provider's or Contracted Provider's (or any of their respective subcontractors') noncompliance.

2.15 Program Integrity Required Disclosures. The following shall apply with respect only to any Medicaid Product(s) in which Provider and Contracted Providers participate under this Agreement. Provider agrees to furnish Health Plan with complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B, or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include, but are not limited to, (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

2.16 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Per NCQA Standards, Provider and each Contracted Provider agree to cooperate with Company's quality improvement ("**QI**") activities including, but not limited to, the collection of performance measurement data and participation in Company's clinical and service measure QI programs.

2.17 Provider Directory Information. Provider and Contracted Providers agree to facilitate the prompt and timely updating of Payor's provider directory by (a) promptly responding to all requests from Health Plan regarding provider directory accuracy; (b) promptly notifying Health Plan if Provider or Contracted Providers become aware of an error or inaccuracy in Provider's or Contracted Provider's provider-directory listing; and (c) promptly providing Health Plan notice if Provider's or Contracted Provider's provider-directory information changes including, but not limited to, providing prompt notification of any changes to Provider's or Contracted Provider's phone number, physical address for patient visits, TIN, National Provider Identifier (NPI), group name or affiliation, specialties, office hours and whether Provider or Contracted Provider is accepting new patients.

ARTICLE 3 - CLAIMS SUBMISSION, PROCESSING AND COMPENSATION

3.1 Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall timely submit to Payor complete and accurate claims and coding for payment for Covered Services rendered to Covered Persons. If Contracted Provider is not otherwise required to submit a claim (e.g., certain capitation arrangements), Contracted Provider shall submit complete and accurate encounter data to Payor in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information and be supported by the medical record. Payor may deny payment to Contracted Provider if Contracted Provider fails to submit timely, complete and accurate claims for payment or encounter data in accordance with the Provider Manual and/or Policies or if Contracted Provider fails to provide the medical record supporting the claim when reasonably requested by Payor.

3.2 Compensation. Compensation payable for Covered Services provided to a Covered Person will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service, subject to the terms of this Agreement, Provider Manual and/or Policies ("**Compensation Amount**"). Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount, less any applicable Cost-Sharing Amounts. Provider and Contracted Provider agree that under no circumstances shall Company or Payor be responsible for Cost-Sharing Amounts. Claims for services not included in the applicable Product benefit plan, pursuant to the applicable Coverage Agreement, are not reimbursable under this Agreement, notwithstanding any other term of this Agreement. If a governmental authority imposes a reduction to the federal or State funds that Health Plan receives under a Governmental Contract, Health Plan may

adjust its payments to Provider and/or Contracted Providers by an equivalent or comparable amount, effective as of the dates such reductions are imposed on Health Plan.

3.3 Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4 Hold Harmless. Provider and each Contracted Provider agree that in no event, including, but not limited to, non-payment by a Payor, a Payor's insolvency or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any Cost-Sharing Amounts. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5 Recovery Rights. Payor shall have the right to offset or recoup amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to Provider or a Contracted Provider under this Agreement or any other agreement. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now or hereafter have jurisdiction over Provider or Contracted Provider. Provider acknowledges that Payor reserves the right to identify overpayments inadvertently paid to Provider or Contracted Providers through an audit process and that any amounts so identified shall be subject to recoupment under this section.

ARTICLE 4 - RECORDS AND INSPECTIONS

4.1 Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons including, but not limited to, a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to other health care providers that provide health care services to such Covered Person, at no charge.

4.2 Access. Company and/or Payor require access to and copies of records as provided for in this section for purposes of complying with a wide array of regulatory, statutory and business data collection and reporting requirements and Company Policies including, but not limited to, requirements relating to quality (e.g., HEDIS®) gaps closure, accurate risk adjustment, clinical and population health stratification and prioritization, investigation of potential quality of care concerns, and continuity of care and care planning purposes, among others. During the Term and for a period of 10 years following termination hereof, Provider and each Contracted Provider shall provide access to their respective books and records (including, but not limited to, medical records) relating to services provided or payment under this Agreement to each of the following, including any delegate or duly authorized agent thereof, upon request, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon reasonable prior notice, which may be by electronic mail; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request, which may include providing records through Provider's electronic record system. Such copies shall be provided within the timeframe reasonably requested by Health Plan, including as necessary to allow Company to comply with Regulatory Requirements or requests from state or federal governmental agencies. Each Contracted Provider shall obtain such Covered Person's authorization or consent as may be required to release medical records and information to Company or Payor. Provider and each Contracted Provider shall additionally cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, any authorized government officials, upon reasonable prior notice, which notice may be by electronic mail, during the

Term. Provider and each Contracted Provider shall compile and make available such information as necessary for the expeditious completion of such on-site inspection.

4.3 EMR Access. For purposes of facilitating Company's and/or Payor's access to records as set forth in this Agreement, subject to applicable Regulatory Requirements, Provider will make such electronic medical record (EMR) data relating to Covered Persons that is requested by Company available and accessible to Company within 120 days of the Effective Date and at all times during the Term (and for such periods following termination of this Agreement during which Company has access to Provider records under this Agreement) through one or more of the following methodologies, or any other methodology agreed to by the Parties: 1) connectivity with Company's preferred EMR platform; 2) Company electronic access to APIs (Application Programming Interfaces); 3) use of HL7 and FHIR data transfer protocols; and/or 4) data-formatted content delivered via Continuity of Care Document (CCD) data specifications. Provider shall work with Company in good faith to ensure that the implementation of such methodology is successful and that Company is able to access records through Provider's EMR system thereafter for purposes set forth in this Agreement. In the event that Provider fails to comply with this provision, Company or Payor shall be entitled to withhold payments payable to Provider under this Agreement until such time that Provider has fully implemented EMR access, and during any subsequent periods in which Provider has not maintained Company's EMR access, as set forth in this section. Provider agrees where applicable to waive any and all interest and penalties that may otherwise be payable to Provider in connection with such withheld amounts.

ARTICLE 5 - INSURANCE AND INDEMNIFICATION

5.1 Insurance. During the Term and for any applicable continuation period as set forth in Article 7 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and each Contracted Provider, their respective employees and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries, bodily injuries or death alleged to have been caused or caused by its, his or her performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier with an AM Best rating of A- VII or better, and in a minimum amount of \$1,000,000 per occurrence, and \$3,000,000 in the aggregate, unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse or adverse material modification of such coverage. Upon Health Plan's request, Provider will furnish Health Plan with evidence of such insurance.

5.2 Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and each of their respective officers, directors, agents and employees ("**Representatives**") from and against any and all third party claims for any loss, damages, liability, costs or expenses (including reasonable attorney's fees), judgments or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Provider, Contracted Provider or any of their respective Representatives.

5.3 Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers and their Representatives from and against any and all third party claims for any loss, damages, liability, costs or expenses (including reasonable attorney's fees), judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Company or its Representatives.

ARTICLE 6 - DISPUTE RESOLUTION

6.1 Informal Dispute Resolution. As a condition precedent to arbitration under Section 6.2, any dispute between Provider and/or a Contracted Provider, as applicable (the "**Provider Party**"), and Health Plan and/or Company or Payor, as applicable (including any Company acting as Payor) (the "**Administrator Party**"), with respect to any claim or cause of action, whether sounding in tort, contract, under statute, or otherwise (a "**Dispute**") shall first

be addressed by timely exhausting the applicable procedures in the Provider Manual pertaining to appeals and disputes (including the associated timeframes for such appeals and disputes), claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date upon which the claim(s) at issue in the Dispute were initially adjudicated by Health Plan. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below.

6.2 Arbitration. If either the Provider Party or the Administrator Party (the “Parties” for the purposes of this paragraph) wishes to pursue the Dispute as provided in Section 6.1, and has exhausted the requirements of Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association (“AAA”). In no event may any arbitration be initiated more than one year following exhaustion of Health Plan’s appeals process or the date of notice of termination of this Agreement. This one-year period shall not be estopped, waived or tolled, other than by express mutual written agreement. In addition to any notice requirements under this Agreement, if the Provider Party initiates arbitration, notice of the initiation of the arbitration shall be sent via registered mail to the mailing address of the registered agent of the Administrator Party on file with the applicable state office maintaining registered agent information for the purposes of filing a lawsuit or legal action. Arbitration proceedings shall be conducted under the laws of the State by an arbitrator chosen in accordance with the Commercial Arbitration Rules of the AAA at a mutually agreed upon location. The Parties agree that both the existence and conduct of the arbitration is confidential, and nothing related to the arbitration including, but not limited to, any rulings or awards by the arbitrator shall be disclosed to any third party. The arbitrator shall have no authority to award any punitive, indirect, consequential, special or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than \$100,000 shall be conducted in a single hearing day. The Parties and Provider and/or Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. The Provider Party and the Administrator Party shall each bear its own costs and attorneys’ fees related to the arbitration except that the AAA’s administrative fees, and all arbitrator compensation and travel and other expenses, shall be borne equally by the Parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, the Provider Party and the Administrator Party shall each continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein or in Section 6.1 shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Neither Party shall petition a court of competent jurisdiction for confirmation of an award earlier than 30 days after the award is issued. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) or the arbitration award in the public court record, except this section 6.2. Nothing contained in this Article 6 shall limit a Party’s right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE 7 - TERM AND TERMINATION

7.1 Term. This Agreement is effective as of the Effective Date, and will remain in effect for an initial term (“**Initial Term**”) of three year(s), after which it will automatically renew for successive terms of one year each (each a “**Renewal Term**”) (such Initial Term and each Renewal Term to be collectively referred to as the “**Term**”), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 180 days prior to the end of the Term. In addition, either Party

may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving the other Party written notice of such non-renewal not less than 180 days prior to the end of the Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination or non-renewal of a Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or such Contracted Provider's participation in any other Product in which the Contracted Provider participates under this Agreement. Anything in this Article 7 may, with respect to a particular Product, be superseded by provisions in the applicable Product Attachment.

7.2 Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1 Upon Notice. This Agreement may be terminated by Provider after the Initial Term by giving Health Plan at least 180 days prior written notice of such termination. This Agreement may be terminated by Health Plan giving Provider at least 180 days prior written notice of termination. The participation of any Contracted Provider as a Participating Provider in a particular Product may be terminated by Health Plan giving at least 180 days prior written notice to Provider; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2 With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this section must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3 Immediate Suspension. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons; or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4 Immediate Termination. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria including, but not limited to, if the Contracted Provider (i) loses, relinquishes or has materially affected its license to provide Covered Services in the State; (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it, or if a Party has been convicted of a criminal offense related to involvement in any state or federal health care program, or is excluded, debarred, suspended or otherwise ineligible to participate in any state or federal health care program.

7.3 Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those rights and obligations

arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements and, if requested by Company, each affected Contracted Provider shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until the earliest such time that Health Plan can reasonably assign or transfer Covered Person to another Participating Provider; and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4 Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement including, without limitation, Sections 2.8, 2.10, 2.14, 3.1, 3.2, 3.4, 3.5, 4.2, 4.3, 5.1, 5.2, 5.3, 6.1, 6.2, 7.3 and Article 8, survive the expiration or termination of this Agreement.

ARTICLE 8 - MISCELLANEOUS

8.1 Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors; none of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer or other relationship.

8.2 Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3 Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Any change in control of Provider resulting from a merger, consolidation, stock transfer or asset sale shall be deemed an assignment or transfer for purposes of this Agreement. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement. Company may at any time, at its discretion, delegate all or a portion of its obligations under this Agreement to one or more third parties. Provider and Contracted Providers shall cooperate with such third-party vendor.

8.4 Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define or extend the specific terms of the section so designated.

8.5 Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws. This Agreement (including all Attachments) shall be construed in a manner that is compliant with all applicable Regulatory Requirements and shall be understood to be automatically updated to conform with such Regulatory Requirements.

8.6 Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Notwithstanding the above, except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7 Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1 Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2 Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the 30-day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8 Entire Agreement. Unless otherwise provided herein, all prior or concurrent agreements, promises, negotiations or representations, either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect. Notwithstanding the above, in the event that at any time during the Term, in addition to this Agreement, (i) Provider or Contracted Provider is included in a Product network pursuant to the terms of an agreement between Provider or Contracted Provider and a third party; or (ii) Provider is a party to a participating provider agreement directly with Company, Health Plan shall select between or among the agreements which agreement will be operationalized with respect to Company, Provider and/or Contracted Provider, as applicable.

8.9 Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10 Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11 Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been (i) personally delivered; (ii) deposited in the United States mail, postage paid; or (iii) delivered in hard copy by a service that provides written receipt or acknowledgment of delivery, or electronically with proof of delivery, addressed as follows:

To Health Plan at:
Attn: President
Carolina Complete Health, Inc.
1701 N. Graham St., Suite 101
Charlotte, NC 28206-3571

To Provider at:
Attn:
Test Provider
,

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12 Proprietary Information. Provider is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from Company (or from an Affiliate thereof) during the course of this Agreement, except to agents of such party as necessary for such party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements, or to communicate with regulatory authorities as deemed reasonably necessary or appropriate by Company. Information that is disclosed by Provider for the purpose of complying with Regulatory Requirements including, but not limited to, state or federal price transparency requirements, may not be further disclosed by Provider to third parties except as set forth in this section. Provider acknowledges and agrees that all

information relating to Company's programs and policies is proprietary information and Provider shall not disclose such information to any person or entity without Company's express written consent.

8.13 Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has legal authority to contract on behalf of and to bind all Contracted Providers to the terms of this Agreement. Administrative activities undertaken by Company hereunder may be undertaken by an Affiliate. Where Company is not the Payor, Payor may from time to time perform administrative and/or decision-making functions of Company under this Agreement. Payor functions hereunder may be undertaken by a delegate. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively, and such references in no way impose any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company, Payor, or Health Plan Affiliate including, but not limited to, Health Plan.

* * * * *

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**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION
THAT MAY BE ENFORCED BY THE PARTIES.**

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:

Carolina Complete Health, Inc.

Authorized Signature:

Print Name: Ajhezza Martinez

Title: Vice President, Network Development & Contracting

Signature Date: {{ \$IntDate }}

ICM #: ICMProviderAgreementNC 442

PROVIDER:

Test Provider

(Legibly Print Name of Provider)

Authorized Signature:

Print Name: {{ *Name_es_ :Signer1 }}

Title: {{ *Ttl1_es_ :Signer1 :title }}

Signature Date: {{ \$ExtDate }}

Tax Identification Number: 00-0000000

To be completed by Health Plan only:

Effective Date: {{ \$EffDate }}

{{#ExtDate=ExtSignDate_es_ :signer1 :date }}
{{#IntDate=IntSignDate_es_ :signer2 :date }}

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital (“**Hospital**”), the following provisions apply.

1.1. 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons 24 hours per day, 7 days per week.

1.2. Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company’s medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. “**Emergency Care**” (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, “Emergency Care” means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. “**Emergency Medical Condition**” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3. Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company’s Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital’s medical staff and bylaws, rules and regulations.

1.4. Discharge Planning. Each Hospital agrees to comply with Company’s Policies relating to the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care. Hospital shall be responsible for coordinating the discharge and transfer of Covered Persons, though Company will cooperate and may assist in such efforts.

1.5. Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) (“**Practitioner**”), the following provisions apply.

2.1. Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider (“**Participating Hospital**”) with respect to each Product in which the Practitioner participates. Upon Company’s request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2. Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient. Execution of this Agreement shall constitute Provider and Contracted Provider's agreement to timely schedule appointments to see Covered Persons in all Products hereunder within the timeframes required under applicable Regulatory Requirements, or if no such requirements exist, within a reasonable time period consistent with the timeframes made available to Contracted Provider's other patients.

2.3. Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including, but not limited to, a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center) ("**Ancillary Provider**"), the following provision applies.

3.1. Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("**FQHC**"), the following provision applies.

4.1. FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("**FTCA**") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "**FTCA Coverage**"), the "Insurance" section of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. The "Insurance" section of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Long Term Services and Supports ("**LTSS**") and Home and Community-Based Services ("**HCBS**") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

5.1. Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility or other institutional setting. HCBSs are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

5.2. HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

5.3. Conditions for Reimbursement. No payment shall be made to Provider unless Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program including, but not limited to, not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this schedule, "**HCBS Waiver Program**" shall mean any special Medicaid program operated under a waiver approved by the Centers

for Medicare & Medicaid Services (CMS) which allows the provision of a special package of approved services to Covered Person.

5.4. Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

5.5. Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, by written notice or telephone contact at a number to be provided by Health Plan, within the following time frames:

5.5.1. Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

5.5.2. Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

5.5.3. Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

5.5.4. Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change (examples of changes in condition are set forth in the Provider Manual).

5.5.5. Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue (examples of safety issues are set forth in the Provider Manual).

5.5.6. Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

5.6. Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be by electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

5.7. Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

5.8. Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

5.9. Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted Provider or sub-contracted provider. Provider shall pay any costs associated with such criminal background checks.

6. Person-Centered Planning, Care/Service Plan and Services (“PCSP”). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans and services including, but not limited to:

6.1. Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

6.2. The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

6.3. LTSS provider shall be aware of, respect and adhere to a Covered Person’s preferences for the delivery of services and supports.

6.4. LTSS provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable) and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

6.5. Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS provider(s) responsible for implementation.

7. Laboratories. If Provider or Contracted Provider is a laboratory, the following provision applies.

7.1. Informatics Data. Notwithstanding anything contained in this Agreement to the contrary, Provider shall only be obligated to provide aggregations of clinical data, utilization reports, clinical results, patient-specific details, outcomes analysis, financial performance indicators, full Healthcare Effectiveness Data and Information Set (HEDIS) requirement tracking indicators, data tapes or electronic transmission containing clinical and demographic information as may be specifically set forth in, as applicable, a “Lab Data Services Agreement,” or other such agreement as agreed to by the Parties, executed between the Parties.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B PRODUCT PARTICIPATION

Provider will be designated as a “Participating Provider” in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid

- Schedule A: Governmental Program Requirements (Standard Plan)
- Schedule A-1: Tailored Plan Program (select one or both):
 - Partners Health Management
 - Trillium Health Resources

Attachment B: [Reserved]

Attachment C: [Reserved]

Attachment D: [Reserved]

Attachment E: [Reserved]

Attachment F: [Reserved]

Attachment G: [Reserved]

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PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C CONTRACTED PROVIDER INFORMATION

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Panel status (accepting new patients Y/N)
17. Languages spoken at office
18. Languages spoken by provider
19. Telehealth
20. Office contact person
21. Office hours
22. Billing office
23. Billing office address
24. Billing office telephone and facsimile numbers
25. Billing office e-mail address
26. Billing office contact person
27. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT North Carolina

This MEDICAID PRODUCT ATTACHMENT (“*Product Attachment*”) is made and entered between Carolina Complete Health, Inc. (“*Health Plan*”) and Provider.

WHEREAS, Health Plan and Provider entered into a provider agreement, as the same may have been amended and supplemented from time to time (“*Agreement*”), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement or, if not defined there, in the State Contract (as herein defined). All technical managed care terms used in this Product Attachment are defined in the Agreement or this Product Attachment and are consistent with definitions included in Covered Person materials issued in conjunction with the Medicaid managed care program. Citations to governmental authority requirements are provided herein for convenience only and shall not affect the meaning or interpretation of the terms of this Product Attachment. Such citations shall be deemed to be automatically updated, as applicable.

1.1 “*Amendment*” means any change to the terms of a contract, including terms incorporated by reference that modifies fee schedules. A change required by federal or state law, rule, regulation, administrative hearing or court order is not an amendment.

1.2 “*Clean Claim*” means a claim submitted to a prepaid health plan (PHP) by a service provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system (claims that will deny). It does not include a claim from a provider who is suspended or under investigation for fraud or abuse, or a claim under review for medical necessity. 42 C.F.R. § 447.45(b). Determination of whether a claim is clean rest with Health Plan and must be determined for each claim, provided applied consistently and reasonably. (85 FR 72754, 72819)

1.3 “*Emergency Medical Condition*” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in the following: placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. “Emergency Medical Condition” also means a medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.

1.4 “*Emergency Services*” means inpatient and outpatient services furnished by a qualified provider needed to evaluate or stabilize an Emergency Medical Condition.

1.5 “**Health Care Provider**” means an individual who is licensed, certified or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes of North Carolina or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes of North Carolina or is owned or operated by the State of North Carolina in which health care services are provided to patients.

1.6 “**Medicaid Product**” refers to those programs and health benefit arrangements offered by Health Plan or other Company pursuant to a State Contract. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product’s attachment to the Agreement.

1.7 “**Medically Necessary Service**” or “**Medically Necessary**” is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature. (Section VII, G(1)(b)(i))

1.8 “**Objective Quality Standards**” means the objective standards for quality determinations identified by Health Plan that assess a provider’s ability to deliver care; include specific defined thresholds for adverse quality determinations; meet standards established by the National Committee on Quality Assurance (NCQA); and are not discriminatory.

1.9 “**Primary Care Provider**” or “**PCP**” means the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Covered Person to provide and coordinate the Covered Person’s health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians and internal medicine physicians.

1.10 “**State**” means the state of North Carolina.

1.11 “**State Contract**” means a contract between Health Plan or other Company and one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so.

2. Medicaid Product.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the “Medicaid Product Attachment” and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply to maintain such participation. This Product Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2 Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This attachment constitutes the Product Attachment and Compensation Schedule(s) for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from Health Plan. To the extent any provision of the Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Product Attachment. The effective date of any Participating Provider added under the Agreement shall be the later of the Effective Date of the Agreement, or if amended, the amendment effective date, or the date by which the Participating Provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s). (Section VII, G(3)(h))

4. State Mandated Program Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract to be included in the Agreement with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

5. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A GOVERNMENTAL PROGRAM REQUIREMENTS NORTH CAROLINA

This schedule sets forth the special provisions that are specific to the North Carolina Medicaid Product under the State Contract.

1. Compliance.

1.1 Compliance with State and Federal Laws. Participating Provider understands and agrees that it, he or she 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 Agreement and State Contract, and all persons or entities receiving state and federal funds. Participating Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to the Agreement, or any violation of the State Contract, could result in liability for money damages and/or civil or criminal penalties and sanctions under state and/or federal law. (Section VII, Section G(3)(a))

1.2 Department Authority Related to the Medicaid Program. Participating Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services (“*NC DHHS*”) 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. (Section VII, G(3)(e))

1.3 Credentialing. Each Participating Provider shall be enrolled as a Medicaid provider as required by 45 C.F.R. § 455.410 and maintain enrollment for the term of the Agreement. Participating Provider shall maintain licensure, accreditation and credentials sufficient to meet Health Plan’s network participation requirements, as outlined in the State’s Credentialing and Re-credentialing Policy. Participating Provider shall notify NC DHHS of changes in the status of any information relating to Participating Provider’s professional credentials. Participating Provider shall complete reenrollment or re-credentialing before renewal of the Agreement as set forth below:

(a) during the provider credentialing transition period, no less frequently than every five years;
and

(b) during the provider credentialing under full implementation, no less frequently than every three years, except as otherwise permitted by NC DHHS. (*Section VII, G(1)(f)*)

1.4 Liability Insurance. Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to Health Plan. Participating Provider shall notify Health Plan of subsequent changes in the status of Participating Provider’s professional liability insurance on a timely basis. (Section VII, G(1)(g))

1.5 Utilization Management. Participating Provider shall comply with Health Plan’s utilization management programs, quality management programs and provider sanction programs, except to the extent that any of these programs conflict with Participating Provider’s professional or ethical responsibility or interfere with Participating Provider’s ability to provide information or assistance to patients. (Section VII, G(1)(o))

1.6 Dispute Resolution. Participating Provider shall use the applicable dispute resolution procedures outlined in the Agreement to resolve disputes between Health Plan and Participating Provider. (Section VII, G(1)(q))

1.7 Reporting Requirements. Participating Provider shall promptly provide Health Plan with the data and information that Health Plan requests to meet its reporting requirements under the State Contract. (Section VII, J. Table 1)

1.8 Hours of Operation. Participating Provider will offer hours of operation to Covered Persons that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Participating Provider serves only Medicaid members. (Section V, D(1)(d)(iii))

2. Entire Agreement. The Agreement identifies the documents that constitute the entire contract between the parties. (Section VII, G(1)(a))

3. Hold Harmless. Participating Provider agrees to hold the Covered Person harmless for charges for any Covered Service. Participating Provider agrees not to bill a Covered Person for Medically Necessary Services covered by Health Plan so long as the Covered Person is eligible for coverage. (Section VII, G(3)(b)). Participating Provider will not hold Covered Person's responsible for any of the following: (a) Health Plan's debts in the event of its insolvency; (b) Covered Services provided to the Covered Person for which (i) NC DHHS does not pay Health Plan or (ii) NC DHHS, or Health Plan, does not pay the Participating Provider; (c) payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if Health Plan covered the services directly. (42 C.F.R. § 438.106) (Section V, C(1)(i)(iii) and Section V, C(2)(r)(iii))

4. Liability. Participating Provider understands and agrees that NC DHHS does not assume liability for the actions of, or judgments rendered against, Health Plan, Payors, its employees, agents or subcontractors. Further, Participating Provider understands and agrees that there is no right of subrogation, contribution or indemnification against NC DHHS for any duty owed to Participating Provider by Health Plan or Payor or any judgment rendered against Health Plan or Payor. (Section VII, G(3)(c))

5. Non-Discrimination.

5.1 Equitable Treatment of Covered Persons. Participating Provider agrees to render provider services to Covered Persons with the same degree of care and skills as customarily provided to Participating Provider's patients who are not Covered Persons, according to generally accepted standards of medical practice. Participating Provider and Health Plan agree that Covered Persons and non-Covered Persons should be treated equitably. Participating Provider agrees not to discriminate against Covered Persons on the basis of race, color, national origin, age, sex, gender or disability. (Section VII, G(3)(d))

5.2 Interpreting and Translation Services. Participating Provider shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Covered Person. Participating Provider shall ensure that Participating Provider's staff are trained to appropriately communicate with patients with various types of hearing loss. Participating Provider shall report to Health Plan, in a format and frequency determined by Health Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided. (Section VII, G(1)(t))

6. Term; Termination.

6.1 Term. This Product Attachment is coterminous with the Agreement, unless otherwise agreed to by the parties, but in no event will the term of this Product Attachment exceed the term of the State Contract (including, for avoidance of doubt, any renewals of the State Contract). (Section VII, G(1)(c))

6.2 Termination. The Agreement sets forth the basis for termination of the Agreement by either party and the related notice requirements. Notwithstanding anything in the Agreement or this Product Attachment to the contrary, Health Plan may immediately terminate the Agreement or this Product Attachment and a Participating Provider's participation thereunder upon (1) a confirmed finding of fraud, waste or abuse by NC DHHS or the North

Carolina Department of Justice Medicaid Investigations Division or (2) failure of the Participating Provider to maintain enrollment as a Medicaid provider. (Sections VII, G(1)(d) and G(1)(f)(i))

6.3 Insolvency. If the Agreement or this Product Attachment terminates as a result of Health Plan's or Payor's insolvency, Participating Provider will cooperate in the transition of administrative duties and records and ensure the continuation of care when inpatient care is on-going in accordance with the requirements of the Agreement, this Product Attachment and the State Contract. If Health Plan or Payor provides for or arranges for the delivery of health care services on a prepaid basis, Participating Provider will continue inpatient care until the patient is ready for discharge. (Section VII, G(1)(e))

7. Covered Person Services.

7.1 Covered Person Billing. Participating Provider shall not bill any Medicaid Managed Care Covered Person for Covered Services, except for specified coinsurance, copayments and applicable deductibles. Participating Provider is responsible for collecting applicable deductibles, copayments, coinsurance and fees for non-Covered Services. This provision does not prohibit a Participating Provider and Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense, as long as the Participating Provider has notified the Covered Person in advance that a Payor may not cover or continue to cover specific services and the Covered Person to receive the services. (Section VII, G(1)(h))

7.2 Provider Accessibility. Participating Provider shall provide call coverage or other back-up to provide service in accordance with Health Plan's standards for provider accessibility addressed set forth herein, in the Provider Manual and/or in the State Contract. (Section VII, G(1)(i)). Participating Provider agrees to meet NC DHHS standards for timely access to care and services, taking into account the urgency of need for services. (Section V, D(1)(d)(ii)). Participating Provider shall provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Covered Persons with physical or mental disabilities. (Section V, (1)(d)(vi))

7.3 Eligibility Verification. Health Plan or Payor shall provide a mechanism that allows Participating Provider to verify Covered Person eligibility, based on current information held by Health Plan or Payor, as applicable, before rendering Covered Services. (Section VII, G(1)(j))

7.4 Covered Person Appeals and Grievances. Participating Provider shall cooperate with Covered Person regarding Covered Person appeals and grievance procedures. (Section VII, G(1)(l)). Participating Provider has the right to file a grievance or appeal. Health Plan's internal appeal processes must be completed before seeking other legal or administrative remedies under state or federal law. (Section V, D(2)(c)(xi)). Health Plan will accept Participating Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Covered Person as Provider's approved representative for a claim or prior authorization in review or dispute. (Section VII, G(1)(bb))

7.5 Appointment Wait Times. Participating Provider shall cooperate with Health Plan to ensure that appointment wait times for Covered Persons do not exceed the requirements set forth below, to the extent applicable. (Section VII, F. Table 3)

(a) If Participating Provider is a PCP providing preventative care services, appointment wait time shall not exceed 30 calendar days for adults (21 years of age and older) and children ages six months to 20 years of age, and 14 calendar days for children less than six months of age.

(b) If Participating Provider is a PCP providing urgent care services, appointment wait time shall not exceed 24 hours.

(c) If Participating Provider is a PCP providing services for routine/check-up without symptoms, appointment wait time shall not exceed 30 calendar days.

(d) If Participating Provider is a PCP providing after-hours access for emergent and urgent care, care shall be administered immediately upon presentation at a service delivery site.

(e) If Participating Provider provides prenatal care, appointment wait time for initial appointments within the first or second trimester shall not exceed 14 calendar days and appointment wait time for initial appointments within the third trimester or for a high-risk pregnancy shall not exceed five calendar days.

(f) If Participating Provider provides specialty care, appointment wait time shall not exceed 24 hours for urgent care services or 30 calendar days for routine/check-up without symptoms services. For after-hours access for emergent and urgent care, care shall be administered immediately upon presentation at a service delivery site.

(g) If Participating Provider provides behavioral health care, appointment wait time shall not exceed 30 minutes for Mobile Crisis Management Services; 24 hours for Urgent Care Services for Mental Health or Urgent Care Services for SUDs; and 14 calendar days for Routine Services for Mental Health or Routine Services for SUDs. For Emergency Services for Mental Health or SUDs, care should be administered immediately upon presentation at a service delivery site.

(h) To the extent Participating Provider performs Emergency Services, Participating Provider shall make Emergency Services available 24 hours a day, 365 days a year.

7.6 Retroactive Requests for Prior Authorization. With respect to outpatient procedures for which Health Plan requires a prior authorization, Health Plan will accept retroactive requests for authorization 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 result of clinical findings or outcomes arising during the authorized procedure. Participating Provider shall submit such retroactive requests for authorization within three business days of concluding the authorized outpatient procedure. (Section VII, G(1)(aa))

8. Tobacco-Free Policy.

8.1 Providers Who May Elect to Implement a Tobacco-Free Policy. Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings or manufacturing sites that employ adults who receive group services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy.

8.2 Providers Subject to a Partial Tobacco-Free Policy. Starting January 1, 2027, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult intellectual/developmental disabilities (I/DD) residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

8.2.1 Use of tobacco products is prohibited indoors when the building or home in which the Participating Provider operates is under the Participating Provider's control as owner or lessee;

8.2.2 Outdoor areas of the property, under Participating Provider's control as owner or lessee shall:

(i) Ensure access to common outdoor space(s) free from exposure to tobacco use.

(ii) Prohibit staff/employees from using tobacco products anywhere on the property.

Contracts with Intermediate care facilities for adults with ICF-IID and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirements shall retain the option to implement a 100 percent tobacco-free campus policy for the safety of clients and staff.

8.3 Providers Subject to Full Tobacco-Free Policy. Starting on January 1, 2027, contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy. Participating Providers shall develop and implement a tobacco-free policy covering any portion of the property on which 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, such as electronic, heated and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on Participating Provider from purchasing, accepting as donations or distributing tobacco products to individuals Participating Provider serves.

9. Records.

9.1 Medical Records. Participating Provider shall maintain confidentiality of Covered Person medical records and personal information and other health records as required by law. Participating Provider shall maintain adequate medical and other health records according to industry and Health Plan standards. Participating Provider shall make copies of such records available to Health Plan, Payor and NC DHHS in conjunction with its regulation of Health Plan. Participating Provider shall make available and furnish the records immediately upon request in either paper or electronic form, at no cost to the requesting party. (*Section VII, G(1)(k)*). Notwithstanding anything in this “Records” section to the contrary, Health Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to Provider and which allows Participating Provider 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) 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. (*Section VII, G(1)(z)*)

9.2 Access to Provider Records.

(a) Participating Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable and adequate access to Health Plan or Payor and the Agreement and any records, books, documents and papers that relate to Health Plan or Payor and the Agreement and/or Participating Provider’s performance of its responsibilities under the Agreement 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) 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; and (ix) any other state or federal entity identified by NC DHHS or any other entity engaged by NC DHHS.

(b) Participating Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews or other program integrity activities conducted by NC DHHS.

(c) 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. (Section VII, G(3)(f))

10. Provider Payment.

10.1 Methodology. The Agreement includes a provider payment provision that describes the methodology to be used as a basis for payment. Such provision does not include a rate methodology that provides for automatic increases in rates, consistent with N.C. Gen. Stat. 58-3-227(a)(5). (Section VII, G(1)(m))

10.2 G.S. 58-3-225, Prompt Claim Payments Under Health Benefit Plans. Unless otherwise provided by NC DHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy or Care Management for At-Risk Children Policy, Participating Provider shall submit all claims for a date of service on or before June 30, 2023 to the Payor for processing and payments within 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 365 Calendar Days of the date of the provision of care. When a member is retroactively enrolled, Payor shall not limit the time in which claims may be submitted by the Participating Provider to fewer than 180 Calendar Days from the date of enrollment for health care provider and health care provider facility claims and 365 Calendar Days for Pharmacy point of sale claims. Participating Provider shall submit all claims with a date of service on or after July 1, 2023, to the Payor for processing and payment within 365 Calendar Days from the date of covered service or discharge (whichever is later). When a member is retroactively enrolled, Payor shall not limit the time in which claims may be submitted by the Participating Provider to fewer than 365 Calendar Days from the date of enrollment for health care provider, health care provider facility claims, and Pharmacy point of sale claims. However, Participating Provider's failure to submit a claim within these time frames will not invalidate or reduce any claim if it was not reasonably possible for Participating 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 year from the time submittal of the claim is otherwise required. (Section VII, G(3)(h))

(a) For medical claims (including behavioral health), Payor shall comply with the requirements set forth below.

- (i) The Payor shall within 18 calendar days of receiving a Medical Claim notify Participating Provider whether the claim is clean, or pend the claim and request from Participating Provider all additional information needed to process the claim. The Payor shall have the capability to request additional information via 277 Health Care Claim Request for additional information EDI transaction, via electronic means (including through a portal or email) and via mail. The Payor shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by NC DHHS.
- (ii) The Payor shall pay or deny a medical Clean Claim within 30 calendar days of receipt of the Clean Claim or the first scheduled provider reimbursement cycle following adjudication.
- (iii) A medical pended claim shall be paid or denied within 30 calendar days of receipt of the requested additional information.

(b) For pharmacy claims, Payor shall comply with the requirements set forth below.

- (i) The Payor shall within 14 calendar days of receiving a pharmacy claim pay or deny a pharmacy Clean Claim or notify Participating Provider that more information is needed to process the claim.

(ii) A pharmacy pended claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.

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

(d) If the Payor fails to pay a Clean Claim in full pursuant to this provision, the Payor shall pay interest. Late payments will bear interest on the portion of the claim payment that is late at the annual rate of 18 percent beginning on the first day following the date that the claim should have been paid or was underpaid.

(e) The Payor shall pay the interest from subsections (c) and (d) as provided in those subsections and shall not require Provider to request the interest.

(f) For purposes of claims payment, Payor shall be deemed to have paid the claim as of the Date of Payment, and Payor shall be deemed to have denied the claim as of the date the remittance advice is sent to the Participating Provider. Payor defined Date of Payment as either the date of Electronic Funds Transfer (EFT) to the Participating Provider or the date a paper check is mailed to the Participating Provider.

10.3 Government Funds. Participating Provider and Health Plan acknowledge that funds used for provider payments are government funds. (Section VII, G (1)(s))

11. Data to Provider. Health Plan will provide certain data and information to Provider, and changes to such information, which may include performance feedback report if compensation is related to efficiency criteria, information on benefit exclusions, administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. (Section VII, G(1)(n))

12. Provider Directory. Participating Provider authorizes Health Plan and/or Payor to include and Health Plan and/or Payor shall include the name of Participating Provider and/or Participating Provider's group in the provider directory distributed to Covered Persons. (Section VII, G (1)(p))

13. Assignment. Participating Provider shall not assign, delegate or transfer any of its duties and/or responsibilities under the Agreement without prior written consent of Health Plan. Health Plan shall notify Provider in writing of any duties or obligations that are to be delegated or transferred before the delegation or transfer. (Section VII, G (1)(r))

14. Providers of Perinatal Care. To the extent that Participating Provider offers prenatal, perinatal and postpartum services, or is an obstetrician, Participating Provider shall comply with NC DHHS's Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs among participating providers. Participating Provider shall (a) complete the standardized risk-screening tool at each initial visit; (b) allow Health Plan or Health Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators; (c) commit to maintaining or lowering the rate of elective deliveries prior to 39 weeks gestation; (d) commit to decreasing the cesarean section rate among nulliparous women; (e) offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation; (f) complete a high-risk screening on each pregnant Medicaid Managed Care Covered Person in the program and integrate the plan of care with local pregnancy care management; (g) decrease the primary cesarean delivery rate if the rate is over NC DHHS's designated cesarean rate (NC DHHS will set the rate annually at or below 20%); and (h) ensure comprehensive postpartum visits occur within 56 days of delivery. (Section VII, G(1)(u)) and M(3))

14.1 High-Risk Pregnancies Information Requirement. Participating Provider shall send all screening information and applicable medical record information for Covered Persons in the Care Management of High-Risk Pregnancies to Health Plan and the Local Health Departments or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the provider completing the screening. (Section VII, M(3.3.i.))

15. Advanced Medical Homes. To the extent Participating Provider is an Advanced Medical Home (“*AMH*”), Participating Provider shall comply with NC DHHS’ Advanced Medical Home Program and the Advanced Medical Home Manual, including the requirements set forth below. (Section VII, G(1)(v))

15.1 Identified as PCP. Participating Provider shall accept Covered Persons and be listed as a PCP in Health Plan’s Covered Person-facing materials for the purpose of providing care to Covered Persons and managing their health care needs.

15.2 Care Coordination Services. Participating Provider shall provide primary care and patient care coordination services to each Covered Person, in accordance with Health Plan policies.

15.3 Primary Care Coverage. Participating Provider shall provide or arrange for primary care coverage for services, consultation or referral and treatment for emergency medical conditions, 24 hours per day, 7 days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

15.4 Minimum Office Hours. Participating Provider shall provide direct patient care a minimum of 30 office hours per week.

15.5 Preventive Services. Participating Provider shall provide preventive services, in accordance with Section VII. Attachment M. Table 1: Required Preventive Services of the State Contract, as set forth on Attachment A: Medicaid, Appendix A to Schedule A, Governmental Program Requirements, to the Agreement.

15.6 Unified Medical Record. Participating Provider shall maintain a unified patient medical record for each Covered Person following Health Plan’s medical record documentation guidelines.

15.7 Referrals. Participating Provider shall promptly arrange referrals for Medically Necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

15.8 Medical Record Transfer. Participating Provider shall transfer the Covered Person medical record to the receiving provider upon the change of PCP at the request of the new PCP or Health Plan (if applicable) and as authorized by the Covered Person within 30 days of the date of the request, free of charge.

15.9 Appointments. Participating Provider shall authorize care for the Covered Person or provide care for the Covered Person based on the standards of appointment availability as defined by Health Plan’s network adequacy standards.

15.10 Second Opinion. Participating Provider shall refer for a second opinion as requested by the Covered Person, based on NC DHHS guidelines and Health Plan standards.

15.11 Utilization Management. Participating Provider shall review and use Covered Person utilization and cost reports provided by Health Plan for the purpose of AMH level utilization management and advise Health Plan of errors, omissions or discrepancies if they are discovered.

15.12 Enrollment Report. Participating Provider shall review and use the monthly enrollment report provided by Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities. (Section VII, M(2))

15.13 Oversight.

15.13.1 Within 90 Calendar Days of contract execution with the provider, the Company shall share with each AMH practice a description of the oversight process it will use to monitor practices' performance against Tier-specific AMH requirements. The oversight process shall contain a process for Corrective Action Plans, or equivalent, as a mechanism to allow practices to remediate compliance problems. For AMH practices affiliated with a clinically integrated network (CIN)/other partner, the description shall include the process that the Company will employ to monitor performance at the CIN/other partner level, including how Corrective Action Plans will apply at the CIN/other partner level and how the Company will keep AMH practices informed if a Corrective Action Plan is imposed at the CIN/other partner level. (Section V, C(6)(b)(iv)(d)(9))

15.13.2 In the case of any corrective actions imposed at the CIN/other technology partner level, the Company shall provide notice to each AMH practice affiliated with that CIN/other technology partner within 60 Calendar Days that the corrective action has been imposed. The Company shall provide individual AMH practices affiliated with the CIN/other technology partner notice of their options, which shall include contracting directly with the Company as an AMH Tier 3, contracting with another CIN/other technology partner as an AMH Tier 3 or reverting to AMH Tier 2. (Section V, C(6)(b)(iv)(d)(10))

15.14 Advanced Medical Home Tier 3 Standard Terms and Conditions. If Provider or a Contracted Provider is a Tier 3 AMH Participating Provider, the Agreement must include provisions that outline the AMH Tier 3 care management model and requirements consistent with the State Contract as set forth below. (Section VII, M(2 - 4 (a-e)))

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a CIN with which the practice has a contractual agreement that contains equivalent contract requirements. Health Plan shall maintain a contractual relationship with the AMH (not the CIN).

15.14.1 Tier 3 AMH practices must be able to risk stratify all empaneled patients.

- (a) The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by Health Plan are reconciled with the practice's panel list and up to date in the clinical system of record.
- (b) The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
- (c) The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from Health Plan with clinical information to score and stratify the patient panel.
- (d) The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the State Contract of identifying "priority populations" for care management.
- (e) The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
- (f) The Tier 3 AMH practice must define the process and frequency of risk score review and validation.

15.14.2 Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.

- (a) The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
- (b) The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
 - (i) Patients immediate care needs and current services;
 - (ii) Other state or local services currently used;
 - (iii) Physical health conditions, including dental;
 - (iv) Current and past behavioral and mental health and substance use status and/or disorders;
 - (v) Physical, intellectual developmental disabilities;
 - (vi) Medications — prescribed and taken;
 - (vii) Priority domains of social determinants of health (housing, food, transportation and interpersonal safety);
 - (viii) Available informal, caregiver or social supports, including peer supports.
- (c) The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.
- (d) For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

15.14.3 Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

- (a) The Tier 3 AMH practice must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.
- (b) The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.
- (c) The Tier 3 AMH practice must incorporate findings from the Health Plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.
- (d) The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:
 - (i) Measurable patient (or patient and caregiver) goals;
 - (ii) Medical needs, including any behavioral health and dental needs;
 - (iii) Interventions, including medication management and adherence;
 - (iv) Intended outcomes; and
 - (v) Social, educational and other services needed by the patient.

(e) The Tier 3 AMH practice must have a process to update each Care Plan as Covered Person needs change and/or to address gaps in care including, at a minimum, review and revision upon re-assessment.

(f) The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

(g) The Tier 3 AMH practice must periodically evaluate the care management services provided by the practice to high-risk, high-need patients to ensure services are meeting the needs of empaneled patients and refine the care management services as necessary.

(h) The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.

(i) The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

- (i) Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions; for example, arranging rapid follow up after an ED visit to avoid an admission.
- (ii) Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
- (iii) Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge).

15.14.4 Tier 3 AMHs must be able to provide short-term, transitional care management, along with medication reconciliation, to all empaneled patients who have an emergency department visit or hospital admission/discharge/transfer and who are at risk of readmissions and other poor outcomes.

(a) The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all the following:

- (i) Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;
- (ii) Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
- (iii) NICU discharges;
- (iv) Clinical complexity, severity of condition, medications, risk score.

(b) For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

(c) The Tier 3 AMH practice must include the following elements in transitional care management:

- (i) Ensuring that a care manager is assigned to manage the transition;
- (ii) Facilitating clinical handoffs;
- (iii) Obtaining a copy of the discharge plan/summary;
- (iv) Conducting medication reconciliation;
- (v) Following-up by the assigned care manager rapidly following discharge;
- (vi) Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
- (vii) Developing a protocol for determining the appropriate timing and format of such outreach.

15.14.5 Tier 3 AMH practices must use electronic data to promote care management.

(a) The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

15.15 Integrated Care for Kids (InCK). For all ACMs participating in the InCK program (i.e., AMH Tier 3 practices contracted with the Duke Connected Care, UNC Healthcare System and Community Care Physician Network (CCPN)), Provider agrees to comply with the Department’s InCK Program which such program requirements are set forth in the AMH Manual – Appendix D, as same may be amended from time to time. Provider shall familiarize itself with the InCK Model and all requirements of the InCK program. (Section VII, Attachment G, Section 1.ee)

15.15.1 InCK is a state-funded payment and service delivery model of integrated care for children insured by Medicaid and CHIP. InCK is supported by CMS grant funding designed to improve outcomes for children. InCK aims to (i) Understand Needs: more holistically understand the needs of children and youth; (ii) Support and Bridge Services: integrate services across sectors for children and youth who could benefit from additional support; and (iii) Focus Healthcare Investments: find ways to invest resources into what matters most for children, youth and families.

15.15.2 Implementation of InCK in North Carolina is led by a team that spans Duke University, the University of North Carolina and NC DHHS (jointly known as “*NC InCK*”). NC InCK took effect on January 1, 2022, and will run through December 31, 2026.

15.15.3 The role of AMH Tier 3 practices in NC InCK follows the same logic and principles as the broader AMH program described in the AMH Manual. AMH Tier 3 practices have responsibility for care management that is based in the community for high and rising risk Health Plan members, whether that responsibility is organized at the practice level, at the CIN/other partner level or a combination. For children and youth who are identified by NC InCK as part of the NC InCK model and are attributed to AMH Tier 3 practices, those AMH Tier 3 practices (or CINs/other partners on their behalf) are responsible for the enhanced components of the care management, data exchange and quality measurement that are being tested in NC InCK. These requirements are set out in Section D2 of Appendix D of the AMH Manual and are incorporated herein by reference. AMH Tier 3 practices that serve NC InCK members and participate in the InCK program are required to follow those requirements in addition to the requirements for AMH Tier 3 practices described in the AMH Manual.

15.15.4 Should Provider elect to participate in the InCK Alternative Payment Model (APM) as described in Sections D.4 and D.5 of Appendix D of the AMH Manual, Provider shall familiarize itself with and comply with the requirements thereof as well as Health Plan policies and procedures relating thereto.

15.15.5 In addition to all other terms and conditions applicable to AMHs, if Provider is participating in the InCK Program, Provider is also obligated to comply with the following:

Covered Persons.

- (a) Use the Service Integration Level (SIL) to refine Risk Stratification for InCK Covered Persons.
 - (i) Use the SIL assigned to each InCK Covered Person to outreach InCK Covered Persons in SIL 2 and 3 for assessment and care management.
 - (ii) Ensure that the SIL assigned to the InCK Covered Person is reconciled each month in the clinical system of record.
- (b) Provide Integrated Care Support to InCK Priority Populations.
 - (i) Coordinate with Health Plan to screen InCK Covered Persons for food and housing needs for all InCK Covered Persons assigned to SIL 1 and 2 at least annually, and to all InCK Covered Persons in SIL 3 every six months.
 - (ii) AMH Tier 3 practices should perform a Comprehensive Assessment on each Covered Person assigned to SIL 3 within 30 calendar days of Covered Person (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for InCK Covered Persons should also include the educational needs, child welfare needs and juvenile justice needs of the InCK Covered Person in addition to all current required domains.
 - (iii) Assign a Family Navigator to all SIL 2 and SIL 3 InCK Covered Persons who agree to participate in care management as part of the integrated care management team. At a minimum, the InCK Family Navigator will:
 - Serve as the InCK Covered Person's single point of contact;
 - Communicate with the InCK Covered Person's guardian at least quarterly for a period of one year regarding the InCK Covered Person's integrated care needs and make referrals;
 - Identify and convene the integrated care team as defined together with the InCK Covered Person's guardian;
 - Support service referrals across InCK's 10 core child service areas;
 - Ensure that an InCK Shared Action Plan is completed for at least 30% of SIL 3 InCK Covered Persons and at least 10% of SIL 2 InCK Covered Persons; and
 - Attend at least 60% of all monthly Family Navigator capacity building events organized by NC InCK each year.
 - (iv) For each InCK Covered Person in SIL 2 and SIL 3, use the InCK standardized Consent Form to support care team collaboration, access to the InCK integrated care platform and the Shared Action Plan, all of which facilitates integrated care for the InCK Covered Person across InCK's 10 core child service areas. Any completed consent form should be shared with the InCK Covered Persons Integration Consultant for records maintenance.

- (v) For each InCK Covered Person in SIL 2 and SIL 3 actively engaged in integrated care management, convene the InCK Covered Person’s integrated care team and family to align on cross-sector goals and methods of communicating to meet the Covered Person’s integrated care needs.
 - (vi) For InCK Covered Persons in SIL 2 and SIL 3, provide assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, which should also include WIC, Free and Reduced Lunch and school-based services for patients with exceptional needs.
- (c) Develop a Shared Action Plan for at least 30% of InCK Covered Persons assigned to SIL 3 and at least 10% of InCK Covered Persons assigned to SIL 2.
- (i) For at least 30% of InCK Covered Persons assigned to SIL 3 and at least 10% of InCK Covered Persons assigned to SIL 2, complete a InCK Shared Action Plan (SAP) with the family and integrated care team within 30 days of the Comprehensive Assessment being completed. The SAP should be completed with input and participation from the majority of the integrated care team Covered Persons. The ideal is that the majority of the care team convene at a time when they can discuss the plan together and with the family. Any completed consent form should be shared with the Covered Person’s InCK Integration Consultant for records maintenance.
 - (ii) For InCK Covered Persons offered a Shared Action Plan, support the InCK Covered Person in completing the InCK consent process to support sharing of the SAP and ongoing care team collaboration via the InCK Consent Form. Any completed consent form should be shared with the Covered Person’s InCK Integration Consultant for records maintenance.
- (d) Receive and send claims data feeds and other specified data elements in accordance with state-designated security standards.
- (i) Receive and use data from Health Plan on InCK-specific data elements, such as InCK Covered Persons and SIL levels, in the following reports and as specified in the AMH Provider Manual and InCK Technical Specifications:
 - Patient Risk List;
 - Care Needs Screening Results;
 - Quality Measure results.
 - (ii) Send data to the PHP on InCK-specific data elements as specified in the AMH Provider Manual and InCK Technical Specifications, including:
 - Patient Risk List Release 2.0;

16. Care Management for High-Risk Pregnancy. To the extent Participating Provider is a Local Health Department (“*LHD*”) offering care management for high-risk pregnancy, this section applies. Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by LHDs. (Section VII, M(4))

16.1 General Contracting Requirement. Participating Provider shall accept referrals from Health Plan for Care Management for High-Risk Pregnancy Services. Participating Provider shall comply with the requirements NC DHHS' Care Management for High-Risk Pregnancy Policy.

16.2 Care Management for High-Risk Pregnancy: Outreach. Participating Provider shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy. Participating Provider shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

16.3 Care Management for High-Risk Pregnancy: Population Identification and Engagement. Participating Provider shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five calendar days of receipt of risk screening forms. Participating Provider shall use risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome. Participating Provider shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral and provide appropriate assessment and follow up to those patients based on the level of need. Participating Provider shall review available Health Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to Participating Provider. Participating Provider shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

16.4 Care Management for High-Risk Pregnancy: Assessment and Risk Stratification. Participating Provider shall conduct a prompt, thorough assessment, by review of claims history and medical record, patient interview and case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support. Participating Provider shall use assessment findings, including those conducted by Health Plan to determine level of need for care management support. Participating Provider shall document assessment findings in the care management documentation system. Participating Provider shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained. Participating Provider shall assign case status based on level of patient need.

16.5 Care Management for High-Risk Pregnancy: Interventions. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, using those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals. Participating Provider shall provide care management services based upon level of patient need as determined through ongoing assessment. Participating Provider shall develop patient-centered care plans, including appropriate goals, interventions and tasks. Participating Provider shall use NC Resource Platform and identify additional community resources once NC DHHS has certified it as fully functional. Participating Provider shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Covered Person's Health Plan network. Participating Provider shall document all care management activity in the care management documentation system.

16.6 Care Management for High-Risk Pregnancy: Integration with Health Plan and Providers. Participating Provider shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. Participating Provider shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management

Program. Participating Provider shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers. Participating Provider shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county. Participating Provider shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population. Participating Provider shall ensure awareness of Health Plan Covered Persons' "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of Health Plan's prior authorization processes relevant to referrals.

16.7 Care Management for High-Risk Pregnancy: Collaboration with Health Plan. Participating Provider shall work with Health Plan to ensure program goals are met. Participating Provider shall review and monitor Health Plan reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk. Participating Provider shall communicate with Health Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers. Participating Provider shall participate in pregnancy care management and other relevant meetings hosted by Health Plan.

16.8 Care Management for High-Risk Pregnancy: Training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by Health Plan and/or NC DHHS, including webinars, new hire orientation or other programmatic training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Health Plan and/or NC DHHS. Participating Provider shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes. Participating Provider shall ensure that pregnancy care managers and their supervisors use Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

16.9 Care Management for High-Risk Pregnancy: Staffing.

(a) Participating Provider shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW or BS in SW); or master's degree in social work (MSW, MA in SW or MS in SW) from a Council on Social Work Education accredited social work degree program. Care Managers for High- Risk Pregnancy hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position. Participating Provider shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager. Participating Provider shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team. If the Participating Provider only has a single Care Manager for High-Risk Pregnancy, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Health Plan /NC DHHS guidance about communication with Health Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days shall be subject to additional oversight by Health Plan.

(b) Participating Provider shall ensure that Pregnancy Care Managers must demonstrate (i) a high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes; (ii) proficiency with the technologies required to perform care management

functions; (iii) motivational interviewing skills and knowledge of adult teaching and learning principles; (iv) ability to effectively communicate with families and providers; and (v) critical thinking skills, clinical judgment and problem-solving abilities.

(c) Participating Provider shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; (iv) use of reports to actively assess individual care manager performance; and (v) compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

17. Care Management for At-Risk Children. To the extent Participating Provider is an LHD offering care management for at-risk children, this section applies. Care Management for At-Risk Children is care management services provided by to a subset of the Medicaid population ages 0-5 identified as being “high-risk.” (Section VII, M(5))

17.1 Care Management for At-Risk Children: General Requirements. Participating Provider shall accept referrals from Health Plan for children identified as requiring Care Management for At-Risk Children. Participating Providers shall comply with the requirements of NC DHHS’ Care Management for At-Risk Children Policy.

17.2 Care Management for At-Risk Children: Outreach. Participating Provider shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; and disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources. Participating Provider shall communicate regularly with the Advanced Medical Homes and other practice serving children to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services. Participating Provider shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county. Participating Provider shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population. Participating Provider shall use the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by NC DHHS.

17.3 Care Management for At-Risk Children: Population Identification. Participating Provider shall use any claims-based reports and other information provided by Health Plan, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations. Participating Provider shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population. Participating Provider shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

17.4 Care Management for At-Risk Children: Family Engagement. Participating Provider shall involve families (or legal guardians when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care. Participating Provider shall foster self-management skill building when working with families of children. Participating Provider shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

17.5 Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level. Participating Provider shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description. Participating Provider shall review and monitor Health Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care

services and to identify individuals at risk. Participating Provider shall use the information gained from the assessment to determine the need for and the level of service to be provided.

17.6 Care Management for At-Risk Children: Plan of Care. Participating Provider shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards. Participating Provider shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; and provide education about the importance of the medical home. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, using interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals. Participating Provider shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need. Participating Provider shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

17.7 Care Management for At-Risk Children: Integration with Health Plan and Providers. Participating Provider shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs. Participating Provider shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team. Where care management is being provided by Health Plan and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the Health Plan/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services. Participating Provider shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team and to Health Plan. Participating Provider shall ensure awareness of Health Plan Covered Person's "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of Health Plan's prior authorization processes relevant to referrals.

17.8 Care Management for At-Risk Children: Service Provision. Participating Provider shall document all care management activities in the care management documentation system in a timely manner. Participating Provider shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

17.9 Care Management for At-Risk Children: Training. Participating Provider shall participate in NC DHHS/Health Plan-sponsored webinars, trainings and continuing education opportunities as provided. Participating Provider shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

17.10 Care Management for At-Risk Children: Staffing.

(a) Participating Provider shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW, or BS in SW); or master's degree in social work (MSW, MA in SW or MS in SW) from a Council on Social Work Education accredited social work degree program. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions. Participating Provider shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors. If the Participating Provider has only a single Care Management for At-Risk Children care manager, the Participating Provider shall ensure access to

individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, Participating Provider shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following NC DHHS guidance regarding vacancies or extended staff absences, and adhering to NC DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days will be subject to additional oversight. Participating Provider shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications. Participating Provider shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

(b) Participating Provider shall ensure that Care Management for At-Risk Children Care Managers must demonstrate (i) proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system; (ii) ability to effectively communicate with families and providers; (iii) critical thinking skills, clinical judgment and problem-solving abilities; and (iv) motivational interviewing skills, Trauma Informed Care and knowledge of adult teaching and learning principles.

(c) Participating Provider shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; and (iv) use of monthly and on-demand reports to actively assess individual care manager performance.

18. N.C. Gen. Stat. Ch. 58 Requirements.

18.1 N.C. Gen. Stat. § 58-3-200(c), Coverage Determinations. If Health Plan or Payor determines that services, supplies or other items are Covered Services, Health Plan or Payor shall not subsequently retract its determination after such services have been provided, or reduce payments for such services furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person's health condition that was knowingly made by the Covered Person or the provider of the service, supply or other item. (Section VII, G (1)(x)(i))

18.2 N.C. Gen. Stat. § 58-3-227(h), Contract Negotiations. When offering a contract to a Health Care Provider, Health Plan or Payor shall make available to Health Care Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by the class of provider. Upon the request of the Health Care Provider, Health Plan or Payor shall also make available the full schedule of fees for services or procedures billed by that class of provider(s). If Health Care Provider requests fees for more than 30 services and procedures, Health Plan or Payor may require the Health Care Provider to specify the additional requested services and procedures and may limit the Health Care Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by such Health Care Provider. (Section VII, G(1)(x)(ii))

18.3 N.C. Gen. Stat. § 58-50-275(a)-(b), Notice Contact. Provider and Health Plan have set forth in the Agreement a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed Amendments and other notices, pertaining to the contractual relationship between the Parties shall be sent. Notwithstanding anything in the Agreement to the contrary, means for sending all notices provided under the Agreement is one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service,

the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an Amendment if agreed to by Health Plan and Provider. (Section VII, G(1)(x)(iv))

18.4 N.C. Gen. Stat. § 58-50-280(a)-(d), Proposed Amendment. Health Plan shall date, label “Amendment,” sign, include an effective date and send any proposed Amendment to the Agreement or this Product Attachment to the notice contact of Provider. Provider will have 60 days from the date of receipt to object to the proposed Amendment in writing. If Provider fails to object in writing within such 60 days, the Amendment will be effective. If Provider timely objects to a proposed Amendment in writing, then Health Plan may terminate the Agreement or this Product Attachment upon 60 days’ written notice to Provider. (Section VII, G(1)(x)(v))

18.5 N.C. Gen. Stat. § 58-50-285 (a)-(b), Policies and Procedures. Health Plan or Payor shall provide a Health Care Provider with a copy of its policies and procedures prior to execution of a new or amended contract and annually to all Participating Providers. Such policies and procedures may be provided in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on the Health Plan or Payor website. Such policies and procedures will not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail. (Section VII, G(1)(x)(vi))

18.6 N.C. Gen. Stat. § 58-51-37(d)-(e), Pharmacy Participation. To the extent Participating Provider is a pharmacy or pharmacist, this section applies. Participating Provider shall not waive, discount, rebate or distort a copayment or a Covered Person’s portion of a prescription drug coverage or reimbursement. If Participating Provider provides a pharmacy service to a Covered Person that meets the terms and requirements of the Coverage Agreement, Participating Provider shall provide its pharmacy services to all Covered Persons covered by that Coverage Agreement on the same terms and requirements. A violation of the foregoing is a violation of the Pharmacy Practice Act subjecting the pharmacist to disciplinary authority of the North Carolina Board of Pharmacy. At least 60 days before the effective date of a Payor providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, Health Plan or Payor shall notify, in writing, all pharmacies within the geographical coverage area of the Coverage Agreement and offer to the pharmacies the opportunity to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. Health Plan shall, through reasonable means, on a timely basis, and on regular intervals to effectuate the purposes of this section, inform the Covered Persons of the Coverage Agreement of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and Health Plan. The pharmacy notification provisions of this section do not apply when an individual or group is enrolled, but when Health Plan enters a particular county of the State. (Section VII, G(1)(x)(vii))

19. Indian Health Care Providers. To the extent Participating Provider is an Indian Health Care Provider, Participating Provider shall execute and comply with the Medicaid Managed Care Addendum for Indian Health Care Providers. (Section VII, H)

20. Conflict of Interest. Participating Provider will comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the Social Security Act, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C. Participating Provider agrees that financial considerations will not influence decisions to provide medically appropriate care. Participating Provider shall abide by his or her professional obligations to patients and Covered Persons and will not take any actions that conflict with such obligations. (Section V, A.9.i)

21. Vaccines for Children Program. If Participating Provider is a Primary Care Provider who services Covered Persons under age 19, Participating Provider is encouraged to participate in the Vaccines for Children Program. If Participating Provider is a Primary Care Provider, Participating Provider will administer vaccines consistent with the AAP/Bright Future periodicity schedule. (Section V, C(1)(c)(ix) and Section V, C(2)(v)(vii))

22. PCPs. If Participating Provider is a Primary Care Provider, Participating Provider will (a) perform, during preventive service visits, and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral

hygiene counseling for children under 21 years of age in accordance with NC DHHS's Oral Health Periodicity Schedule; (b) refer infant Medicaid Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one, per the requirements of NC DHHS's Oral Health Periodicity Schedule; (c) include all of the following components in each medical screening: (i) routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents," screening for developmental delay at each visit through the fifth year and screening for Autistic Spectrum Disorders per AAP guidelines, (ii) comprehensive, unclothed physical examination, (iii) all appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices and (iv) laboratory testing (including blood lead screening appropriate for age and risk factors); and (d) provide health education and anticipatory guidance for both the child and caregiver. (Section V, C.2.i)

23. Behavioral Health Providers. If Participating Provider is a behavioral health provider, Participating Provider will coordinate with Primary Care Providers and specialists conducting Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings. (Section V, C.2.j)

24. 340B Covered Entities. If Participating Provider is a 340B covered entity, the Participating Provider will (a) submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program; (b) identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by NC DHHS (42 C.F.R. § 438.3(s)(3)); (c) comply with the point of sale identification of drugs purchased through the 340B program (42 C.F.R. § 438.3(s)(3)); and (d) resubmit the claims with the appropriate NCPDP 340B claims identification codes when 340B claims are retroactively identified (42 C.F.R. § 438.3(s)(3)). (Section V, C(3)(i)(v))

25. Exclusion. Participating Provider represents and warrants that he, she or it is not excluded from participation in federal health care programs under either Section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b). Participating Provider will immediately notify Health Plan in writing upon any change regarding foregoing. (Section V, D(2)(c)(iv))

26. High Level Clinical Setting Discharge. Participating Provider will notify Health Plan when a Covered Person in a high level clinical setting is being discharged. For the purpose of this section, a High Level Clinical Setting includes, but is not limited to:

- (a) Hospital/Inpatient acute care and long-term acute care
- (b) Nursing Facility
- (c) Adult Care Home
- (d) Inpatient behavioral health services
- (e) Facility-based crisis services for children
- (f) Facility-based crisis services for adults
- (g) ADATC

(Section V, D(2)(c)(xiv))

27. Claim Submission. Participating Provider will not submit claim or encounter data for services covered by Medicaid managed care and Health Plan directly to NC DHHS. (Section V, D(2)(c)(xviii))

28. Provider Preventable Conditions. Participating Provider will comply with 42 C.F.R. § 438.3(g), which, at a minimum, means non-payment of provider-preventable conditions as well as appropriate reporting, as required by Health Plan. (Section V, D(2)(d)(ii))

29. Program Integrity. Participating Provider (a) will have compliance plans that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005; (b) will have policies and procedures that recognize and accept Medicaid as “the payer of last resort”; and (c) is prohibited from billing Covered Persons for Covered Services any amount greater than would be owed if the Participating Provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). (*Section V, D(2)(f)*; Section V, J(2)(b)(iii)(c))

30. No Auto-Enrollment in Other Products. Health Plan will not require individual practitioners, as a condition of contracting with it, to agree to participate or accept other products offered by Health Plan nor will Health Plan automatically enroll the provider in any other product offered by it. This requirement does not apply to facility providers. (Section V, D(2)(c) (viii))

31. Grievance and Appeals. Health Plan shall handle appeals and grievances raised by Provider in connection with the Medicaid Product promptly, consistently, fairly and in compliance with state and federal law and NC DHHS requirements, through an appeals and grievance system that is distinct from that offered to Covered Persons. Such appeals and grievance system, additional information about which is set forth in the Provider Manual, shall meet the requirements set forth below:

(a) Grievances. Health Plan will have a process in place to receive and resolve complaints or disputes with Provider, in a timely manner, where remedial action is not requested. Health Plan will accept and resolve Provider’s grievances regarding Health Plan that are referred from NC DHHS. Health Plan will make available to Provider a method for submitting grievances through Health Plan’s provider portal.

(b) Appeals. Health Plan will offer Provider appeal rights as described in the State Contract and Provider Manual. Health Plan will provide written notice of Provider’s right to appeal along with any notice of a decision giving rise to Provider’s right to appeal. Health Plan will make available to Provider a method for submitting appeals through Health Plan’s provider portal. Health Plan will accept a written request for an appeal from Provider within 30 calendar days of the date on which (i) Provider received written notice from Health Plan of the decision giving rise to the right to appeal; or (ii) Health Plan should have taken a required action and failed to take such actions. Health Plan will acknowledge receipt of each appeal request within five calendar days of receipt of the request and will extend such timeframe by 30 calendar days if Provider’s request is for an appeal for good cause shown, as determined by Health Plan. Health Plan will consider the voluminous nature of required evidence/supporting documentation, and the appeal of an adverse quality decision, as good cause reasons to extend such timeframe. Provider shall exhaust Health Plan’s internal appeals process before seeking recourse under any other process permitted by contract or law.

(c) Resolution of Appeal. Health Plan will establish a committee to review and make decisions on Provider’s appeals, which committee will consist of at least three qualified individuals who were not involved in the original decision, action or inaction giving rise to the right to appeal, as well as an external peer reviewer when the issue on appeal involves whether the provider met the Objective Quality Standards. Health Plan will provide written notice of decision of the appeal (which notice shall include information regarding further appeal rights) within 30 calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all evidence is submitted to Health Plan. Provider may be represented by an attorney during the appeals process.

(d) Appeals of Suspension or Withhold of Provider Payment. In cases of the suspension or withholding of Provider payments, Health Plan will limit the issue on appeal to whether Health Plan had good cause to commence the withholding or suspension of payments to Provider; Health Plan will not address whether Provider has or has not committed fraud or abuse. Health Plan will offer Provider an in-person or telephone hearing when Provider is appealing whether Health Plan has good cause to withhold or suspend payments to Provider. Health Plan will schedule such hearing and issue a written decision regarding whether Health Plan had good cause to suspend or withhold payments within 15 business days of receiving Provider’s appeal. Upon a finding that Health Plan did not have good cause to suspend or withhold payments, Health Plan will reinstate any payments that were withheld or suspended

within five business days. Health Plan will pay interest and penalties for overturned denials, underpayments or findings that it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial. (Attachment G-1.q)

32. Contract Amendments with Individual Providers. For the purposes of this “Contract Amendments with Individual Providers” section only, the following terms shall have the following definitions:

(i) “**Amendment**” shall mean any change to the terms of this Medicaid Product Attachment, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing or court order is not an Amendment.

(ii) “**Contract**” shall mean the Agreement, which is an agreement between Health Plan and Provider for the provision of health care services by the provider on a preferred or in-network basis.

(iii) “**Health Benefit Plan**” shall mean a policy, certificate, contract or plan as defined in N.C. Gen. Stat. § 58-3-167.

(iv) “**Health Care Provider**” shall mean Provider if Provider is an individual who is licensed, certified or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(v) “**Insurer**” shall mean Health Plan (as otherwise defined herein), which is an entity as defined in N.C. Gen. Stat. § 58-3-227(a)(4).

Insurer shall send any proposed Contract Amendment to the notice contact of Health Care Provider pursuant to N.C. Gen. Stat. § 58-50-275. The proposed Amendment shall be dated, labeled “Amendment,” signed by the Insurer, and include an effective date for the proposed Amendment. Health Care Provider receiving a proposed Amendment shall be given at least 60 days from the date of receipt to object to the proposed Amendment. The proposed Amendment shall be effective upon Health Care Provider failing to object in writing within 60 days. If Health Care Provider objects to a proposed Amendment, then the proposed Amendment is not effective and the initiating Insurer shall be entitled to terminate the Contract upon 60 days written notice to Health Care Provider. Nothing in this part prohibits Health Care Provider and Insurer from negotiating Contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent or alternative notice contacts. (Attachment G-1.x.iii)

Attachment A: Medicaid

**APPENDIX A TO
SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS**

Section VII. Attachment M.2. Table 1: Required Preventative Services				
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes).		
Reference Number	AMH Preventative Health Requirements	0 to 5	6 to 21	22 to 121
1	Adult Preventative and Ancillary Health Assessment			Y
2	Blood Lead Level Screening	Y	Y	
3	Cervical Cancer Screening (applicable to Females only)		As Needed	Y
4	Vaccines per ACIP recommendations https://www.cdc.gov/vaccines/hcp/acip-recs/index.html	Y	Y	Y
5	Reserved			
6	Health Check Screening Assessment	*	*	
7	Hearing	*	*	
8 & 9	Hemoglobin or Hematocrit	*	*	As Needed
10	Reserved			
11	Reserved			
12	Reserved			
13	Reserved			
14	Reserved			
15	Standardized Written Development	*		
16	Reserved			
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	*	*	Y
18	Urinalysis		*	Y
19	Reserved			
20	Vision Assessment	*	*	Y

*Please refer to the American Academy of Pediatrics: Bright Futures Periodicity Schedule for information on when preventative services should be delivered to children under the age of 21. The AAP Bright Futures Periodicity Schedule can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Attachment A: Medicaid

SCHEDULE A-1 – TAILORED PLAN PROGRAM PROGRAM PARTICIPATION NORTH CAROLINA

This Schedule A-1, Tailored Plan Program, Program Participation schedule (this “*Schedule*”) sets forth requirements specific to the Tailored Plan Program, defined herein.

1. Background. The North Carolina Tailored Plan program is an integrated Medicaid Managed Care program in which certain managed care plans (called “*BH I/DD Tailored Plans*”) provide physical health, behavioral health, intellectual and developmental disability, traumatic brain injury, long-term care, and pharmacy services to Covered Persons enrolled in such Tailored Plans. Health Plan has subcontracted with two Tailored Plans, Partners Health Management (“*Partners*”) and Trillium Health Resources (“*Trillium*”) (collectively, the “*Tailored Plans*”), to provide physical health Covered Services to the Tailored Plans’ Covered Persons through Health Plan’s network of Participating Providers. For the elimination of confusion, this Schedule shall not apply with respect to pharmacy or behavioral health Covered Services, except as may be expressly provided herein.

2. Applicability of Schedule A-1. This Schedule sets forth requirements that apply to Health Plan Participating Providers that agree to participate as Participating Providers in the Partners and/or Trillium networks (such participation to be referred to as participation in the “*Tailored Plan Program*”). Participating Providers in Health Plan’s Medicaid network are not required to participate in the Tailored Plan Program. Where the Participating Provider elects to participate in the Tailored Plan Program, the Tailored Plan Program is expressly included as part of the Medicaid Product.

3. Participation. Except as may otherwise be provided in this Schedule or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Tailored Plan Program and will provide to Covered Persons enrolled with the Tailored Plan(s) identified below, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Schedule, those physical health Covered Services (and, if as expressly provided, those behavioral health Covered Services) that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Schedule and the Agreement (including the Provider Manual). Provider acknowledges and agrees that the Tailored Plan(s) identified herein shall list Provider in the applicable Tailored Plan provider directory(ies) and will cooperate fully with those Tailored Plan(s) consistent with this Schedule.

4. Components of the Tailored Plan Program. The Tailored Plan Program consists of (i) the base provisions of the Agreement; (ii) the base provisions of the Medicaid Product at Attachment A (but which do not include the “Governmental Program Requirements” set forth at Schedule A that are specific to Health Plan’s Medicaid managed care plan (i.e., the Standard Plan); (iii) this Schedule A-1, including the “Tailored Plan Program Requirements” attachment consisting of requirements from the Tailored Plans’ State Contracts; and (iv) the applicable Compensation Schedule(s) to Attachment A as such Compensation Schedule(s) apply to physical health Covered Services (and to behavioral health Covered Services, if and as expressly provided). With respect to the base provisions of the Agreement, the following terms as used in the Agreement shall have the following meanings for the purposes of this Schedule: individuals enrolled in a Tailored Plan shall be considered “Covered Persons”; the Tailored Plan Contract (as defined in the attached Tailored Plan Contract Provider Requirements) shall be considered a “Governmental Contract”; the Tailored Plan Program shall be considered a “Product”; the Tailored Plan covered benefit as determined by the North Carolina Department of Health and Human Services (“*NC DHHS*”) shall be considered the “Coverage Agreement”; and services covered under the Tailored Plan covered benefit shall be considered “Covered Services.”

5. Construction. In the event of a conflict between the provisions of the Agreement (including Attachment A) and the provisions of this Schedule, this Schedule will govern with respect to health care services,

supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Tailored Plan. In the event that Provider participates in the Tailored Plan networks of both Tailored Plans, any reference to “the Tailored Plan” in the Tailored Plan Program Requirements attachment to this Schedule shall be understood to be a reference to the applicable Tailored Plan individually, and not to the Tailored Plans collectively.

6. Cooperation. Notwithstanding the fact that neither Tailored Plan is a party to this Schedule, the applicable Tailored Plan shall have a right to participate and assist in Tailored Plan provider compliance issues, as well as the resolution or attempted resolution of any and all disputes arising out of a Provider’s participation in such Tailored Plan’s network. Provider consents to any motion to intervene filed by the applicable Tailored Plan in any appeal, dispute or other litigation.

7. Term and Termination. This Schedule will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement (including Attachment A) or this Schedule. The participation of Provider or any Contracted Provider as a Participating Provider in the Tailored Plan Program (i) with respect to a particular Tailored Plan, shall be terminated immediately upon the termination of such Tailored Plan’s Tailored Plan Contract or upon the termination of the business arrangement between such Tailored Plan and Health Plan; and (ii) with respect to either or both Tailored Plans, may be terminated by either Party giving the other Party at least 120 days prior written notice of such termination. In the event of termination of this Schedule with respect to either or both Tailored Plans, Provider shall immediately notify the affected Contracted Provider of such termination. The termination of this Schedule, or of Provider’s and/or Contracted Provider’s participation in the Tailored Plan Program, with respect to either or both Tailored Plans, shall not have the effect of terminating the Medicaid Product Attachment with respect to Provider’s and/or Contracted Provider’s participation in Health Plan’s Medicaid managed care plan (i.e., the Standard Plan). Likewise, the termination of the Medicaid Product Attachment with respect to Provider’s and/or Contracted Provider’s participation in Health Plan’s Medicaid managed care plan (i.e., the Standard Plan) shall not have the effect of terminating this Schedule or Provider’s and/or Contracted Provider’s participation in the Tailored Plan Program with respect to either or both Tailored Plans. Finally, termination of this Schedule, or of Provider’s and/or Contracted Provider’s participation in the Tailored Plan Program, with respect to one of the Tailored Plans shall not have the effect of terminating this Schedule, or of Provider’s and/or Contracted Provider’s participation in the Tailored Plan Program, with respect to the other Tailored Plan. For the elimination of confusion, termination of this Schedule, or of Provider’s and/or Contracted Provider’s participation in the Tailored Plan Program, does not result in or constitute Provider’s or such Contracted Provider’s disenrollment from the North Carolina Medicaid, NC Health Choice or State-funded Services programs.

8. Regulatory Approval. Provider acknowledges that this Schedule is subject to approval and modification by NC DHHS. Health Plan will forward to Provider, in writing, any changes required by NC DHHS to this Schedule. Any such changes shall automatically be effective with respect to the parties to the extent that this Schedule is executed.

9. Selection of Tailored Plans. By checking the box(es) below, Provider agrees that Provider and the Contracted Providers will participate as Participating Providers in the networks of the following Tailored Plans (please check all that apply):

- Partners Health Management
- Trillium Health Resources

Attachment A: Medicaid

SCHEDULE A-2 – TAILORED PLAN PROGRAM TAILORED PLAN CONTRACT - PROVIDER REQUIREMENTS NORTH CAROLINA

This Schedule A-2, Tailored Plan Program, Tailored Plan Contract - Provider Requirements schedule (“*Schedule*”) sets forth special provisions that are specific to the North Carolina Tailored Plan Program. The Tailored Plan Contract’s Provider requirements set out in this Schedule are intended to reflect the requirements of the Tailored Plan Contract and shall be understood to be automatically updated to conform and comply with the Tailored Plan Contract in the event that the Tailored Plan Contract is revised. References herein to various of Tailored Plan’s programs, standards, procedures, etc. shall, as applicable, be understood to be references to Health Plan’s such programs, standards, procedures, etc., where such are applicable to the Tailored Plan Program and approved by Tailored Plan. Obligations assigned to Tailored Plan hereunder may, from time to time, be carried out by Health Plan at the direction of Tailored Plan.

1. **Definitions.** For purposes of Provider’s participation in the Tailored Plan Program, the following terms have the meanings set forth below, unless otherwise defined in the Tailored Plan Contract. Terms used in this Schedule and not defined below will have the same meaning set forth in the Agreement or, if not defined there, in the Tailored Plan Contract (as defined below).

1.1 “*Adult Care Home*” or “*ACH*” means a licensed facility with seven or more beds that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

1.2 “*Advanced Medical Home*” or “*AMH*” are State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.

1.3 “*Advanced Medical Home Plus*” or “*AMH+*” are primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population and have certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch) as such.

1.4 “*Appeal*” has the same meaning as Appeal as defined in 42 CFR 438.400(b).

1.5 “*Behavioral Health Intellectual/Developmental Disability Tailored Plan*” or “*BH I/DD Tailored Plan*” has the same meaning as BH I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4).

1.6 “*Business Day*” is defined as a traditional State workday, Monday – Friday and includes traditional work hours 8:00 AM – 5:00 PM EST. State holidays are excluded. A list of North Carolina State holidays is located at <https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays>.

1.7 “*Calendar Day*” includes the time from midnight to midnight each day, and all days in a month, including weekends and holidays. Unless otherwise specified herein or within the Tailored Plan Contract, days are tracked as Calendar Days.

1.8 “*Care Management*” means team-based, person centered approach to effectively managing patients’ medical, social and behavioral conditions. Care Management shall include, at a minimum, the following: (a) high-risk care management (e.g., high utilizers / high-cost beneficiaries); (b) Care Needs Screening; (c) identification of Covered Persons in need of care management; (d) development of Care Plans (across priority populations); (e) development of comprehensive assessments (across priority populations); (f) Transitional Care Management: Management of Covered Person needs during transitions of care and care transitions (e.g., from hospital to home); (g) Care Management for special populations (including pregnant women and children at-risk of physical,

development, or socio-emotional delay); (h) chronic care management (e.g., management of multiple chronic conditions); (i) coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals); (j) management of unmet health-related resource needs and high-risk social environments; (k) management of high-cost procedures (e.g., transplant, specialty drugs); (l) management of rare diseases (e.g., transplant, specialty drugs); (m) management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and (n) development and deployment of population health programs.

1.9 “**Care Management Agency**” or “**CMA**” means a provider organization with experience delivering behavioral health (“**BH**”), I/DD and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management to BH I/DD Tailored Plan members assigned to it, under the Tailored Care Management model as certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch).

1.10 “**Care Management for At-Risk Children**” means care management services provided to a subset of the Medicaid population ages 0-5 identified as being “high-risk.”

1.11 “**Care Management for High-Risk Pregnancy**” or “**CMHRP**” means care management services provided to a subset of the Medicaid population who is pregnant and identified as “high-risk” by providers, LHDs, social service agencies, Standard Plans and/or Tailored Plan.

1.12 “**Care Plan**” means a written individualized person-centered plan of care for Covered Persons with BH needs, that is developed using a collaborative approach led by the Covered Person or their guardian when appropriate, incorporates the results of the care management comprehensive assessment and identifies the Covered Person’s desired outcomes and the training, therapies, services, strategies and formal and informal supports needed for the Covered Person to achieve those outcomes.

1.13 “**Care Transitions**” means the process of assisting a Covered Person to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g., school-related transitions).

1.14 “**Claim**” means a request for payment by a healthcare provider to an insurer for rendered services. Claims may be filed for professional, institutional, dental and pharmacy transactions in conformance with existing laws (e.g., HIPAA) and using relevant industry standards (e.g., ASC X12N, NCPDP) and typically include information on the patient, provider, diagnoses, procedures performed or services rendered, and related charges.

1.15 “**Claim Adjudication**” means the process of paying claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.

1.16 “**Claim Adjudication Date**” means the date Tailored Plan or its subcontractor processed for determination of claim payment, acceptance, denial, or rejection.

1.17 “**Clean Claim**” means a medical or pharmacy claim submitted to a Tailored Plan by a service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

1.18 “**Contract Year**” means the period beginning with when Tailored Plan begins covering services under the Tailored Plan Contract until the next June 30 and each subsequent 12-month period thereafter. Contract Year will coincide with Tailored Plan’s fiscal Year.

1.19 “**Credentialing**” means the approach to collecting and verifying provider qualifications (e.g., the provider’s training and education, licensure, liability record); and determining, for Medicaid Managed Care and State-funded Services, whether to allow the provider to be included in Tailored Plan’s network, subject to certain Department requirements.

1.20 “**Cultural and Linguistic Competency**” or “**Culturally and Linguistically Competent**” means the ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of the individuals are met. The ability to interact effectively with people of different cultures helps to ensure the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location or profession. Cultural and Linguistic Competency means to be respectful, responsive and sensitive to the health beliefs and practices and cultural and linguistic needs of diverse populations groups.

1.21 “**Date of Payment**” means the point in time following the Claim Adjudication Date when reimbursement is generated for services, either initiated by date of Electronic Funds Transfer (EFT) or processes to generate a paper check.

1.22 “**Denied Claim**” refers to when Health Plan, as a subcontractor of Tailored Plan, refuses to reimburse a service provider for all or a portion of the services submitted on the medical or pharmacy claim.

1.23 “**Department**” or “**NC DHHS**” means the North Carolina Department of Health and Human Services.

1.24 “**Encounter**” means a record of a rendered service provided by a healthcare provider irrespective of whether payment is required. Encounter data typically includes information otherwise present on a claim.

1.25 “**Enrollment**” means the process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, BH I/DD Tailored Plan, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program.

1.26 “**Excluded Person**” means a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one or more of the Exclusion Lists.

1.27 “**Exclusion List**” means the lists that Tailored Plan must check to determine the exclusion status of all providers and ensure that Tailored Plan does not pay federal funds to excluded persons or entities, including (a) State Exclusion List, including NC DHHS-specific exclusion list; (b) U.S. Department of Health and Human Services, Office of Inspector General’s (HHS-OIG) List of Excluded Individuals/Entities (LEIE); (c) The System of Award Management (SAM); (d) The Social Security Administration Death Master File (SSADMF); (e) to the extent applicable, National Plan and Provider Enumeration System (NPPES); and (f) Office of Foreign Assets Control (OFAC).

1.28 “**Fee-for-Service**” means a payment model in which providers are paid for each service provided. NC Medicaid and NC Health Choice’s Fee-for-Service program is also known as NC Medicaid Direct.

1.29 “**Grievance**” as it relates to a Covered Person has the same meaning as Grievance as defined in 42 CFR 438.400(b).

1.30 “**Grievance**” as it relates to a Covered Person has the same meaning as Grievance as defined in 42 CFR 438.400(b).

1.31 “**Innovations Waiver**” means the Section 1915(c) Home and Community-Based Services (“**HCBS**”) waiver for eligible individuals with I/DD operated by Tailored Plan.

1.32 “**Indian Health Care Provider**” or “**IHCP**” means an IHCP as defined by 42 C.F.R. § 438.14(a).

1.33 “**Individual Support Plan**” or “**ISP**” means a written individualized person-centered plan of care for Covered Persons with I/DD and TBI needs, including Innovations waiver and TBI waiver enrollees, that is developed using a collaborative approach led by the Covered Person or their guardian when appropriate, incorporates the results

of the care management comprehensive assessment, and identifies the Covered Person's desired outcomes and the training, therapies, services, strategies and formal and informal supports needed for the Covered Person to achieve those outcomes. For individuals enrolled in the Innovations or TBI waiver, the ISP also documents the waiver services that a Covered Person is authorized to obtain.

1.34 “**I/DD**” means Intellectual or Developmental Disabilities as defined by applicable law, including N.C.G.S. § 122C-3(17a).

1.35 “**Interest**” means, for the purposes of claim payment or encounter submission, an amount from Tailored Plan that is due to a provider for failing to timely or correctly pay a clean claim.

1.36 “**Limited English Proficient**” or “**LEP**” has the same meaning as LEP as defined in 42 C.F.R. § 438.10(a).

1.37 “**Local Management Entity/Managed Care Organization**” or “**LME/MCO**” has the same meaning as LME/MCO as defined in N.C. Gen. Stat. § 122C-3(20c).

1.38 “**Long Term Service and Supports**” or “**LTSS**” includes (a) care provided in the home, in community-based settings or in facilities; (b) care for older adults and people with disabilities who need support because of age, physical, cognitive, developmental or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; (c) a wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as: eating; taking baths; managing medications; grooming; walking; getting up and down from a seated position; using the toilet; cooking; driving; getting dressed; or managing money; (d) care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.

1.39 “**Medicaid Managed Care**” means North Carolina's program under which contracted Managed Care Organizations arrange for medical and other services to be delivered to Medicaid and NC Health Choice enrollees. Medicaid Managed Care will include four types of plans: (1) Standard Plans, (2) BH I/DD Tailored Plans, (3) Statewide Foster Care Plan and (4) Eastern Band of Cherokee Indians (EBCI) Tribal Option.

1.40 “**Medical Claim**” means a request for a payment that a healthcare provider submits to an insurer for rendered medical services.

1.41 “**Medically Necessary**” is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

1.42 “**National Provider Identifier**” or “**NPI**” means a standard unique health identifier for health care providers adopted by the Secretary of US Department of Health and Human Services in accordance with HIPAA.

1.43 “**Network**” means group of providers, including, without limitation, doctors, hospitals, pharmacies, and others contracted, directly or indirectly, by Tailored Plan to provide health care services to its Medicaid Managed Care members or State-funded Services recipients.

1.44 “**Non-Participating Provider**” means a physician or other health care providers that have not entered into a contractual agreement with Tailored Plan and/or are not part of Tailored Plan's Network, unlike Participating Providers. They may also be called out-of-network providers.

1.45 “**North Carolina Health Choice**” or “**NC Health Choice**” means the NC Health Choice Health Insurance Program for Low Income Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the

North Carolina State Plan of the Health Insurance Program for Children and authorized under Social Security Act Title XXI.

1.46 “**Objective Quality Standard**” means the objective standards that the Department applies during the Provider Enrollment process.

1.47 “**Outpatient Commitment**” occurs when a judge orders a person to receive treatment in the community for their BH condition. Before ordering Outpatient Commitment, the outpatient provider must agree to accept the patient into treatment and serve as the responsible party for the management and supervision of the Outpatient Commitment order.

1.48 “**Participating Provider**” means providers who are physicians or other health care providers that have a contractual agreement, direct or indirect, with Tailored Plan and are included in Tailored Plan’s Network. Participating Providers may also be called “in-network providers.”

1.49 “**Pharmacy Claim**” means a request for payment that a healthcare provider submits to an insurer for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims.

1.50 “**Primary Care Provider**” or “**PCP**” means the participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the Covered Person to provide and coordinate all the Covered Person’s health care needs and to initiate and monitor referrals for specialized services, when required.

1.51 “**Provider Enrollment**” means the process by which a provider is enrolled in the North Carolina’s Medicaid, NC Health Choice or State-funded Services programs with credentialing as a component of enrollment.

1.52 “**Provider Grievance**” means any oral or written complaint or dispute by Provider over any aspects of the operations, activities or behavior of Tailored Plan except for any dispute over for which Provider has appeal rights.

1.53 “**Reasonable Accommodation**” means a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with disabilities to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces, or to fulfill their program obligations.

1.54 “**Reasonable Accommodation**” means a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with disabilities to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces, or to fulfill their program obligations.

1.55 “**Significant Change**” means any change in the services offered by Tailored Plan, the benefits covered under the contract, the geographic service area and the composition of or payments to Tailored Plan’s network, and the enrollment of a new population in Tailored Plan.

1.56 “**Standard Plan**” or “**Standard Benefit Plan**” has the same meaning as Standard Plan as defined in N.C. Gen. Stat. § 108D-1(36).

1.57 “**State**” means the State of North Carolina, the Department as an agency or in its capacity as the Using Agency.

1.58 “**State Contract**” means the Tailored Plan Contract.

1.59 “**Tailored Care Management**” means the care management model for Covered Persons.

1.60 “**Tailored Plan**” means the BH I/DD Tailored Plan (or the applicable BH I/DD Tailored Plan) identified on Schedule A-1, Tailored Plan Program, Program Participation.

1.61 “**Tailored Plan Contract**” means the contract between a Tailored Plan and NC DHHS to provide integrated Medicaid managed care services to Medicaid and NC Health Choice populations with more severe BH conditions, including mental illness and severe substance use disorders, as well as I/DD and TBI, as may be amended from time to time by NC DHHS. A copy of the Tailored Plan Contract may be found at <https://medicaid.ncdhhs.gov/transformation/requests-proposals-rfps-and-requests-information-rfis>.

1.62 “**TBI**” means Traumatic Brain Injury, as defined by applicable law, including N.C.G.S § 122C-3(38a).

1.63 “**Traumatic Brain Injury (TBI) Waiver**” means the Section 1915(c) Home and Community-Based Services (HCBS) waiver for eligible individuals with TBI operated by Tailored Plan.

1.64 “**Telehealth**” means the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

1.65 “**Using Agency**” means the sub-division of the funded agency for whose use a project is provided. (N.C. Admin. Code 30F.0103(6)).

2. Compliance with State and Federal Laws. 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 Tailored Plan Contract and Tailored Plan Contract with NC DHHS, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to the Agreement, or any violation of the Tailored Plan Contract, could result in liability for money damages, including liquidated damages and/or civil or criminal penalties and sanctions under state and/or federal law. (Section VII. Attachment G.1.3(a) p 83)

3. Hold Covered Person Harmless. Provider agrees to hold the Covered Person harmless for charges for any Covered Service. Provider agrees not to bill a Covered Person for medically necessary services covered by Tailored Plan so long as the Covered Person is eligible for coverage. (Section VII. Attachment G.1.3(b) p 83) Provider shall hold Covered Persons harmless for the costs of medically necessary Covered Services, except for applicable cost sharing. (Section V.B.1.ii(i)(c)(3) p. 61)

4. Liability. Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, Tailored Plan, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution or indemnification against NC DHHS for any duty owed to Provider by Tailored Plan or its subcontractors, or any judgment rendered against Tailored Plan. (Section VII. Attachment G.1.3(c) p 84)

5. Non-Discrimination, Equitable Treatment of Members. Provider agrees to render Covered Services to Covered Persons with the same degree of care and skills as customarily provided to Provider’s patients who are not Covered Persons, according to generally accepted standards of medical practice. Provider and Tailored Plan agree that Covered Persons and non-Covered Persons should be treated equitably. Provider agrees not to discriminate against Covered Persons on the basis of race, color, national origin, age, sex, gender, LGBTQ status or disability. (Section VII. Attachment G.1.3(d) p 84)

6. Department Authority Related to the Medicaid Program. Provider agrees and understands that in the State of North Carolina, NC DHHS, 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. (Section VII. Attachment G.1.3(e) p 84)

7. Access to Provider Records. Provider agrees to provide, at no cost, the following entities or their designees with prompt, reasonable and adequate access to this Schedule and any records, books, documents and papers that relate to this Schedule and/or Provider's performance of its responsibilities under this Schedule 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) 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; and (iv) any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS, including the Tailored Plan. (Section VII. Attachment G.1.3(f) p 84)

Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews or other Program Integrity activities conducted by the NC DHHS, Tailored Plan or Health Plan.

Nothing in this section shall be construed to limit the ability of the federal government, CMS, 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.

8. Provider Ownership Disclosure. Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, related to ownership and control, business transactions and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations and requirements for disclosure of ownership, business transactions and information on persons convicted of crimes related to any federal health care programs. Provider agrees to notify, in writing, Tailored Plan and the NC DHHS of any criminal conviction within 20 days of the date of the conviction. (Section VII. Attachment G.1.3(g) p 85)

9. Prompt Claim Payments Under Health Benefit Plans. This Section 9 shall apply if and as required by law. Where applicable, Provider shall submit all claims for a date of service on or before June 30, 2023, to Health Plan, as a subcontractor of Tailored Plan, for processing and payments within 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 365 Calendar Days of the date of the provision of care. Participating Provider shall submit all claims with a date of service on or after July 1, 2023, to Health Plan for processing and payment within 365 Calendar Days from the date of covered service or discharge (whichever is later). Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, in no event later than one year from the time submittal of the claim is otherwise required.

a. For Medical Claims (including BH): (i) Tailored Plan or Health Plan, as applicable, shall, within 18 Calendar Days of receiving a Claim, notify Provider whether the claim is clean or pend the claim and request from Provider all additional information needed to process the claim; Health Plan shall have the capability to request additional information via 277 Health Care claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email) and via mail. Health Plan shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by NC DHHS; (ii) Tailored Plan or Health Plan, as applicable, shall pay or deny a clean medical claim at lesser of 30 Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication; and (iii) a medical pended claim shall be paid or denied within 30 Calendar Days of receipt of the requested additional information.

b. For Pharmacy Claims: (i) Tailored Plan shall, within 14 Calendar Days of receiving a pharmacy claim, pay or deny a clean pharmacy claim or notify Provider that more information is needed to process the claim; and (ii) a pharmacy pended claim shall be paid or denied within 14 Calendar Days of receipt of the requested additional information.

c. If the requested additional information on a medical or pharmacy pended claim is not submitted within 90 days of the notice requesting the required additional information, Tailored Plan or Health Plan, as applicable, shall deny the claim per applicable law. Tailored Plan or Health Plan, as applicable, shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

d. If Tailored Plan or Health Plan, as applicable, fails to pay a clean claim in full pursuant to this provision, Tailored Plan or Health Plan, as applicable, shall pay Provider interest and liquidated damages to the extent required by law. Late payments will bear interest at the annual rate of 18 percent, beginning on the date following the day on which the claim should have been paid or was underpaid.

e. Failure to pay a clean claim within 30 days of receipt will result, to the extent required by law, in Tailored Plan or Health Plan, as applicable, paying Provider liquidated damages equal to one 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.

f. Tailored Plan or Health Plan, as applicable, shall pay any required interest and liquidated damages from subsections (iv) and (v) as provided in that subsection and shall not require Provider to request the interest or the liquidated damages. (Section VII. Attachment G.1.3(h) p 85-86)

10. Termination. Health Plan may immediately terminate the Agreement at Tailored Plan's request upon a confirmed finding of fraud, waste or abuse by NC DHHS or the North Carolina Department of Justice Medicaid Investigations Division ("**MID**"), or serious quality of care concerns by Tailored Plan or the MID, or upon termination of the Tailored Plan Contract by the State. Health Plan may immediately suspend some or all activities under the Agreement at Tailored Plan's request upon finding a credible allegation of fraud, waste, abuse or serious quality of care concerns by Tailored Plan or the MID. Upon termination of the Agreement, Provider shall notify Tailored Plan and Health Plan of any Covered Persons who have scheduled appointments with Provider following such termination. (Section VII. Attachment G.1.1(d) p 79)

11. Survival. If the Agreement or the Tailored Plan Program Attachment terminates as a result of Provider's, Health Plan's or Tailored Plan's insolvency, Provider will cooperate in the transition of administrative duties and records and ensure the continuation of care when inpatient care is on-going in accordance with the requirements of the Agreement and the Tailored Plan Contract. If Health Plan or Tailored Plan provides for or arranges for the delivery of health care services on a prepaid basis, Provider will continue inpatient care until the patient is ready for discharge. (Section VII. Attachment G.1.1(e) p 79)

12. Credentialing. Provider shall maintain licensure, accreditation and credentials sufficient to meet Tailored Plan's network participation requirements as outlined in Tailored Plan's Credentialing and Re-credentialing Policy (which shall align with NC DHHS centralized credentialing process, criteria and applicable Regulatory Requirements) and shall notify NC DHHS of changes in the status of any information relating to Provider's professional credentials. Provider must at all times during the term of this Schedule be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410 (Section V.B.4.ii(iii)(a) p 204); failure to maintain such enrollment shall constitute grounds for immediate termination of this Schedule by Health Plan. Provider shall complete reenrollment/re-credentialing before renewal of this Schedule and in accordance with the following: (a) during provider credentialing transition period, no less frequently than every five years; and (b) during provider credentialing under full implementation, no less frequently than every three years, except as otherwise permitted by NC DHHS. (Section V.B.4.ii(iii); (f) p 205; Section VII. Attachment G.1.1(f) p 79)

13. Liability Insurance. Provider must maintain professional liability insurance coverage in an amount acceptable to Health Plan and to notify Health Plan of subsequent changes in status of professional liability insurance on a timely basis. (Section VII. Attachment G.1.1(g) p 80)
14. Member Billing. Provider shall not bill any Covered Person for Covered Services, except for specified coinsurance, copayments and applicable deductibles. Nothing in this provision shall prohibit Provider from agreeing with a Covered Person to continue non-Covered Services at the Covered Person's own expense, as long as Provider has notified the Covered Person in advance that Tailored Plan may not cover or continue to cover specific services. Provider shall have the responsibility to collect from the Covered Person applicable deductibles, copayments, coinsurance and fees for non-Covered Services. (Section VII. Attachment G.1.1(h) p 80)
15. Provider Accessibility. Provider shall arrange for call coverage or other back-up to provide service in accordance with Tailored Plan's standards for provider accessibility. Provider will in addition:
- a. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if Provider serves only Medicaid beneficiaries;
 - b. Make Covered Services available to Covered Persons 24 hours a day, 7 days a week, including holidays, when medically necessary; and
 - c. Have a "no-reject policy" for referrals within the capacity and parameters of Provider's competencies. Provider agrees to accept all referrals meeting criteria for Covered Services that it provides when there is available capacity. (Section VII. Attachment G.1.1(i) p 80)
16. Eligibility Verification. Tailored Plan or Health Plan shall provide a mechanism that allows Provider to verify Covered Person eligibility, based on current information held by Tailored Plan or Health Plan, before rendering health care services. (Section VII. Attachment G.1.1(j) p 80)
17. Medical Records. In accordance with 42 C.F.R. § 438.208(b)(5), Provider shall (i) maintain confidentiality of Covered Person 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 Tailored Plan standards; and (iii) make copies of such records available to Health Plan, Tailored Plan and NC DHHS in conjunction with NC DHHS's regulation of Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party. (Section VII. Attachment G.1.1(k) p 80)
18. Member Appeals and Grievances. Provider shall cooperate with Covered Persons in regard to Covered Person appeals and grievance procedures. (Section VII. Attachment G.1.1(l) p 81)
19. Services Provided Under Outpatient Commitment. With respect to services provided to a Covered Person under Outpatient Commitment, Provider shall notify Tailored Plan, at an address to be provided by Health Plan, of the Outpatient Commitment order upon receipt. (Section VII. Attachment G.1.1(m) p 81)
20. LGBTQ Covered Persons. Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) Covered Persons who obtain Covered Services shall not be subject to treatment or bias by Provider that does not affirm such individuals' orientation. (Section VII. Attachment G.1.1(n) p 81)
21. Data to Provider. Tailored Plan or Health Plan shall provide the following data and information to Provider:
- a. Performance feedback reports or information, if compensation is related to efficiency criteria.
 - b. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.

c. Notification of changes in such requirements that allows time for Provider to comply with such changes. (Section VII. Attachment G.1.1(p) p 81)

22. Utilization Management (UM). Provider shall comply with Tailored Plan's UM programs, quality management programs, and provider sanctions programs, provided that such programs shall not override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Provider's patients. (Section VII. Attachment G.1.1(q) p 81)

23. Quality Management. Provider shall participate in Tailored Plan's compliance process and Network Continuous Quality Improvement process. (Section VII. Attachment G.1.1(r) p 81)

24. Provider Directory. Tailored Plan shall include Provider's name in Tailored Plan's provider directory distributed to Covered Persons; Provider hereby authorizes such inclusion. (Section VII. Attachment G.1.1(s) p 81) Provider shall provide timely, accurate and updated provider information to Health Plan sufficient to allow Tailored Plan to comply with Tailored Plan Contract requirements relating to Provider Directories. (Section V.B.4.ii(x)(g) p 213)

25. Dispute Resolution. Contractual disputes between Health Plan and Provider shall be resolved pursuant to the "dispute resolution" provisions of the Agreement and as applicable, Tailored Plan's and/or Health Plan's Provider Grievance and Appeals policy. Any such dispute resolution process shall comply with the requirements relating to Provider Grievance and Appeals set forth in Section V.B.4.v. of the Tailored Plan Contract. (Section VII. Attachment G.1.1(t) p 81)

26. Assignment. Provider's duties and obligations under the Agreement as they relate to the Tailored Plan Program, including this Schedule, shall not be assigned, delegated or transferred without the prior written consent of Health Plan. Health Plan shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. (Section VII. Attachment G.1.1(u) p 81)

27. Government Funds. Provider acknowledges that funds used for provider payments under the Agreement are government funds. (Section VII. Attachment G.1.1(v) p 82)

28. Interpreting and Translation Services. Provider shall (i) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Covered Person; (ii) ensure Provider's staff is trained to appropriately communicate with patients with various types of hearing loss; and (iii) report to Health Plan, in a format and frequency to be determined by Health Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided. (Section VII. Attachment G.1.1(w) p 82)

29. Advanced Medical Homes. If Provider is an AMH, Provider agrees to comply with the requirements of the NC DHHS AMH Program set forth at Exhibit 1 to this Schedule. (Section VII. Attachment G.1.1(y) p 82; Section VII. Attachment G.1.2(a)-(d) p 83; Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members)

30. Providers of Perinatal Care. If Provider is an Obstetrician, Provider agrees to comply with the requirements of the NC DHHS Pregnancy Management Program set forth at Exhibit 2 to this Schedule. (Section VII. Attachment G.1.1(x) p 82; Section VII. Attachment G.1.2(a)-(d) p 83; Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members)

31. Local Health Departments. If Provider is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, Provider agrees to comply with the requirements of the NC DHHS Care Management for High-Risk Pregnancy Policy, set forth at Exhibit 3 to this Schedule, and the Care Management for At-Risk Children Policy, set forth at Exhibit 4 to this Schedule. (Section VII. Attachment G.1.1(z) p 82; Section VII. Attachment G.1.2(a)-(d) p 83; Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy)

for Medicaid and NC Health Choice Members and Section VII. Attachment M.6. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members)

32. Residential Substance Use Disorder Treatment Providers. If Provider is a residential substance use disorder treatment provider, Provider shall either provide medication assisted treatment (“*MAT*”) on-site or refer to an in-network MAT provider. (Section VII. Attachment G.1.1(aa) p 82)

33. Special Requirements.

a. Coverage Determinations. If Tailored Plan or its authorized representative determines that services, supplies or other items are covered under its health benefit plan or dental plan, including any determination under G.S. 58-50-61 or the Tailored Plan Contract, as applicable, Tailored Plan shall not subsequently retract its determination after the services, supplies or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person’s health condition that was knowingly made by the Covered Person or Provider. (Section VII. Attachment G.1.1(bb)(i) p 82; G. S. 58-3-200(c) (to the extent applicable))

b. Health Plan Fee Schedules. Provider acknowledges that Health Plan shall make available to Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by the same class of provider. Upon Provider’s request, Health Plan shall also make available the full schedule of fees for services or procedures billed by the same class of provider, or for each class of provider, if this Schedule applies to multiple classes of providers. If Provider requests fees for more than 30 services and procedures, Health Plan may require the provider to specify the additional requested services and procedures and may limit Provider’s access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by Provider. (Section VII. Attachment G.1.1(bb)(ii) p 82; G.S. 58-3-227(h) (to the extent applicable))

c. Definitions. Unless the context or Tailored Plan Contract clearly requires otherwise, the following definitions apply below for the remainder of the “Special Requirements” section.

(i) **“Amendment”** - Any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing or court order is not an amendment.

(ii) **“Contract”** - An agreement between an insurer and a Health Care Provider for the provision of health care services by the provider on a preferred or in-network basis.

(iii) **“Health Care Provider”** - An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients. (Section VII. Attachment G.1.1(bb)(iii) p 82; G.S. 58-50-270(1), (2) and (3a) (to the extent applicable))

d. Notice Contract Provisions. In addition to the means for sending legal notices provided under the “notices” provision of the Agreement, the means for sending all notices provided under this Schedule shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider. (Section VII. Attachment G.1.1(bb)(iv) p 82; G.S. 58-50-275 (a) and (b) to the extent applicable))

e. Contract Amendments.

(i) Health Plan shall send any proposed contract amendment to the notice contact Provider pursuant to G.S. 58-50-275, if applicable, or Tailored Plan Contract. The proposed amendment shall be dated, labeled "Amendment," signed by Health Plan and include an effective date for the proposed amendment.

(ii) Provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the Health Care Provider failing to object in writing within 60 days.

(iii) If Provider objects to a proposed amendment, then the proposed amendment is not effective and Health Plan shall be entitled to terminate this Schedule upon 60 days written notice to Provider.

(iv) Nothing in this part prohibits Provider and Health Plan from negotiating contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent or alternative notice contacts. (Section VII. Attachment G.1.1(bb)(v) p 82; G.S. 58-50-280 (a) through (d) (to the extent applicable))

f. Policies and Procedures.

(i) Health Plan shall provide a copy of Tailored Plan's policies and procedures pertaining to Health Care Providers to Provider prior to execution of a new or amended contract, and annually to all contracted Health Care Providers. Such policies and procedures may be provided to the Health Care Provider in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on Tailored Plan's Web site.

(ii) Tailored Plan's policies and procedures shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail. (Section VII. Attachment G.1.1(bb)(vi) p 82; G.S. 58-50-285 (a) and (b) (to the extent applicable))

g. Pharmacy of Choice.

(i) If Provider is a pharmacy, Pharmacy may not—by or through a pharmacist acting on its behalf as its employee, agent or owner—waive, discount, rebate or distort a Tailored Plan Program copayment, or a Covered Person's coinsurance portion of a prescription drug coverage or reimbursement, and if Provider, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to a Covered Person that meets the Tailored Plan's terms and requirements, the pharmacy shall provide its pharmacy services to all Covered Persons on the same terms and requirements of Tailored Plan. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.

(ii) At least 60 days before the effective date of Tailored Plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, Tailored Plan shall notify, in writing, all pharmacies within Tailored Plan's geographical coverage area, and offer to the pharmacies the opportunity to participate with Tailored Plan. All pharmacies in such geographical coverage area shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. Tailored Plan shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform Covered Persons of the names and locations of pharmacies that are participating with Tailored Plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and Tailored Plan. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the Tailored Plan enters a particular county of the State. (Section VII. Attachment G.1.1(bb)(vii) p 82; G.S. 58-51-37 (d) and (e) (to the extent applicable))

34. Critical Incident Reporting. Provider shall comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. (Section VII. Attachment G.1.1(cc) p 83; Section V.B.4.ii(v)(e) p 208)
35. Disaster Plan. Provider shall have a plan for delivering, and shall deliver, all necessary care to Covered Persons during a disaster or emergency. (Section V.A.2.vi(x)(h))
36. Fraud, Waste and Abuse Prevention Procedures. Provider shall comply with the following:
- a. Provider shall have a compliance program that meets the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meets the Deficit Reduction Act of 2005 requirements. Provider shall have and implement a policy recognizing Medicaid as the payer of last resort. (Section V.A.3.ii(ii)(f)(4), (6) & (7) p. 38)
 - b. Provider shall comply with Tailored Plan's polices and processes relating to prepayment review, as well was with Tailored Plan's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation, procedures relating to provider visit verifications and announced and unannounced provider site visits and field audits. (Section V.A.3.iii(v)(c)(13) and (14)(vi), (x) p. 42, 43)
37. Program Integrity. Provider shall have a compliance program that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005. Provider shall have policies and procedures that recognize and agree that Medicaid is "the payer of last resort," except in the instances that a Covered Person is also accessing State-funded services where State-funded services are "the payer of last resort." Provider shall refrain from billing Covered Persons for Covered Services any amount greater than would be owed if Provider provided the service directly as provided in 42 C.F.R. §§ 438.106(c) and 438.108. (Section V.B.4.ii(vii)(b),(c) & (d) p 209)
38. First- and Third-Party Payments. Provider shall pursue all applicable first and third-party payments for services, including Medicaid funding and the Division of Vocational Rehabilitation Services (DVRS) funding for Supported Employment, in order to minimize the usage of State resources. Provider shall comply with Tailored Plan's first- and third-party payment requirements. (Section V.A.3.iv(v)(i) and (iv) p. 47)
39. Transition of Care. Provider shall comply with Tailored Plan's Transition of Care Policy. (Section V.B.1.ii(i)(d)(3) and (4) p.63)
40. Member Rights. Provider acknowledges and agrees that Covered Persons are free to exercise their rights as Medicaid Managed Care plan members, and that the exercise of those rights will not adversely affect the way Provider treats such Covered Person. (42 C.F.R. § 438.100(c)) (Section V.B.1.v(vii) p. 79)
41. Non-Discrimination. Provider shall comply with the non-discrimination requirements specified in the Tailored Plan Contract, as well as with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination against Covered Persons in the course of obtaining or receiving services from Tailored Plan or Provider including, but not limited to, the following:
- a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
 - b. Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identify and national origin;
 - c. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;

d. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;

e. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;

f. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;

g. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;

h. Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities;

i. The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ 15 or more employees;

j. The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;

k. The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and

l. Abide by the non-discrimination provisions in North Carolina Executive Order 24, dated October 18, 2017, by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation and gender identity or expression.

Provider shall not discriminate against members, recipients, providers or employees in the provision of services or administration of the program, nor shall Provider discriminate against individuals eligible to enroll on the basis of health status or need for health care services. (42 C.F.R. § 438.3(d)(3), 42 C.F.R. § 438.100(d)) (Section V.B.1.v(viii) p. 79; Section V.A.1.vii p 9)

42. Cultural and Linguistic Competency. Provider shall provide Covered Services to Covered Persons in a Culturally and Linguistically Competent manner, including those Covered Persons with limited proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation or gender identity. Provider shall not subject Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) Covered Persons who obtain Covered Services to treatment that does not affirm their orientation. (Section V.B.4.i(iii)(f) p 198)

43. Reasonable Accommodations for Covered Persons. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities. If Provider is a nursing home, community ICF-IID, behavioral health residential treatment facility or adult care home, Provider shall cooperate with Tailored Plan's efforts to assess the capacity of Providers to ensure that Covered Persons residing in Provider's facility(ies) have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. (Section V.B.4.i(vii)(a)(1)(v)(c) & (d) p 200)

44. Request for Continuation of Benefits. Provider shall not be allowed to request continuation of benefits on behalf of a Covered Person. (42 C.F.R. § 438.402(c)(1)(ii)) (Section V.B.1.vi(iv)(c) p. 87)

45. Vaccines for Children. If Provider is a primary care provider who serves Covered Persons under age 19, Provider shall administer vaccines consistent with the American Academy of Pediatrics (AAP)/Bright Future periodicity schedule. Provider is additionally encouraged to participate in the Vaccines for Children (VFC) program, which allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age 19. (Section V.B.2.i(iii)(k) p. 97-98)

46. Provider-Specific Provisions.

a. Advanced Medical Homes. If Provider is an AMH practice ready to take primary responsibility for care management under Tailored Plans, Provider shall become certified as an AMH+ practice as described in the Tailored Plan Contract (Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs), through which it will become eligible to receive a fixed Tailored Care Management payment from NC DHHS. (Section V.B.1.vi(vii)(i)(a)(3) and (4) p. 91; Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members p. 140)

b. Behavioral Health Provider Requirements. If Provider is a BH provider, Provider shall coordinate with primary care providers and specialists conducting EPSDT screenings of Covered Persons. (Section V.B.2.ii(x) p 114); (Section V.B.2.i(v)(p)(5)(iii)(a) p. 104)

c. Nursing Facility Requirements. If Provider is a nursing facility, Provider shall include any approved Specialized Services as part of the Plan of Care for the Covered Person. (Section V.B.2.i(ix)(b)(1) p. 110)

d. Primary Care Provider Requirements. If Provider is a primary care provider, Provider shall:

(i) Perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under 21 years of age in accordance with NC DHHS's Oral Health Periodicity Schedule.

(ii) Refer infant Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one, per requirements of NC DHHS's Oral Health Periodicity Schedule.

(iii) Include all of the following components in each medical screening: (A) routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents," including (1) screening for developmental delay at each visit through the fifth year and (2) screening for Autistic Spectrum Disorders per AAP guidelines; (B) comprehensive, unclothed physical examination; (C) all appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices; (D) laboratory testing (including blood lead screening appropriate for age and risk factors); and (E) health education and anticipatory guidance for both the child and caregiver. (Section V.B.2.ii(ix) p 114).

(iv) Perform EPSDT screenings for Covered Persons less than 21 years of age in accordance with Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members. (Section V.B.4.ii(iii)(o) p 206)

e. 340B Covered Entity Requirements. If Provider is a 340B covered entity, Provider shall as follows:

(i) Submit national Council for Prescription Drug Programs (NCPDP) code "8" in Basis of Cost Determinations filed 423-DN or in Compound Ingredient Basis of Cost Determination filed 490-UE or a '20' in the

submission clarification code field (NCPDP D.0 field 420-DK) at the point of sale to identify claims submitted for drugs purchased through the 340B program.

(ii) Identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by NC DHHS. (42 C.F.R. § 438.3(s)(3))

(iii) Specify in Provider's written agreements with contracted pharmacies that such contracted pharmacies shall comply with the point of sale identification of drugs purchased through the 340B program (42 C.F.R. § 438.3(s)(3)) and, for those contracted pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. (42 C.F.R. § 438.3(s)(3) (Section V.B.2.iii(ix)(e) p 122))

f. Institutional Discharge/Transition Planning. If Provider is an institution (e.g., a hospital, residential setting, rehabilitation setting, State Operated Health Care Facility, ICF-IID, other facility-based treatment setting or LTSS provider), Provider shall:

(i) Permit transition staff, including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator, to engage in and help coordinate the discharge planning process;

(ii) Notify Health Plan of Covered Person admissions/pending discharges, and contact the assigned organization providing Tailored Care Management (if applicable) to integrate the organization into the discharge/transition planning process;

(iii) Share relevant information (including the Covered Person's current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team Covered Persons and the Covered Person's care team if applicable and establish relationships with AMH+ practices and CMAs to facilitate care transitions. (Section V.B.3.iii(viii)(c) p 157)

g. Screening Tool Results for PMP Providers. If Provider is a PMP provider, Provider shall provide standardized screening tool results to Health Plan on a scheduled to be determined by Tailored Plan. (Section V.B.3.v(iii)(a)(4) p 162)

h. System of Care Principles for Provider Agencies. If Provider is a provider agency, Provider shall cooperate with Tailored Plan's efforts to ensure the fidelity of Provider and its staff in the implementation of System of Care principles and processes. (Section V.B.3.vii(ii)(b)(4) p 168)

i. Discharge Service Orders for Facility Providers. If Provider is a facility, Provider shall work cooperatively with Tailored Plan to develop the necessary discharge service orders for post-discharge services required to meet the Covered Person's individual needs. (Section V.B.3.viii(iv)(m) p 173)

j. Avoidance of Duplicative Care Management Services. If Provider is providing to a Covered Person either in-reach and transition services or another care management service besides Tailored Care Management, Provider's in-reach and transition staff and the provider of the duplicative service (or, if Provider is the provider of the duplicative service, vice-versa) shall explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services. (Section V.B.3.viii(xii)(b) p 181)

k. Outpatient Commitment Order. If Provider provides services under Outpatient Commitment to a Covered Person, Provider shall notify Tailored Plan at an address to be provided by Health Plan, of the Outpatient Commitment order upon receipt. (Section V.B.4.i(iii)(d)(3) p 195)

l. Innovations or TBI Waiver Services. If Provider is a provider of Innovations and/or TBI waiver services, Provider shall comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and the requirements set forth by NC DHHS. Provider must have achieved national accreditation with at least one of the designated accrediting

agencies if required by the waiver(s). The organization must be established as a legally constituted entity capable of meeting all of Tailored Plan's requirements. (Section V.B.4.i(iii)(g)(1) p 196)

m. Indian Health Care Providers. If Provider is an IHCP, Provider shall comply with the requirements set forth on the Addendum for Indian Health Care Providers, attached hereto at Exhibit 5 to this Schedule, and shall adhere to the Tribal Payment Policy attached hereto at Exhibit 6 to this Schedule (Section VII.M.16. Tribal Payment Policy). (Section V.B.4.ii(vi)(a) p 208)

47. Change of PCP For Cause. Provider acknowledges that Covered Persons shall be allowed to change their PCP with cause at any time, and that NC DHHS considers Provider's failure to furnish accessible and appropriate medical care, services or supplies to which the Covered Person is entitled to be appropriate "cause" for Covered Person PCP changes. Such failure includes, but is not limited to, the failure to (i) provide primary care services; (ii) arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary; (iii) arrange for consultation appointments; (iv) coordinate and interpret any consultation findings with an emphasis on continuity of medical care; (v) arrange for services with qualified licensed or certified providers; and (vi) coordinate the Covered Person's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury. (Section V.B.1.vi(vii)(ii)(h)(i)(1) p. 92)

48. Timely Access to Care. Provider shall comply with the following.

a. Wait Time Standards. Provider shall meet NC DHHS standards for timely access to care and services, taking into account the urgency of need for services, and shall take corrective action to meet such timely access requirements where requested by Tailored Plan. Provider shall comply with the applicable wait time standards set forth in Exhibit 7 to this Schedule. (Section V.B.4.i(iii)(b) p 197; Section V.B.4.i(vii)(d)(1) p 203)

b. Hours of Operation. Provider shall offer hours of operation that are not less than the hours of operation offered to commercial members or, if Provider serves only Medicaid or NC Health Choice, hours that are comparable to Medicaid Fee for Service. (Section V.B.4.i(iii)(c) p 197)

c. Reasonable Accommodations. Provider shall provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all Covered Persons with physical disabilities or needs. (Section V.B.4.i(2) p 197; Section V.B.4.i(iii)(e) p 198)

d. EPSDT Services. Provider shall ensure that a Covered Person shall have a scheduled appointment for an EPSDT service no more than six calendar weeks from the date of the request for an appointment. (Section V.B.2.ii(xii) p 114)

e. Notice of Significant Changes. Provider shall notify Health Plan of any Significant Change that would affect the adequacy or capability of services provided by Provider, or Provider's time/distance from Covered Persons and appointment wait time standards established by NC DHHS as described in the Tailored Plan Contract (Section VII. Attachment F. Tailored Plan Network Adequacy Standards). Provider shall cooperate with Tailored Plan's efforts to monitor Provider's compliance with the same. (Section V.B.4.i(vii)(d)(1) p 203)

49. EQRO Network Adequacy Validation. Provider shall comply and cooperate with EQRO network adequacy validations and activities including (i) annual validation of Tailored Plan's network adequacy and compliance with state and federal network requirements; and (ii) telephone surveys of providers to verify accuracy of reported data or other aspects of program requirements or performance. (Section V.B.4.i(vii)(b)(1)&(2) p 202)

50. Tobacco-Free Policy.

50.1 Providers Who May Elect to Implement a Tobacco-Free Policy. Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings or manufacturing sites that employ adults who receive group services, are not required to develop or maintain

a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy.

50.2 Providers Subject to a Partial Tobacco-Free Policy. Starting January 1, 2027, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

- i Use of tobacco products is prohibited indoors when the building or home in which the Participating Provider operates is under the Participating Provider's control as owner or lessee;
- ii Outdoor areas of the property, under Participating Provider's control as owner or lessee shall:
 - a. Ensure access to common outdoor space(s) free from exposure to tobacco use.
 - b. Prohibit staff/employees from using tobacco products anywhere on the property.

Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirements shall retain the option to implement a 100% tobacco-free campus policy for the safety of clients and staff.

50.3 Providers Subject to Full Tobacco-Free Policy. Starting January 1, 2027, contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy. Participating Providers shall develop and implement a tobacco-free policy covering any portion of the property on which 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, such as electronic, heated and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on Participating Provider from purchasing, accepting as donations or distributing tobacco products to individuals Participating Provider serves.

51. Grievances and Appeals. Provider shall have the right to file a Grievance or Appeal. Internal Appeals processes must be exhausted before Provider may seek other legal or administrative remedies under state or federal law. (Section V.B.4.ii(iii)(m) p 206)

52. Discharge of Covered Person in High Acuity Setting. Provider shall notify Health Plan when a Covered Person in a high acuity clinical setting is being discharged. (Section V.B.4.ii(iii)(p) p 207)

53. Encounter Data. Provider shall submit accurate, complete and timely encounter data that adhere to applicable NC DHHS benchmarks. (Section V.B.6.ii(ii) p. 236; Section V.B.6.ii(v)(i) p. 237) Provider shall not submit claim or encounter data for services covered by Medicaid Managed Care and Tailored Plans directly to NC DHHS. (Section V.B.4.ii(iii)(t) p 208)

54. Provider Preventable Conditions. Provider will comply with 42 C.F.R. § 438.3(g), which, at a minimum, means non-payment of provider-preventable conditions as well as appropriate reporting, as required by Tailored Plan. (Section V.B.4.ii(iv) p 208)

55. Change of Circumstances. Provider shall promptly notify Health Plan in writing in the event of a change in a Provider's circumstances that may affect Provider's eligibility to participate in the Medicaid Managed Care program. (42 C.F.R. § 438.608(a)(4) (Section V.A.3.i(ii)(a)(1) p. 34))

56. Appearance on Exclusion List. Provider shall notify Health Plan, or Tailored Plan at an address to be provided by Health Plan, in writing immediately if Provider appears on one or more of the Exclusion Lists. In such event, Health Plan may immediately terminate this Schedule and Health Plan, as a subcontractor of Tailored Plan, shall withhold all payments owed to Provider hereunder. (Section V.A.3.ii(ii)(a)(4) p. 36; (Section V.B.4.ii(iii)(d) p 205))

57. Suspension of Payments. In the event that NC DHHS notifies Tailored Plan that payments to Provider have been suspended or are being withheld, Health Plan, as a subcontractor of Tailored Plan, shall suspend payments to or withhold payments from Provider in accordance with NC DHHS's instructions within one Business Day of receipt of the notice or as otherwise instructed. (Section V.A.3.ii(ii)(c)(2), (3) p. 37)

58. Termination/Suspension of Claims. Health Plan, as a subcontractor of Tailored Plan, shall suspend payment of claims hereunder and/or terminate this Schedule in the event of the following.

a. Due to Provider's Non-Enrollment with Medicaid. Health Plan shall terminate this Schedule immediately upon Tailored Plan's notification from the State that Provider cannot be enrolled as a Medicaid provider, or upon the expiration of 120 days without enrollment of Provider as a Medicaid provider. (42 C.F.R. § 438.602(b)(2) (Section V.B.4.ii(viii)(f)(1) p 210))

b. Due to Provider's Termination from Medicaid. Health Plan, as a subcontractor of Tailored Plan, shall remove Provider from claims payment system and Health Plan shall terminate this Schedule within one Business Day of receipt of a notice from NC DHHS or Tailored Plan that Provider is terminated as a Medicaid provider. If Tailored Plan or Health Plan had previously suspended provider payments to Provider, then upon notice by NC DHHS or Tailored Plan that Provider is terminated from Medicaid, Health Plan, as a subcontractor of Tailored Plan, shall release applicable claims and deny payment for dates of service after the date of termination from Medicaid. (Section V.B.4.ii(x)(e)(2) p 213)

c. Due to Provider's Failure to Submit Re-Credentialing Documentation. Health Plan, as a subcontractor of Tailored Plan, shall suspend claims payment to Provider within one Business Day of Tailored Plan's receipt of a notice from NC DHHS for dates of services after the effective date provided by NC DHHS in its notice to Tailored Plan that payment must be suspended for Provider's failure to submit re-credentialing documentation to NC DHHS, or otherwise failing to meet Department requirements. Health Plan, as a subcontractor of Tailored Plan, shall reinstate payment to Provider upon notice to Tailored Plan from NC DHHS that NC DHHS has received the requested information from Provider. Neither Tailored Plan nor Health Plan shall be liable for interest or liquidated damages for payment suspension when directed by NC DHHS. (Section V.B.4.ii(x)(e)(1) p 212)

59. List of Scheduled Covered Persons in the Event of Termination. In the event of termination of this Schedule, upon request by Tailored Plan or Health Plan, Provider shall provide Tailored Plan, at an address to be provided by Health Plan, with a list of Covered Persons who:

a. Are scheduled to receive services from Provider within the 60 Calendar Day period immediately preceding the date of notice of termination, except if Provider is a PCP, AMH+ or CMA for a Covered Person (42 C.F.R. § 438.10(f)(1)) (Section V.B.1.ii(i)(d)(2)(i) and (ii) p. 63)); and

b. Received primary care from, or were seen in the previous 12 months by, Provider. (Section V.B.4.ii(x)(f) p 213)

60. Claims Timeliness. Provider shall submit claims within 180 Calendar Days after the date of the provision of care to the Covered Person and, in the case of health care provider facility claims, 180 Calendar Days after the date of the Covered Person's discharge from the facility. (N.C. Gen. Stat. § 58-3-225(f) (Section V.B.6.i(iv)(c) p. 235))

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EXHIBIT 1 to SCHEDULE A-2

Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members

Background.

The Advanced Medical Home (AMH) program refers to an initiative under which a Standard Plan or BH I/DD Tailored Plan must pay Medical Home Fees to all participating primary care practices that act as PCPs. In the context of BH I/DD Tailored Plans, only AMH practices certified as AMH+ practices will play the lead role in providing Tailored Care Management.

An AMH “practice” will be defined by an NPI and service location.

AMH Providers shall comply with the following in connection with AMH Covered Services provided to Tailored Plan Covered Persons:

- i. Accept members and be listed as a PCP in the BH I/DD Tailored Plan’s member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- ii. Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.
- iii. Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, 7 days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- iv. Provide direct patient care a minimum of 30 office hours per week.
- v. Provide preventive services, in accordance with Table 1: Required Preventive Services, attached hereto.
- vi. Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan’s medical record documentation guidelines.
- vii. Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
- viii. Transfer the member’s medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within 30 days of the date of the request, free of charge.
- ix. Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan’s network adequacy standards.
- x. Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.
- xi. Review and use member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level UM and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.
- xii. Review and use the monthly enrollment report provided by the BH I/DD Tailored Plan for the purpose of participating in BH I/DD Tailored Plan or practice-based population health or care management activities.

Table 1: Required Preventive Services

Section VII. Attachment M.2. Table 1: Required Preventative Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus, Pertussis Vaccine (DTap)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenza Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8 & 9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Development	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Section VII. Attachment M.2. Table 1: Required Preventative Services

		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

BH I/DD Tailored Plan Request for Applications

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EXHIBIT 2 to SCHEDULE A-2

Pregnancy Management Program Policy for Medicaid and NC Health Choice Members

Background.

The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing healthcare costs among participating providers.

Providers of prenatal, perinatal and postpartum care shall comply with the following in connection with Covered Services provided to Tailored Plan Covered Persons:

- i. Complete the standardized risk-screening tool at each initial visit.
- ii. Allow Tailored Plan or Tailored Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
- iii. Commit to maintaining or lowering the rate of elective deliveries prior to 39 weeks' gestation.
- iv. Commit to decreasing the cesarean section rate among nulliparous women.
- v. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
- vi. Complete a high-risk screening on each pregnant Covered Person in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.
- vii. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below 20 percent).
- viii. Ensure comprehensive postpartum visits occur within 56 days of delivery.
- ix. Require that Tailored Plan network providers send, within one Business Day of the provider completing the screening, all screening information and applicable medical record information for Covered Persons in care management for high-risk pregnancies to the applicable Tailored Plans, AMH+ practices or CMAs (as applicable), and the LHDs that are contracted for the provision of providing care management services for high-risk pregnancy.

EXHIBIT 3 to SCHEDULE A-2

Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members

Background.

“Care Management for High-Risk Pregnancy” refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs).

Providers of Care Management for High-Risk Pregnancy shall comply with the following in connection with Covered Services provided to Tailored Plan Covered Persons.

1. LHD shall accept referrals from the Tailored Plan for Care Management for High-Risk Pregnancy services.
2. Care Management for High-Risk Pregnancy: Outreach.
 - i. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
 - ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.
3. Care Management for High-Risk Pregnancy: Population Identification and Engagement.
 - i. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five Calendar Days of receipt of risk screening forms.
 - ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.
 - iii. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.
 - iv. LHD shall review available Tailored Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.
 - v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.
4. Care Management for High-Risk Pregnancy: Assessment and Risk Stratification.
 - i. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support.

ii. LHD shall utilize assessment findings, including those conducted by the Tailored Plan, to determine level of need for care management support.

iii. LHD shall document assessment findings in the care management documentation system.

iv. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.

v. LHD shall assign case status based on level of patient need.

5. Care Management for High-Risk Pregnancy: Interventions.

i. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and/or other interventions needed to achieve Care Plan goals.

ii. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.

iii. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.

iv. LHD shall utilize NCCARE360 to identify and connect Covered Persons with additional community resources.

v. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the Covered Person's Tailored Plan Network.

vi. LHD shall document all care management activity in the care management documentation system.

6. Care Management for High-Risk Pregnancy: Integration with the Tailored Plan and Health Care Providers.

i. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.

ii. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.

iii. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.

iv. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.

v. LHD shall ensure awareness of Covered Persons' "in network" status with providers when organizing referrals.

vi. LHD shall ensure understanding of the Tailored Plan's prior authorization processes relevant to referrals.

7. Care Management for High-Risk Pregnancy: Collaboration with Tailored Plan.

- i. LHD shall work with the Tailored Plan to ensure program goals are met.
- ii. LHD shall review and monitor Tailored Plan reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.
- iii. LHD shall communicate with the Tailored Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
- iv. LHD shall participate in pregnancy care management and other relevant meetings hosted by the Tailored Plan.

8. Care Management for High-Risk Pregnancy: Training.

- i. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by the Tailored Plan and/or the Department, including webinars, new hire orientation or other programmatic training.
- ii. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the Tailored Plan and/or the Department.
- iii. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
- iv. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and trauma-informed care techniques on an ongoing basis.

9. Care Management for High-Risk Pregnancy: Staffing.

- i. LHD shall employ care managers meeting pregnancy care management competencies, defined as having at least one of the following qualifications:
 - a. Registered nurses.
 - b. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
 - c. Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a Bachelor's or Master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.
- ii. LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
- iii. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.

iv. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

v. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.

vi. LHD shall ensure that pregnancy care managers demonstrate:

- a. Proficiency with the technologies required to perform care management functions.
- b. Motivational interviewing skills and knowledge of adult teaching and learning principles.
- c. Ability to effectively communicate with families and providers.
- d. Critical thinking skills, clinical judgment and problem-solving abilities.

vii. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

- a. Provision of program updates to care managers.
- b. Daily availability for case consultation and caseload oversight.
- c. Regular meetings with direct service care management staff.
- d. Utilization of reports to actively assess individual care manager performance.
- e. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Tailored Plan/Department guidance about communication with the Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days shall be subject to additional oversight by the Tailored Plan.

EXHIBIT 4 to SCHEDULE A-2

Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members

Background.

Care Management for At-Risk Children are care management services provided by LHDs to a subset of the Medicaid population ages zero to five identified as being “high risk.”

Providers of Care Management for At-Risk Children shall comply with the following in connection with Covered Services provided to Tailored Plan Covered Persons.

1. Care Management for At-Risk Children: General Requirements.

i. LHD shall collaborate with out-of-county organizations providing Tailored Care Management - AMH+ practices, CMAs and Tailored Plans - to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.

ii. LHD shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population.

iii. LHD shall utilize NCCARE360 to identify and connect Covered Persons with additional community resources.

2. Care Management for At-Risk Children: Family Engagement.

i. LHD shall involve families (or a legal guardian, when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.

ii. LHD shall foster self-management skill building when working with families of children.

iii. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

3. Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level.

i. LHD shall review and monitor Tailored Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to ensure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.

ii. LHD shall use the information gained from the assessment to determine the need for services and the level of service to be provided.

4. Care Management for At-Risk Children: Plan of Care.

i. LHD shall provide information and/or education to meet families’ needs and encourage self-management using materials that meet literacy standards.

ii. LHD shall ensure children/families are well linked to the child’s PCP.

iii. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving Care Plan goals.

iv. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child and use any locally developed resource list (including NCCARE360) to ensure families are well linked to resources to meet the identified need.

v. LHD shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

5. Care Management for At-Risk Children: Integration with Tailored Plans and Health Providers.

i. LHD shall collaborate with the Covered Person's PCP to facilitate implementation of patient-centered plans and goals targeted to meet individual children's needs.

ii. LHD shall ensure that changes in the care management level of care or in the need for patient support and follow-up and other relevant updates (especially during periods of transition) are communicated to the PCP and to the Tailored Plan.

iii. LHD shall ensure awareness of Covered Persons' "in network" status with providers when organizing referrals.

iv. LHD shall ensure understanding of Tailored Plans' prior authorization processes relevant to referrals.

6. Care Management for At-Risk Children: Service Provision.

i. LHD shall document all care management activities in the care management documentation system in a timely manner.

ii. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and shall work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

7. Care Management for At-Risk Children: Training.

i. LHD shall participate in Department or Tailored Plan-sponsored webinars, trainings and continuing education opportunities as provided.

ii. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high-risk children.

8. Care Management for At-Risk Children: Staffing.

i. LHD shall hire care managers who meet Care Management for At-Risk Children care coordination competencies and have at least one of the following qualifications:

1. Registered nurses.

2. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as social workers under the Office of State Personnel guidelines.

ii. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.

iii. LHD shall ensure that Care Management for At-Risk Children care managers demonstrate:

1. Proficiency with the technologies required to perform care management functions - particularly as pertains to claims data review and the care management documentation system.

2. Ability to effectively communicate with families and providers.

3. Critical thinking skills, clinical judgment and problem-solving abilities.

4. Motivational interviewing skills, knowledge of trauma-informed care and knowledge of adult teaching and learning principles.

iv. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.

v. If the LHD has only a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

vi. LHD shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, LHD shall complete and submit a vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

vii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to NC DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days will be subject to additional oversight.

viii. LHD shall ensure that community health workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children care manager.

ix. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

1. Provision of program updates to care managers.

2. Daily availability for case consultation and caseload oversight.

3. Regular meetings with direct service care management staff.

4. Utilization of monthly and on-demand reports to actively assess individual care manager performance.

x. LHD shall ensure that supervisors who carry a caseload also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

EXHIBIT 5 to SCHEDULE A-2

Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this BH I/DD Tailored Plan Addendum for Indian Health Care Providers (IHCPs) (“*Addendum*”) is to apply special terms and conditions necessitated by federal law and regulations to the Agreement by and between Health Plan, in connection with the Tailored Plan Contract entered into by the Tailored Plan (herein “BH I/DD Tailored Plan”) and Provider (herein “Indian Health Care Provider (IHCP)”). To the extent that any provision of the Agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

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

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

i. Is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;

ii. Is an Eskimo or Aleut or other Alaska Native;

iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;

iv. Is determined to be an Indian under regulations issued by the Secretary.

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

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

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

d. “*Indian Health Service*” or “*IHS*” means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661. “*Indian tribe*” has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).

e. “*Tribal health program*” has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).

f. “*Tribal organization*” has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).

g. “*Urban Indian organization*” has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

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

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

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

Neither the BH I/DD Tailored Plan nor Health Plan shall impose any enrollment fee, premium or similar charge, and no deduction, copayment, cost sharing or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

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

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

The BH I/DD Tailored Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian’s primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the BH I/DD Tailored Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. §§ 438.14(b)(3) and 457.1209.

6. Agreement to Pay IHCP.

Health Plan, as a subcontractor of Tailored Plan, shall pay the IHCP for covered Medicaid Managed Care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

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

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

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

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

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a BH I/DD Tailored Plan to collect or remit any federal, state or local tax.

10. Insurance and Indemnification.

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

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

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

11. Licensure and Accreditation.

Pursuant to 25 USC §§ 1621t and 1647a, neither the Tailored Plan nor Health Plan shall apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, neither the BH I/DD Tailored Plan nor Health Plan shall require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

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

13. Governing Law.

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

Nothing in the Agreement or any addendum thereto shall subject an Indian tribe, tribal organization or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

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

15. Claims Format.

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

16. Payment of Claims.

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

17. Hours and Days of Service.

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

18. Coordination of Care/Referral Requirements.

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

19. Sovereign Immunity.

Nothing in the Agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

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

Applicable Federal Laws Referenced in Section 8 of this Addendum:

(a) The IHS as an IHCP:

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

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

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

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

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

EXHIBIT 6 to SCHEDULE A-2

Tribal Payment Policy

1. Background.

This Tribal Payment Policy (“**Policy**”) outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by Health Plan. Indian Health Care Provider (IHCP) refers to a “health care program” operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or Urban Indian Organization (otherwise known as an I/T/U) as defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by State-recognized Tribes are not considered IHCPs. In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a “Tribal Provider Attestation.” This “Tribal Provider Attestation” letter from the EBCI Chief’s office shall be submitted to the Department as part of the Department’s centralized credentialing process. The information about Tribal providers will be shared with Health Plan through the Department’s existing process.

2. Scope.

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

3. Policy Statement.

Health Plan shall implement the Tribal Payment Policy described below by developing and maintaining a written Tribal Payment Policy relating to all IHCPs/Tribal providers regardless of the provider’s contracting status consistent with the Department’s Tribal Payment Policy.

a. Claim Submission.

i. Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.

ii. Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NC Tracks in Medicaid Fee-for-Service.

b. Payment.

i. Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the Office of Management and Budget (OMB) rate, for applicable AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. Health Plan shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with Health Plan shall continue to follow those arrangements. OMB tribal rates for hospital inpatient and outpatient services are included and identified on the hospital fee schedule available on the Fee Schedule and Covered Codes Portal.

A. If a Covered Person seeks care at an Indian health provider out-of-state, the services to the Covered Person should be reimbursed by the OMB rate, if applicable.

ii. To promote same day access and reduce barriers or burdens to a Covered Person such as transportation or taking time off from work, providers receiving the AIR rate may receive encounters per day (single day of service) such as, but not limited to, the following:

- A. Medical;
- B. Dental;
- C. Behavioral; and
- D. One other, such as optical.

iii. Health Plan shall reimburse I/T/U pharmacies for pharmacy claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan (a maximum of two pharmacy AIR per patient per day):

- A. High-Cost Drugs are excluded and are paid based on the Department’s outpatient pharmacy ‘lessor of logic’.
- B. If more than two drugs are filled, additional drugs beyond the two will be paid at zero dollars (\$0) and should be used by Health Plan for medication reconciliation.
- C. The Pharmacy Point of Sale OMB encounter rate (ER) fee schedule is found on the fee schedule and covered codes portal. The fee schedule name is Indian Tribal (I/T/U) Pharmacy fee schedule.
- D. There is no Tribal OMB rate for Ambulatory Surgical Center services. Health Plan should follow the Ambulatory Surgical Center Fee Schedule available on the Fee Schedule and Covered Codes portal.

iv. Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.

v. Health Plan shall comply with *PHP Contract Section V.D.4.h. Indian Health Care Provider (IHCP) Payments.*

- A. In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), Health Plan shall reimburse IHCPs as follows:
 - 1. Those that are not enrolled as a FQHC, regardless of whether they participate in Health Plan’s network:
 - a. The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - b. The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.
 - 2. Those that are enrolled as FQHCs, but do not participate in Health Plan’s network, an amount equal to the amount Health Plan would pay a network FQHC that is not an IHCP.
- B. Health Plan shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

- C. The Indian Tribal (I/T/U) Home Health Fee schedule is posted on the fee schedule and covered codes portal and specific to just the Tribe codes and rates.
- D. The Skilled Nursing Facility Fee schedule is posted on the fee schedule and covered codes portal and specific to just the Tribe codes and rates.

vi. Health Plan shall comply with *PHP Contract Section V.F.1. Engagement with Federally Recognized Tribes* with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.

- A. Health Plan shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

vii. Ambulatory Surgical.

- A. All procedures billed that fall under \$1,000.00 will be billed at the Outpatient OMB Rate.
- B. All procedures that are \$1,000.00 and above will be billed at the Medicaid Fee Schedule.

viii. All non-OMB rates for Tribal payment follows the regular Medicaid Fee-for-Service methodology and fee schedules for Health Plan, unless otherwise defined in the Tribal Payment Policy.

c. Prompt Pay.

i. Health Plan shall comply with *PHP Contract Section V.H.1.d., Prompt Payment Standards.*

- A. Health Plan shall promptly pay Clean Claims, regardless of provider contracting status. Health Plan shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.

1. Medical Claims.

- a. Health Plan shall, within 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 timely process the claim.
- b. Health Plan shall pay or deny a Clean Medical Claim within 30 Calendar Days of receipt of the claim.
- c. A Medical Pended Claim shall be paid or denied within 30 Calendar Days of receipt of the requested additional information.

2. Pharmacy Claims.

- a. Health Plan shall within 14 Calendar Days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.

- b. A Pharmacy Pended Claim shall be paid or denied within 14 Calendar Days of receipt of the requested additional information.
 3. If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within 90 Calendar Days of the notice requesting the required additional information, Health Plan may deny the claim in accordance with NCGS § 58-3-225(d).
 4. For purposes of claims payment, Health Plan shall be deemed to have paid the claim as of the Date of Payment, and Health Plan shall be deemed to have denied the claim as of the date the remittance advice is sent.
- B. Health Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this section (including interest and penalties if applicable).
- C. Claim Submission Timeframes.

1. For any claims with a date of services on or before June 30, 2023:

- a. Pursuant to NCGS § 58-3-225(f), Health Plan may require that claims be submitted within 180 Calendar Days after the date of the provision of care to the Covered Person by the health care provider and, in the case of health care provider facility claims, within 180 Calendar Days after the date of the Covered Person's discharge from the facility. However, Health Plan may not limit the time in which health care provider and health care facility claims may be submitted to fewer than 180 Calendar Days. Unless otherwise agreed to by Health Plan 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 year from the time submittal of the claim is otherwise required.
- b. Health Plan may require that claims be submitted within 365 Calendar Days after the date of the provision of care to the Covered Person for pharmacy point of sale claims and may not limit the time to fewer than 365 Calendar Days.
- c. When a Covered Person is retroactively enrolled, Health Plan may not limit the time in which claims may be submitted to fewer than 180 Calendar Days from the date of enrollment for health care provider and health care provider facility claims and 365 Calendar Days for pharmacy point of sale claims.
- d. When a claim requires financial eligibility determination, Health Plan may not limit the time in which claims may be submitted to fewer than 180 Calendar Days from the date the patient monthly liability (PML) is determined.

2. For any claims with a date of service on or after July 1, 2023:
 - a. Consistent with NCGS § 58-3-225(f), Health Plan may require that claims be submitted within 365 Calendar Days after the date of the provision of care to the Covered Person by the health care provider and, in the case of health care provider facility claims, within 365 Calendar Days after the date of the Covered Person's discharge from the facility. However, Health Plan may not limit the time in which health care provider and health care facility claims may be submitted to fewer than 365 Calendar Days. Unless otherwise agreed to by Health Plan 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 year from the time submittal of the claim is otherwise required.
 - b. When a Covered Person is retroactively enrolled, Health Plan may not limit the time in which claims may be submitted to fewer than 365 Calendar Days from the date of enrollment.
 - c. When a claim requires financial eligibility determination, Health Plan may not limit the time in which claims may be submitted to fewer than 365 Calendar Days from the date the patient monthly liability (PML) is determined.
3. For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, Health Plan shall allow the provider 180 Calendar Days from the primary insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to the Covered Person's assigned Prepaid Health Plan (PHP). The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment.

D. Interest.

1. Health Plan shall pay interest to the provider on the portion of the claim payment that is late at the annual percentage rate of 18% beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Agreement.
 2. Health Plan shall not be subject to interest payments under circumstances specified in NCGS § 58-3-225(k).
- E. Health Plan shall maintain written or electronic records of its activities under this section in accordance with NCGS § 58-3-225(i).
- F. For purposes of actions which must be taken by Health Plan as found in *PHP Contract Section V.H.1.d. Prompt Pay Standards*, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

d. Other Payment Sources.

i. Due to the change in payer hierarchy, Health Plan will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.

ii. Tribal self-funded insurance is not a billable source for the Eastern Band of Cherokee Indians (EBCI), and therefore, Health Plan shall not attempt to coordinate benefits with that plan.

e. Sovereignty.

i. No contractual relationship shall deny or alter Tribal sovereignty.

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EXHIBIT 7 to SCHEDULE A-2

Applicable Wait Time Standards

Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within 30 calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within 14 calendar days for member less than six months of age Within 30 calendar days for members six months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available 24 hours a day, 365 days a year}
3	Urgent Care Services	Care provided for a non- emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within 30 calendar days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within 14 calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five calendar days
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available 24 hours a day, 365 days a year}
7	Urgent Care Services	Care provided for a non- emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within 24 hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within 30 calendar days
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Within two hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non- Hospital Medical Detox)	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Emergency Services available immediately {available 24 hours a day, 365 days a year}
11	Emergency Services for Mental Health	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Immediately {available 24 hours a day, 365 days a year}
12	Emergency Services for SUDs	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Immediately {available 24 hours a day, 365 days a year}
14	Urgent Care Services for Mental Health	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Within 24 hours
15	Urgent Care Services for SUDs	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Within 24 hours
16	Routine Services for Mental Health	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Within 14 calendar days

Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid

Reference Number	Visit Type	Description	Standard
17	Routine Services for SUDs	Refer to Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	Within 48 hours

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