North Carolina
Healthcare Association

Uniting hospitals, health systems and
care providers for healthier communities

June 11, 2018

The Honorable Mandy Cohen, MD, MPH
North Carolina Department of Health and Human Services
Office of the Secretary
2001 Mail Service Center
Raleigh, NC 27699-2001

Submitted via email to Medicaid.Transformation@dhhs.nc.gov

Dear Secretary Cohen:

Thank you for the opportunity to comment on the two recent concept papers: Supporting Provider Transition to Medicaid Managed Care and Prepaid Health Plans in NC Medicaid Managed Care. We appreciate the guidance and transparency the Department has provided throughout this process as well as the continuing efforts to obtain stakeholder input. We believe that the fundamentals outlined in the Department's papers for Medicaid managed care reform are sound. However, there are certain issues that we want to highlight where we have concerns, disagreements, or further questions. We are also disappointed that issues we have raised on behalf of hospitals and other providers in previous comment letters remain unaddressed.

Good faith negotiations

The concept paper continues to recommend a one-sided approach to contractual negotiations between providers and plans, stating that providers will be expected to negotiate in good faith. As noted in our September 8, 2017 comment letter on Medicaid reform, while we support good faith in all negotiations, it should be expected of both parties. If the Department plans to impose a good faith requirement, it should apply equally to PHPs and providers. As currently worded, the implication is that there are no repercussions for plans for acting in bad faith. The Department's May 31, 2018 document entitled "Provider Rate Floor and Reimbursement Scenarios" stated:

> The PHP will be required to develop policies and procedures regarding provider contracting including defining a "good faith" contracting effort and the objective quality standards used in contracting decisions that will be subject to Department review. Each PHP will be expected to consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.

However, the Department fails to clarify the means of measuring the failure to act in "good faith." There is nothing in the concept paper that defines what constitutes good faith. What legal process will the Department follow in deeming a negotiation to be in bad faith? What appeal rights and recourse will the parties to the negotiation have once such a finding is made? Providers may disagree with contracting with a plan for any number of legitimate reasons, including, for example: (i) the plan is unable to manage claims efficiently; (ii) the plan

lacks adequate "downstream" contracts with nursing homes and home health providers in the market, forcing patients to be hospitalized longer; (iii) the plan has a documented history of not working well with providers for prior authorization or timely payment, and (iv) the plan imposes excessive administrative burdens or policies that adversely affect the providers or their patients. (We note that the Department has proposed giving plans a great deal of flexibility on clinical and other policies). What criteria does the Department intend to apply to determine "good faith" when a provider raises and documents the above or similar objections?

The Department's desire to promote provider participation is appreciated. Given that there are good and valid reasons why a provider may decide to not participate in any given PHP, however, means the 90% cap on out-of-network providers will likely have a negative impact on beneficiaries who have little or no experience with managed care. The reduced reimbursement will make continued provision of services unaffordable for out-of-network providers. Beneficiaries struggling to adapt to their new plan's network or encountering gaps in their plan's network will likely find access more challenging than it would be without the payment reduction. While this may be the long-term goal of the program, the negative consequences in a transition period should be re-considered so that the beneficiaries have an opportunity to adapt to managed Medicaid in a more protective environment. To avoid a decline in access to care, while beneficiaries learn how to navigate their managed care plan, the minimum out-of-network should be 100% of the Medicaid rate.

Network adequacy

Please refer to our March 29, 2018 comment letter for our initial comments concerning network adequacy. Our comments on network adequacy are as follows:

- We support the development of provider-to-enrollee ratios now, with adjustments being made as necessary in the future. Most states with risk-based managed care plans include provider-to-enrollee ratios as one of their network adequacy requirements, particularly for primary care providers. (See *State Standards for Access to Care in Medicaid Managed Care, DHHS Office of Inspector General, September 2014, Appendix C*). Time and distance standards are also important in establishing network adequacy, but they must be accompanied by provider-to-enrollee ratios in order to ensure meaningful network adequacy.
- In establishing any standards – whether time, distance, provider-to-enrollee ratios or others – the Department must require specific, measurable quantitative standards. The lack of such standards in the commercial market in North Carolina, where plans essentially define their own standards, have undermined any true State-established network adequacy standards to which plans can be held accountable in that market. The Department should be able to enforce network adequacy from its own objective, established standards.
- We disagree with the suggested change from ≥ 2 hospitals within 30 minutes or 15 miles for at least 95% of enrollees to ≥ 1 hospital within 30 minutes or 15 miles for at least 95% of enrollees. Hospitals are a crucial component of Medicaid beneficiaries' access to healthcare.
- Network adequacy standards for hospitals should be enhanced to include specialized services that are not offered by other providers in the area.

- PHPs should make direct payment to out-of-network providers.
- The processes used by DHHS and the external review organization to monitor network adequacy should be thorough and robust and must hold plans accountable for failure to meet objective network standards.
- PHPs must provide complete, accurate, real time provider directories. Please see our March 29th letter for more detail on the information that should be included.
- PHPs should be able to demonstrate at bidding fully-developed networks that have the true capacity to meet the complex health care needs of Medicaid beneficiaries. If such a standard cannot be applied, NCHA recommends that the PHP demonstrate it has a fully contracted network in place at least 60 days prior to the implementation date for managed care.
- PHPs should be required to rectify any approved network adequacy exception within a timeframe mandated by the Department, not to exceed 180 days, barring exceptional circumstances.

Provider credentialing

We support the proposed centralization of the credentialing process, with uniform policies and a single electronic application. This should help address the administrative burden of providers dealing with multiple plans, with varying requirements, on credentialing issues. We also support the Department's proposed oversight, monitoring and auditing of plans' credentialing processes and activities. Please see our March 31, 2018 comment letter on the credentialing process for additional issues we raised, including:

(i) The need for a transition period during which all of the State's clinical coverage policies continue to apply before plans are given the flexibility to change them,
(ii) The need for a process to discuss in advance major policy changes by plans, and
(iii) Our concerns about LME/MCOs being excluded from the centralized credentialing process. We understand this issue is under further discussion in the MCAC Credentialing Subcommittee.

Providers may already be credentialed for network participation with PHPs that have non-Medicaid plans, and the Department should recognize that such plans would typically not require a second, plan-specific credentialing effort. In addition, some provider groups may have the capability and preference to accept delegated credentialing. The Department should not preclude such existing, working solutions for credentialing. We understand through the MCAC Credentialing Subcommittee that the Department does intend to form a small group to review delegated credentialing and related credentialing issues.

Prompt Pay and other provisions

We support the proposed prompt pay requirement for payment of a clean claim within 30 days and 18% interest on late claims. This is consistent with current state law for commercial insurance plans regulated by the Department of Insurance. As you are aware, providers and plans are currently discussing with the legislature a list of specific insurance provisions from Chapter 58 of the General Statutes that will apply to Medicaid managed care. One of those provisions is GS 58-3-225, the prompt pay law.

Additionally, the Department notes in the prompt pay/clean claim section that "PHPs will be responsible for claims processing and payments to providers, and must make timely payments to providers if a claim is submitted within 90 days after the date of service." We recommend and support setting the claims deadline at not less than 180 days subsequent to the date of service or discharge, whichever is later. Providers need additional time in those instances where Medicaid is secondary to allow for resolution of claims by the primary payer.

As you are already aware, the other Chapter 58 provisions currently under discussion in the legislature for inclusion in Medicaid managed care contracts are the following:

a. G.S. 58-3-190, Coverage required for emergency care, excluding subparagraphs (g)(3) and (g)(4).
b. G.S. 58-3-191, Managed care reporting and disclosure requirements.
c. Subsection (c) of G.S. 58-3-200, Miscellaneous insurance and managed care coverage and network provisions.
d. G.S. 58-3-221, Access to non-formulary and restricted access prescription drugs.
e. G.S. 58-3-225, Prompt claim payments under health benefit plans.
f. G.S. 58-3-227, Health plans fee schedules.
g. G.S. 58-3-231, Payment under locum tenens arrangements.
h. G.S. 58-50-26, Physician services provided by physician assistants.
i. G.S. 58-50-30, Right to choose services of certain providers.
j. G.S. §58-50-270, Definitions.
k. G.S. §58-50-275, Notice contact provision.
l. G.S. §58-50-280, Contract amendments.
m. G.S. §58-50-285, Policies and procedures.
n. G.S. §58-50-295, Prohibited contract provisions related to reimbursement rates.
o. G.S. §58-51-37, Pharmacy of choice. G.S. 58-51-37 shall apply to all PHPs regardless of whether the PHP has its own facility, employs or contracts with physicians, pharmacists, nurses, and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its beneficiaries.
p. G.S. §58-51-38, Direct access to obstetrician-gynecologists.
q. G.S. §58-67-88, Continuity of care.

These are in addition to the solvency, financial and pharmacy provisions also under discussion as part of House Bill 156. All of the above provisions are important for both providers and Medicaid beneficiaries.

Other contractual provisions

The Department also asked for feedback in its concept paper on proposed contractual language that should be required in contracts between Medicaid PHPs and providers. There are a number of elements that need to be covered by the contract. The attached addendum contains some of the major contractual provisions that NCHA and several other provider groups support for inclusion in contracts between plans and providers.

For the Departments ease in verifying inclusion of mandated language, and providers' ability to assure PHPs have not deviated from mandates, PHPs should be required to clearly present

state-mandated provisions with a specific North Carolina Managed Medicaid Regulatory Addendum that includes language stating that the addendum supersedes any contradictory terms in the Agreement. The Department should stipulate that only items mandated by the state or federal laws and regulations may be included in the Regulatory Addendum, and only items applicable to the Parties should be included. Changes to the Regulatory Addendum should be permitted only when mandated by the state or federal government. PHPs should be required to provide at least sixty (60) days written notice for changes. The Regulatory Addendum should never be used to change reimbursement terms.

Individual Health Insurance Marketplace Participation

The Department notes that it will encourage PHPs to "participate in other North Carolina insurance markets to increase competition and promote seamless access to health care" and that it expects to incentivize PHPs to provide Qualified Health Plans on the Federally Facilitated Marketplace (FFM) by granting points to PHPs that commit to participate in the market. We share the Department's goal of promoting access to healthcare and expanding health insurance coverage. However, we are concerned that mixing the commercial and Medicaid markets together as part of the RFP award process may adversely impact the Medicaid evaluation. For example, can a PHP overcome deficiencies in the Medicaid portion of its response by committing to participate in the commercial market? What level of participation would be expected? Is participation defined by the number of counties covered? The percentage of population covered? Would the points vary by the level of commitment? We are also unclear as to the Department's plans for action in the event a PHP fails to or is unable to follow through on its commitment.

Plan Solvency

As part of the PHP application for licensing, the Department anticipates the PHPs will be required to submit a $500,000 deposit. If a plan becomes financially unstable, there is some likelihood that this level of deposit will be insufficient to compensate all parties to which payment is owed. How does the Department and the Department of Insurance plan to enable early detection that a plan may be becoming unstable? What will be the frequency of review and reporting, and what will be the corrective actions to safeguard beneficiaries and the provider community? We recommend that the deposit requirement be adjusted to be the greater of $1,000,000 or 2% of the projected claims liability for the plan's assigned membership.

Medical Loss ratio

The Department expects to set an overall minimum MLR threshold of 90 percent that would trigger required community investments and MLR threshold of 88 percent that would be used to trigger premium remittance to DHHS. NCHA supports the increase in the MLR threshold from 88 percent to 90 percent, specifically noting that hospital supplemental payments are now subject to the MLR when they were not originally included.

However, additional improvements are required. Hospital inpatient and outpatient spending represent approximately 30% of the total Medicaid spend (inclusive of supplemental payments). Unlike many other providers of Medicaid services, hospitals fund approximately 50% of their Medicaid payments. The MLR level still results in large additional losses to hospitals as supplemental payments will be subject to diversion from hospital reimbursement. This diversion is estimated to yield approximately $700 million in reduced hospital payments during the first waiver period. To maintain nation-leading access for Medicaid enrollees, PHPs must continue to focus these dollars on the delivery of care.

Given hospitals fund approximately 50% of total Medicaid payments for hospital services, greater losses are at risk if non-federal funding collected by hospitals do not correlate with changes in hospital spending during the first waiver period. To ensure hospitals are not further disproportionately impacted by Medicaid managed care, we recommend that DHHS establish a transparent calculation of non-federal funding requirements and ensure that accurate and timely encounter data be mandated by MCOs, which will serve as the basis in calculations of non-federal funding requirements.

Other issues

- The Department expects to require PHPs to include standard provisions based on those required in commercial insurance provider contracts as found in 11 NCAC 11 20.0202. We agree with this. We do have questions as to what the contract templates will look like and how much discretion will be provided in working from the template.

- The Department notes that it will prohibit a PHP from paying related providers more than unrelated providers for “similar services.” This issue needs to be clarified to account for incentive or quality-based payments that may create a payment differential.

- North Carolina hospitals provide the non-federal funding for a substantial portion of Medicaid reimbursement for hospital services. NCHA recommends that the available data and calculation of non-federal funding be transparent and routinely adjusted for changes in hospital volumes and reimbursement. Encounter data will be vital to ensure that the Department and hospitals can identify the appropriate amount of funding to be provided by hospitals and is reflective of volume and reimbursement changes. NCHA further recommends that the Department mandate that encounter data be accurately submitted to the Department within 90 days following adjudication of the claim.

- We support the Department’s plan for minimum enrollment levels for PHPs to ensure the viability of PHPs and stability for enrollees. The Department’s proposal is unclear as to whether state-wide PHPs will be adjudged on their regional pick up rate or whether this standard only applies to regional PLEs. If this regional standard does not apply to state-wide PHPs, the Department should produce a similar state-wide level. The proposal also fails to address the planned Tailored Plans. The Department’s actuarial data shows proposed Tailored Plans to contain much smaller numbers of high cost enrollees. We would encourage the Department to reduce the number of Tailored Plans to reduce the risk profiles of such plans by increasing the number of covered lives in each Tailored Plan. The Department fails to explain its ten percent minimum

threshold. The raw number minimums below 30,000 covered lives per region would permit PLEs to exists with numbers inadequate to distribute risk. We would recommend increasing the minimum threshold to higher levels to ensure stability.

Thank you for your leadership throughout this process, and feel free to contact me or Linwood Jones (ljones@ncha.org) if you have questions.

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association

ADDENDUM
PROPOSED CONTRACT LANGUAGE

ASSIGNMENT

The assignment by PROVIDER of this Contract or any interest hereunder shall require notice to and the written consent of PHP. Any attempt by PROVIDER to assign this Contract or its interest hereunder without complying with the terms of this Section shall be void and of no effect. PHP may assign this Contract or any interest hereunder in whole or in part upon the prior written consent of PROVIDER, to any successor to the assets or operations of PHP, or to any affiliate of PHP, provided that the assignee agrees to assume PHP's obligations under this Contract. The Parties agrees and acknowledge that the assignment of any of either Party's obligations under this Contract does not relieve the assigning Party from its obligations arising from this Contract.

SUBCONTRACTING AND/OR DELEGATION

When a sub-contractor meets the definition of a delegated or partially delegated entity, as defined by the Waiver Contract or PHP's accrediting body, PROVIDER must obtain written permission from PHP prior to subcontracting any of the services to be provided by PROVIDER under this Contract to such sub-contractor. All services subcontracted or delegated shall continue to be subject to the terms of this Contract. Both PHP and PROVIDER must ensure that any sub-contractor or delegates performing any obligations of this Contract meet all requirements of this Contract in their performance of such obligations. The Parties agree and acknowledge that the subcontracting or delegation of any of either Party's obligations under this Contract does not relieve the contracting or delegating Party from its obligations arising from this Contract.

TELEPSYCHIATRY AND TELEHEALTH

PROVIDER may practice telepsychiatry/telemedicine as permitted by NC DMA Clinical Coverage Policy No. 1H.

Transfer of Medical Records: Upon request from PHP, PROVIDER agrees to transfer a complete, legible copy of the medical records of any Enrollee transferred to another provider for any reason, including termination of this Contract. Record requests from PHP that can be fulfilled through electronic submission, shall be at fifteen ($15) dollars per Enrollee to PHP or another provider. Record requests from PHP that are fulfilled through hard copies shall be reimbursed by PHP or another provider at a rate of twenty-five (25) cents per page, not to exceed a cost of seventy-five ($75) dollars per Enrollee record.

Upon request from an Enrollee, PROVIDER agrees to transfer a complete, legible copy of the medical records of such Enrollee to the Enrollee or Enrollee's designee, at PROVIDER's sole cost and expense, irrespective of the method by which the request is fulfilled. The preference is for PROVIDER's records to be accessed electronically.

PCP-Related Provisions. **APPLIES IF PHP UTILIZES PCP ASSIGNMENT AS PART OF ITS PLAN MANAGEMENT**

a. Primary Care Provider (PCP) includes MDs, DOs and advanced care providers that specialize in internal medicine, family practice and pediatric services.
b. PHP shall include the name of the assigned PCP on the beneficiary's ID card, and the assigned PCP must be returned via electronic eligibility response.
c. PHP's enrolled beneficiaries may make changes in their assigned PCP according to the process defined in the Provider Manual.
d. PCPs may close their practice to new patients if the PCP's practices are closed to other PHPs. PCP practices may close at the practice level, or for individual PCPs within the practice.

PHP APPEALS AND RISK ADJUSTMENT

PROVIDER shall make commercially reasonable efforts to provide all relevant medical and financial records pertaining to Enrollees and to assist PHP with respect to the reconciliation, audit and appeal process pertaining to risk adjustment data. PHP shall mindful of the cost and disruption it creates with audit requests. Audits shall be post-payment, and limited to one per year unless otherwise required by law or regulation. PHP shall schedule audits in a mutually agreed location, using a mutually agreed methodology parameters, and such audits shall be subject to PROVIDERs standard policies for access to records. PROVIDER shall not be required to violate its policies designed to safeguard patient privacy, integrity of data or safety of patients and personnel. In the event that PHP uses a third party for completion of any audit or appeals, PHP shall cause its third party to comply with all applicable terms of the Contract. PHP retains responsibility for all actions of its third party, as if it had directly performed the activity. PHP shall undertake good faith efforts to obtain any necessary data or medical records from North Carolina's Health Information Exchange (HealthConnex) prior to making any request of PROVIDER. PROVIDER shall certify the accuracy, completeness and truthfulness of any reporting. PROVIDER shall be subject to the assistance obligation during the term of this Contract or completion of any audit and appeal process for the risk adjustment data submitted by PHP whichever is later. PHP shall provide to PROVIDER a report of any audit findings within 30 days of the completion of the audit, and shall agree to discuss such findings with the PROVIDER in an exit conference upon PROVIDER's request. All records requested by PHP pursuant to this Section shall be provided by electronic transmission shall be at fifteen ($15) dollars per Enrollee to PHP or another provider.

SUBMISSION OF CLAIMS

a. Claims must be submitted electronically either through HIPAA Compliant Transaction Sets 820 – Premium Payment, 834 – Member Enrollment and Eligibility Maintenance, 835 – Remittance Advice, 837P – Professional claims, 837I – Institutional claims, or the PHP's secure web based billing system.
b. PROVIDER's claims shall be compliant with the National Correct Coding Initiative effective at the date of service.
c. Both Parties shall be compliant with the requirements of the National Uniform Billing Committee.

d. Claims for services must be submitted within one hundred eighty (180) days of the date of service or discharge (whichever is later). All claims submitted past one hundred eighty (180) days of the date of service or discharge (whichever is later) will be denied and cannot be resubmitted except in the instances denominated in subparagraph e. below. PHP is not responsible for processing or payment of claims that are submitted more than one hundred eighty (180) days after the date of service or discharge (whichever is later) except in the instances denominated in subparagraph e. below. The date of receipt is the date the PHP receives the claim, as indicated on the electronic data records.
e. PROVIDER may submit claims subsequent to the one hundred eighty day limit in instances where the Enrollee has primary insurance which has not yet paid or denied its claim. In such instances, PROVIDER may bill the PHP within ninety (90) days of final action (including payment or denial) by the primary insurance or Medicare. If PROVIDER delays submission of the claims due to the coordination of benefits, subrogation of benefits or the determination of eligibility for benefits for the Enrollee, PROVIDER shall submit such claims within ninety (90) days of receipt of the notice of determination of coverage or payment by the third party.
f. If a claim is denied for reasons other than those stated above in subparagraph e., and the PROVIDER wishes to resubmit the denied claim with additional information, PROVIDER must resubmit the claim within ninety (90) days after PROVIDER's receipt of the denial. If the PROVIDER needs more than ninety (90) days to resubmit a denied claim, PROVIDER must request and receive an extension from the PHP before the expiration of the ninety (90) day deadline, such extension not to be unreasonably withheld.
g. All claims shall be adjudicated as outlined in the PHP Provider Operations Manual. PHP shall use industry-standard claims edits only, and such edits shall be universally applied to all provider claims.
h. Billing Diagnosis submitted on claims must be consistent with the service provided.
i. If a specific service (as denominated by specific identifying codes such as CPT or HCPCS) is rendered multiple times in a single day to the same Enrollee, the specific service may be billed as the aggregate of the units delivered rather than as separate line items.
j. The PHP shall not reimburse PROVIDER for "never events."
k. In the event of and underpayment or overpayment, either Party may seek correction of the payment by providing notice within the first three hundred sixty-five (365) days following the date of the initial payment. The Parties shall have ninety (90) days to make a refund or make a corrected payment, as appropriate, or to provide the reason why the payment is correct. If the Parties are unable to resolve the overpayment or underpayment, either Party may escalate the claim(s) to dispute resolution.

PAYMENT OF CLAIM (NOTE: IF HB 156 IS ENACTED AND REQUIRES PLANS TO COMPLY WITH THE STATE PROMPT PAY LAW, THIS SECTION MAY NOT BE NECESSARY):

a. PHP shall reimburse PROVIDER for approved clean claims as defined in 42 CFR §447.45(b) for covered services within thirty (30) days of the date of receipt.
b. Within eighteen (18) days after the PHP receives a claim from PROVIDER, the PHP shall either: (1) approve payment of the claim, (2) deny payment of the claim, or (3) request additional information that is required for making an approval or denial.
    1) If the PHP denies payment of a claim the PHP shall provide PROVIDER the ability to access electronically the specific denial reason.
    2) "Claims Status" of a claim shall be available within five to seven (5-7) days of the PHP receiving the claim.

3) If the PHP determines that additional information in either original or certified copy form is required for making the approval or denial of the claim, PHP shall notify the PROVIDER within eighteen (18) days after the PHP received the claim. The PROVIDER shall have fifteen (15) days to provide the additional information requested, or the claim shall be denied. Upon PHP's receipt of the additional information from the PROVIDER, the PHP shall have an additional eighteen (18) days to process the claim as set forth in Paragraph 2, above.
4) The PHP is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, the PHP may approve a claim in part, deny a claim in part, and/or request additional information for only a part of the claim, as long as the PHP either approves, denies, or requests additional information for each part of the claim within the required eighteen (18) day period.
5) If PIHP fails to pay PROVIDER within these parameters, PIHP shall pay to the PROVIDER interest in the amount of 18% of the claim amount beginning on the date following the day on which the payment should have been made paid, in excess of the Prompt Pay Requirements, compounded daily.

c. The PHP will not reimburse PROVIDER for services provided by staff not meeting licensure, certification, credentialing, or accreditation requirements.
d. PHP will pay PROVIDER the rates as negotiated between PROVIDER and PHP and listed as Attachment __ to this Contract.

CONTROLLING AUTHORITY

This Contract is required by State and Federal law, including 42 C.F.R. §438.206 and §438.214, and shall be governed by the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the "Controlling Authority"):

a. Title XIX of the Social Security Act and its implementing regulations, N.C.G.S. Chapter 108A, the North Carolina State Plan for Medical Assistance, and the N.C. Medicaid Transformation waiver authorized by CMS pursuant to section 1115 of the Act; and
b. The federal anti-kickback statute, 42 U.S.C. §1320a-7b(b) and its implementing regulations; the federal False Claims Act, 31 U.S.C. §3729 – 3733 and its implementing regulations; and the North Carolina Medical Providers False Claims Act, N.C. Gen. Stat. §108A-70-10 *et seq*.; and
c. All federal and state Enrollee's rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 CFR Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2, the Health Information Technology for Economics and Clinical Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5); and
d. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure and credentialing activities as set forth in 42 CFR parts 438, 441, 455, and 456; and
e. State licensure and certification laws, rules and regulations applicable to Contractor; and
f. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. §108A-54.2; and
g. The North Carolina Medicaid and Health Choice Provider Requirements, N.C. Gen. Stat. Ch. 108C; and

h. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and subsequent amendments and regulations developed pursuant thereto, to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, or national origin, be subjected to discrimination in the provision of any services or in employment practices; and
i. The Drug Free Workplace Act of 1988; and
j. Any other applicable federal or state laws, rules or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid-reimbursable services; and
k. The PHP's Provider Operations Manual. In instances where there is discrepancy between any of the terms contained in this Contract and the terms contained in the Provider Operations Manual, the terms of this Contract shall supersede the terms in the Provider Operations Manual

UTILIZATION MANAGEMENT

a. "Medically Necessary" and "Medical Necessity" means/includes services and supplies that are (a.) provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes; (b.) necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms; (c.) within generally accepted standards of medical care in the community; and (d.) not solely for the convenience of the beneficiary, beneficiary's family or the provider.
b. PHPs shall make determinations about whether a service is Medically Necessary prospectively, using information known at the time. Decisions about whether as service is Medically Necessary shall be based on nationally recognized standards that are uniformly applied to all providers. PHPs shall be required to pay for services it has authorized, without change, unless PROVIDER has deliberately withheld information or has misstated information and such misstatement or undisclosed information would have made a difference in the authorization initially provided.
c. PHPs shall be required to provide pre-certification or authorization determinations within 5 business days. Expedited reviews shall be completed within 72 hours of request including weekend and holidays, or services shall be deemed to be pre-certified or pre-authorized as may be required by PHP.
d. The Parties recognize that there may be occasions when prospective review was not possible, either because eligibility could not be verified at the time of service or other reasons. PHPs may review such cases for retrospective authorization. Denials will be limited to providers' deliberate withholding of information or misstatement of information. PHP will pay for all services that are Medically Necessary.
e. To assure continuity of care for beneficiaries assigned to PHP, PHPs shall accept prior plan authorization for beneficiaries switching PHPs if service date or discharge date is within sixty (60) days of change of plan, or date of service/date of discharge is within sixty (60) days of provider becoming aware of change in Medicaid plan.
f. Emergency Services are defined as those services provided consistent with EMTALA, State laws, and prudent layperson standards, based on presenting, not final, diagnosis. PROVIDER will provide PHP with notice of inpatient admissions occurring through the emergency room within the first business day following admission, or the first business day following PROVIDER's identification that patient in enrolled in PHP's plan. PHP must

approve or deny authorization of emergency admissions within 72 hours, including weekend and holidays for urgent/emergent services, or authorization should be deemed as granted. PROVIDER is not required to provide PHP with notices of emergency room services that do not result in inpatient admission. PHP's shall pay properly submitted claims for Emergency Services as billed.

g. PHP engages an independent third-party reviewer to determine Medical Necessity in the event that PROVIDER determines Medical Necessity denials are excessive. PHP shall provide PROVIDER with information necessary to submit requests of review to the third-party reviewer. PHP shall cooperate in submitting any information the third-party reviewer may need to make its determination.

POLICIES AND PROCEDURES

PROVIDER agrees to make commercially reasonable efforts to comply with respect to PHP's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, discharge planning, dispute resolution and other clinical, business and administrative policies and procedures established and revised from time to time in the PHP Provider Manual which is posted by electronic means on the PHP website. Any material changes to the PHP Provider Manual, clinical policies and payment policies shall be posted on the PHP website at least sixty (60) days prior to the effective date of any such changes. PROVIDER shall have the right to accept or reject any changes that PROVIDER deems material to PROVIDER's business operations or ability to comply with the terms of this Contract. In the event PROVIDER rejects such changes, these changes shall not become effective upon PROVIDER until both parties come to an agreement on such changes. If PROVIDER accepts such changes, the changes shall become binding upon PROVIDER sixty (60) days after notice of website publication via an electronic Provider Communication Bulletin. If there are discrepancies between the changes to the PHP Provider Manual, bulletins or other written materials and this Contract, the Parties agree that the terms of this Contract control and shall apply and any such changes shall not apply to PROVIDER.

Termination: This Contract may be terminated under the following circumstances:
Either Party may terminate this Contract without cause by providing at least ninety (90) days' prior written notice to the other Party.

PROVIDER may terminate this Contract with cause with at least thirty (30) days' prior written notice to PHP or such other later date specified in the notice. Cause for termination by PROVIDER shall be documented in writing detailing the grounds for the termination, and may include failure of PHP to timely reimburse PROVIDER for Clean Claims as established in Billing and Reimbursement; failure of PHP to provide payments as required by this Contract; failure of PHP to make authorization as established in of this Contract; or any other material breach by PHP of this Contract not otherwise described above.

PROVIDER may immediately terminate this Contract for loss of Controlling Authority or Waiver Contract, PHP's filing for bankruptcy or invocation of other solvency-related actions; PHP's loss of, or sanction against, any required license(s) to operate in North Carolina; or Determination that PHP, or any of its Owners or Managing Employees, is engaged in fraudulent or abusive business practices.

PHP may terminate this Contract with cause effective upon written notice to the PROVIDER or such other date as specified in the notice. In the event that multiple entities are included in this Contract, the notice of termination shall be specific to the provider(s) creating the for-cause termination action, unless the reason for termination can be shown to be generally true for PROVIDER. Upon the occurrence of "cause," PHP may take any of the following actions: (i) the termination or suspension of this Contract and/or (ii) the bar, suspension, and/or exclusion of the PROVIDER's providers of services credentialing by PHP or in providing future services to any Enrollee through an out-of-network arrangement. Cause shall be documented in writing detailing the grounds for the termination and the grounds for any other of the (i)-(ii) aforementioned action(s) taken. Cause for any action up to and including termination, exclusion and/or revocation includes, but is not limited to:

a. PROVIDER's participation in the Medicare program, NC Medicaid program, or another state's Medicaid program, or N.C. Health Choice program, is suspended, excluded, or terminated; or
b. Any other loss of, or sanction against, required facility or professional licensure, accreditation or certification of the PROVIDER; or
c. Determination by PHP that PROVIDER, or any of its Owners or Managing Employees, fails to meet certification, accreditation or licensure standards prescribed by applicable Controlling Authority; or
d. Determination by PHP that PROVIDER, or any of its Owners or Managing Employees, has failed to provide services as specified in the Contract, including a failure to comply with applicable Controlling Authority; or
e. Determination by PHP that the conduct of PROVIDER, or any of its Owners or Managing Employees, or the standard of services provided threatens to place the health or safety of any Member in immediate jeopardy; or
f. Determination by PHP that PROVIDER, or any of its Owners or Managing Employees, is engaged in fraudulent or abusive billing, documentation, or clinical practices; or
g. Determination by PHP that PROVIDER, or any of its Owners or Managing Employees, has provided fraudulent information to PHP or any Enrollee.

DATA EXCHANGE

Types of Reports

The parties shall provide that standard program reports and data extracts in accordance with the time frames and delivery methods.

Frequency of Reports

Language should reflect timeframes for receiving reports (e.g., quarterly, annually, etc.)

Delay in Transfer of Data

If Provider does not receive completed reports listed herein by the _____ of the month due, Provider may notify (by email or phone) representative of PHP. It the report(s) is not received

by the last day of the month due, Provider will be entitled to compensation $X, X% of the X award value for data exchange and as specified for each report listed herein.

If PHP does not receive a complete report(s) listed herein by _____ of the month due, PHP may notify (by email or phone) the named representative of Provider. If PHP does not receive the report(s) due as outlined by the last day of the month, Provider will forfeit compensation up to $X, X% of the award value for data exchange.

The delayed reporting penalty values will be X for each report and will sum to X% (create table if varies for each report).

Data Delivery Method

Methodology for data delivery should be outlined; i.e. Excel spreadsheets, FTP, Text Files, etc. Data Delivery Method. Any changes to data formatting or delivery will require a 60-day notice from payor.

Reconciliation Guidelines

Within 45 days after receiving final reports, Provider agrees to notify PHP electronically or in writing of any disagreements with their performance results. Provider's written notification must include the following: a) the PHP determination at issue; b) detailed information, including any relevant dates, copies from the member's medical chart, and any other relevant information to support the review request. PHP will respond to Provider within 30 days after receiving Provider's notification. If the parties are unable to reach agreement, either party may initiate dispute resolution under the terms of the Agreement. If PHP does not receive notification within 45 days from the date PHP provided the final reports, Provider will have been deemed to waive any rights to pursue any dispute relating to the performance reports.

ADHOC Reports

The parties may provide ad hoc reports to each other upon mutual agreement, which may include an agreed-upon price. Any reports that support NCDOI, HEDIS, or NCQA inquiries, inquiries/demands from any governmental or regulatory body or performance guarantees by Payor to groups or others, shall not be considered ad hoc, and no fees shall apply.