

Amendment Number 8/9
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

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

Background:

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

1. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
2. Section V. Scope of Services;
3. Section VI. Contract Performance; and
4. Section VII. Attachments A – N.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

- a. **Section III.A. Definitions is revised and restated in its entirety to modify existing defined terms, add newly defined terms, and renumber Section III.A. Definitions as follows:**

A. Definitions

1. **1115 Demonstration Waiver:** As defined by Section 1115 of the Social Security Act, state demonstrations that give states additional flexibility to design and improve their programs by demonstrating and evaluating state-specific policy approaches to better serving Medicaid populations. Specifically, North Carolina’s amended 1115 demonstration waiver application to the federal Centers for Medicare & Medicaid Services (CMS) focuses on the specific items of the Medicaid Managed Care transformation that require CMS waiver approval.
2. **Advanced Medical Home (AMH):** Refers to an initiative under which PHPs delegate care management responsibilities and functions to State-designated AMH practices to provide local care management services.
3. **Adverse Benefit Determination:** Has the same meaning as Adverse Benefit Determination as defined in 42 C.F.R. § 438.400.
4. **Appeal:** Has the same meaning as Appeal defined in 42 C.F.R. § 438.400(b).
5. **Authorized Representative:** An individual, provider or organization designated by a beneficiary, or authorized by law or court order, to act on their behalf in assisting with the individual's participation in the Medicaid Managed Care program. With written consent of the

Member, or as otherwise legally authorized, an authorized representative may, for example, request an appeal, file a grievance, or request a State Fair Hearing on behalf of the beneficiary with the exception that a provider cannot request continuation of PHP benefits.

6. **Auto-Assignment:** Automated process by which the Department enrolls a beneficiary who has not actively selected a PHP during open enrollment or at application.
7. **Automated Call Distribution System (ACD):** An automated call center system that disperses incoming calls of all Members and potential Members to appropriate service line staff.
8. **Automated Voice Response System (AVRS):** An automated system that allows Members to perform self-service activities and resolve simple inquiries without the need to interact with an agent. The AVRS interacts with the Member through voice prompts and recognition or numeric prompts.
9. **Behavioral Health:** For the purposes of the Contract is inclusive of mental health and substance use disorders.
10. **Behavioral Health Intellectual / Developmental Disability Tailored Plan (Behavioral Health I/DD Tailored Plan):** A plan specifically designed to provide targeted care for individuals with severe mental health disorders, substance use disorders, and intellectual and/or developmental disabilities as described in Section 4.(10) of Session Law 2015-245, as amended by Session Law 2018-48.
11. **Beneficiary:** An individual that is eligible to receive North Carolina Medicaid or NC Health Choice benefits but who may or may not be enrolled in the Medicaid Managed Care program.
12. **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals: with HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving 1915(b)(3), Innovations or TBI Waiver services.
13. **Business Associate Agreement (BAA):** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the contract between a HIPAA-covered entity and HIPAA Business Associate. The BAA protects personal health information (PHI) according to HIPAA guidelines
14. **Business Day:** Business days are defined as traditional workdays, 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>.
15. **Calendar Day:** A calendar day includes the time from midnight to midnight each day. It includes all days in a month, including weekends and holidays. Unless otherwise specified within the Contract, days are tracked as Calendar Days.
16. **Care Coordination:** Defined as organizing patient care activities and sharing information among all the participants concerned with a Member’s care to achieve safer and more effective care. Through organized care coordination, Members’ needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.
17. **Care Management:** Defined as a 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 Members 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 Member 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.
18. **Care Management Fees:** Non-visit based payments to AMH Tier 3 practices made in addition to Fee-for-Service and Medical Home Payments, providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.
 19. **Care Management for High Risk Pregnant Women:** 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 and/or PHPs.
 20. **Care Transitions:** The process of assisting a Member 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).
 21. **Children with Special Health Care Needs:** Those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child’s age. This includes, but is not limited to, children or infants: requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.
 22. **Choice Counseling:** Has the same meaning as Choice Counseling as defined in 42. C.F.R. § 438.2.
 23. **Claim Adjudication:** The process of paying claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.
 24. **Claim Adjudication Date:** The date the PHP or its Subcontractor processed for determination of claim payment, acceptance, denial, or rejection.
 25. **Clarification:** A written response from an Offeror that provides an answer or explanation to a question posted by the Department about that Offeror’s response for their proposal. Clarifications are incorporated into the Offeror’s response.
 26. **Clean Claim:** A claim for services submitted to a PHP by a Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

27. **Closed Loop Referral:** The capacity to know whether a Member accessed social services to which they were referred.
28. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
29. **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement.
30. **Compatible Medicaid NCCI Methodologies:** The six NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology with medically unlikely edits for durable medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.
31. **Contract Award Date:** The date the Department publishes the Notice of Award to the Interactive Purchasing System.
32. **Contract Effective Date:** The date Contract is fully executed by the Parties and approved by CMS.
33. **Contractor:** The Offeror awarded the Contract to perform the services and requirements defined therein. The Contractor is a PHP.
34. **Commercial Plan (CP):** A type of Prepaid Health Plan defined in Section 4.(2)a. of Session Law 2015-245, as any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to Members on a prepaid basis except for Member responsibility for copayments and deductibles and holds a PHP license issued by the North Carolina Department of Insurance. A Commercial Plan is a PHP and is a Managed Care Organization (MCO).
35. **Comprehensive Assessment:** A person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive Care Management and will inform the Member's ongoing care plan and treatment.
36. **Credentialing:** 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, whether to allow the provider to be included in a PHP's network, subject to certain Department requirements.
37. **Crossover:** The timeframe immediately before and after implementation of the North Carolina Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.

38. **Cross-over Population:** Refers to North Carolina Medicaid and NC Health Choice beneficiaries that are enrolled in the Medicaid Fee-for-Service program and will transition to Medicaid Managed Care at a specific date determined by the Department.
39. **Cultural Competency:** 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 competency means to be respectful and responsive to the health beliefs and practices and cultural and linguistic needs of diverse populations groups.
40. **Date of Payment:** 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.
41. **Date of Receipt:** The date the PHP receives the claim, as indicated by its date stamp on the claim. 42 C.F.R. § 447.45(d)(5).
42. **Denied Claim:** When a PHP or its Subcontractor refuses to reimburse a medical or pharmacy service provider for all or a portion of the services submitted on the claim.
43. **Designated Care Management Entity:** An entity with which the PHP contracts, that assumes responsibility for performing specific care management and/or care coordination functions with appropriate documentation and oversight. For the purposes of the Contract, Designated Care Management Entities shall include, but shall not be limited to:
 - a. Advanced Medical Home (AMH) practices;
 - b. Local Health Departments (LHDs) carrying out Care Management for High Risk Pregnant Women and At-Risk Children; and
 - c. Other contracted entities capable of performing care management for a designated cohort of Members.
44. **Designated Pilot Care Management Entity:** A Designated Care Management Entity that is assuming care management responsibilities specifically related to the Healthy Opportunities Pilot.
45. **Duplicate Records:** Any claim submitted by a service provider for the same service provided to an individual on a specified date of service that was included in a previously submitted claim.
46. **Durable Medical Equipment (DME):** Has the same meaning as Durable Medical Equipment as defined in 42 C.F.R. § 414.202.
47. **Eastern Band of Cherokee Indian (EBCI):** A federally recognized Indian Tribe located in southwestern North Carolina whose members are exempt with managed care.
48. **Eligibility:** A series of requirements that determine whether an individual is eligible for North Carolina Medicaid or NC Health Choice benefits.
49. **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:
 - a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
 - b. Serious impairment to bodily functions.
 - c. Serious dysfunction of any bodily organ or part.

50. **Emergency Services:** Has the same meaning as Emergency Services as defined in 42 C.F.R. § 438.114(a).
51. **Enrollment:** The process through which a beneficiary selects or is auto-assigned to a PHP to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program.
52. **Enrollment Broker (EB):** Has the same meaning as Enrollment Broker as defined in 42 C.F.R. § 438.810(a).
53. **Excluded Populations:** Beneficiaries in Excluded Populations may not enroll in PHPs and will continue to receive Medicaid services through Fee-for-Service and LME/MCOs (as applicable).
54. **Exempt Population:** Beneficiaries in Exempt Populations may voluntarily enroll in PHPs on an opt-in basis. Members of Exempt Populations are allowed to opt into Medicaid Managed Care or into Medicaid Fee-for-Service at any time, upon request to the Enrollment Broker.
55. **Family Member:** Any household member who is eligible for North Carolina Medicaid or NC Health Choice and included in Medicaid Manage Care.
56. **Family Navigator:** Individual working directly with children and families served by InCK to meet Members' health, social and educational goals. A Family Navigator may be a PHP employee or employee of a Designated Care Management Entity (e.g., Advanced Medical Home).
57. **Fee-for-Service:** A payment model in which providers are paid for each service provided. NC Medicaid's Fee-for-Service program is also known as NC Medicaid Direct.
58. **Foster Care:** Has the same meaning as Foster Care as defined in N.C. Gen. Stat. § 131D-10.2(9).
59. **Gating Target:** A benchmark proportion of all Standard Plans' Members over eleven (11) years old that are fully vaccinated that must be met for the PHPs to become eligible to receive COVID-19 vaccination incentives.
60. **Grievance:** As it relates to a Member has the same meaning as Grievance, as defined in 42 C.F.R. § 438.400(b).
61. **Hardship Payment:** An advanced payment from the PHP to a provider to address a situation in which the provider is experiencing a significant drop in PHP claims payments due to issues beyond the control of the provider.
62. **Health Insurance:** A contract that requires a health insurer to pay some or all of one's health care costs, sometimes in exchange for a premium.
63. **Healthy Opportunities Network Lead (Network Lead):** Formerly known as a Lead Pilot Entity (LPE), a Network Lead is an organization contracted with the Department to create and oversee a network of HSOs for the Healthy Opportunities Pilot. A Network Lead serves as a connection between PHPs and HSOs and facilitates collaboration between health care and human service organizations for the Pilot.
64. **Healthy Opportunities Pilot (the Pilot):** The Enhanced Case Management and Other Services Pilot Program authorized by North Carolina's 1115 Demonstration Waiver. The Pilot will evaluate the effectiveness of a set of select, evidence-based, non-medical interventions and the role of the Healthy Opportunities Network Leads on improving health outcomes and reducing healthcare costs for a subset of high-need Medicaid Members.
65. **Human Service Organization (HSO):** An organization that offers non-medical services within one or more communities. HSOs are also known as community-based organizations or social service agencies.

66. **Implementation Plan:** Comprehensive schedule of events, tasks, Deliverables, and milestones developed and executed by the Offeror to ensure successful implementation and launch of PHP services
67. **InCK Integrated Care Platform:** A standardized, Internet-accessible care integration tool that InCK staff and authorized personnel will use to create, store, view, update, and share InCK member information, including but not limited to basic InCK member data and the SAP. The current InCK Integrated Care Platform is run by Virtual Health.
68. **InCK Members:** Children and youth birth through age 20 whose Medicaid administrative county is one of the following: Alamance, Durham, Granville, Orange or Vance.
69. **In Lieu of Services (ILOS):** Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.
70. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a).
71. **Institute for Mental Disease (IMD):** Has the same meaning as IMD as defined in 42 C.F.R. § 435.1010.
72. **Integrated Care for Kids (InCK):** A payment and service delivery model supported by funding from CMS under a cooperative agreement, designed to improve outcomes for children.
73. **Integration Consultant:** InCK staff member who is an individual responsible for supporting InCK Family Navigators and care teams serving that PHP's Members.
74. **Interactive Purchasing System (IPS):** The State of North Carolina's on-line system for advertising solicitations and publishing award notifications. Vendors can view and search for procurement opportunities. www.ips.state.nc.us.
75. **Interest:** For the purposes of claim payment or encounter submission, an amount from a PHP that is due to a service provider for holding the provider's money inappropriately as result of the late reimbursement or underpayment of a clean claim.
76. **Into the Mouth of Babes (IMB):** A clinical program that trains medical providers to deliver preventive oral health services to young children insured by North Carolina Medicaid. Services are provided from the time of tooth eruption until age 3½ (42 months), including oral evaluation and risk assessment, parent/caregiver counseling, fluoride varnish application, and referral to a dental home.
77. **Licensed Health Organizations (LHO):** Has the same meaning as LHO as defined in N.C. Gen. Stat. § 58-93-5(7).
78. **Limited English Proficient (LEP):** Has the same meaning as LEP as defined in 42 C.F.R. § 438.10(a).
79. **Local Care Management:** Care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible.
80. **Local Management Entity/Managed Care Organization (LME/MCO):** Defined in N.C. Gen. Stat. § 122C-3(20c) as a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act. An LME/MCO is paid a capitated rate by the Department to provide mental health, developmental disability, and substance use services to Medicaid beneficiaries pursuant to a combination of a Section 1915(b) and a Section 1915(c) waiver and manage federal block grant, State, local and county funds for other behavioral health services. For the Medicaid population, these entities are recognized under CMS Medicaid Managed Care rules and are known as a Prepaid Inpatient Health Plans (PIHP).

81. **Long Term Service and Supports (LTSS):** LTSS shall include:
- a. Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
 - 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; and
 - 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:
 - i. Eating;
 - ii. Taking baths;
 - iii. Managing Medications;
 - iv. Grooming;
 - v. Walking;
 - vi. Getting up and down from a seated position;
 - vii. Using the toilet;
 - viii. Cooking;
 - ix. Driving;
 - x. Getting dressed; or
 - xi. Managing money; and/or
 - 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.
82. **Managed Care Organization (MCO):** Has the same meaning as MCO as defined in 42 C.F.R. § 438.2.
83. **Mandatory Populations:** Mandatory Populations are those Medicaid beneficiaries who are required to enroll in a PHP when first offered as a benefit option.
84. **Marketing:** Has the same meaning as Marketing as defined in 42 C.F.R. § 438.104(a).
85. **Marketing Materials:** Has the same meaning as Marketing Materials as defined in 42 C.F.R. § 438.104(a).
86. **Medicaid Enterprise System (MES):** The aggregation of technologies and applications required to operate a State Medicaid Agency (SMA) - the core is typically the MMIS.
87. **Medicaid Managed Care:** The name of the North Carolina managed care program for North Carolina Medicaid and NC Health Choice benefits; does not include LME/MCOs.
88. **Medicaid Management Information System (MMIS):** The Department multi-payer system is a centralized repository for recipient and provider information. MMIS also adjudicates claims for DHB, DMH/DD/SA, Division of Public Health, and Office of Rural Health.
89. **Medical Claim:** Inpatient hospital, outpatient hospital (institutional claims), and physician-administered services.
90. **Medical Home Fees:** Non-visit based payments to AMH practices made in addition to fee for service payments, providing stable funding for care coordination support, and quality improvement at the practice level.
91. **Medically Necessary:** Medical necessity 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.
92. **Members:** Beneficiaries specifically enrolled in and receiving benefits through the North Carolina Managed Care program.

93. **National Correct Coding Initiative (NCCI):** The CMS-developed coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
94. **National Provider Identifier (NPI):** Standard unique health identifier for health care providers adopted by the Secretary of US Department of Health and Human Services in accordance with HIPAA.
95. **Natural Supports:** Support and assistance received from family members, peer supports, and other service providers supporting the Member.
96. **NCCI Edits:** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) medically unlikely edits, or units-of service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
97. **NCCI Methodologies:** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
98. **Network:** A group of doctors, hospitals, pharmacies, and other health care experts contracted by the PHP to provide health care services to its Members.
99. **Non-Participating Provider:** Non-participating or “non-par” providers are physicians or other health care providers that have not entered into a contractual agreement with the PHP and are not part of the PHP’s Provider Network, unlike participating providers. They may also be called out-of-network providers
100. **Non-public Medicaid NCCI Edit Files:** The quarterly Medicaid NCCI Edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure Regional Information Sharing Systems (RISSNET) portal.
101. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
102. **North Carolina Health Choice (NC Health Choice):** The Health Insurance Program for 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
103. **North Carolina Identity Service (NCID).** This is the State’s centralized Identity and access management platform provided by the Department of Information Technology. NCID is a web-based application that provides a secure environment for state agency, local government, business and individual users to log in and gain access to real-time resources, such as customer-based applications and information retrieval. <https://www.ncid.nc.gov>
104. **North Carolina InCK (NC InCK):** The entities implementing InCK in North Carolina, led by Duke University, the University of North Carolina and NC Division of Health Benefits.
105. **North Carolina Session Law 2015-245:** The Medicaid Transformation and Reorganization Act enacted on September 23, 2015, authorizing the transition of the North Carolina Medicaid and NC Health Choice Fee-for-Service programs to a Medicaid Managed Care delivery system.

106. **Objective Quality Standard:** Means, as defined in Section 5.(6) d. of Session Law 2015-245, the objective quality standard the Department applies during the Provider Enrollment Process.
107. **Offeror:** Supplier, bidder, proposer, firm, company, corporation, partnership, individual or other entity submitting an offer in response to this RFP.
108. **Ombudsman Program:** A new Department program to be established to provide education, advocacy, and issue resolution for Medicaid beneficiaries whether they are in the Medicaid Managed Care program or the Medicaid Fee-for-Service program. This program is separate and distinct from the Long-Term Care Ombudsman Program.
109. **Ongoing Course of Treatment:** When a Member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. 42 C.F.R. § 438.62(b).
110. **Ongoing Special Condition:** Has the same meaning as ongoing special condition defined in N.C. Gen. Stat. § 58-67-88(a)(1).
111. **Open Enrollment Period:** Period prior to implementation of North Carolina's Medicaid Managed Care program during which the existing Fee-for-Service, cross-over population will be able to actively select a PHP with the support of the Enrollment Broker.
112. **Participating Provider:** Participating provider or "par" providers are physicians or other health care providers that have a contractual agreement with the PHP and are included in the PHP's Provider Network. These agreements outline the terms and conditions of participation for both the payer and the provider.
113. **Performance Incentive Payments:** Payments additional to fee for service, care management fees and medical home fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics.
114. **Pharmacy Claim:** Includes outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims.
115. **PHP Contract Data Utility (PCDU):** A secure file transfer platform to allow for posting of Department guidance to the PHPs and submission of key contract deliverables and reports by the PHPs for review and approval by the Department.
116. **Pilot Implementation Period:** A period of time during which PHPs, Network Leads, HSOs, and Designated Pilot Care Management Entities build the capacity and infrastructure to participate in the Healthy Opportunities Pilot and prepare for Pilot service delivery.
117. **Pilot Service Delivery Period:** A period of time during which Healthy Opportunities Pilot services are delivered to Pilot enrollees. The Pilot Service Delivery Period is divided into sub-periods to align with State Fiscal Years as provided in *Section V.C.8. Opportunities for Health*.
118. **Post-stabilization Care Services:** Has the same meaning as post-stabilization care services as defined in 42 C.F.R. § 438.114(a).
119. **Potential Member:** A beneficiary enrolled in Medicaid and eligible for enrollment in a PHP or a Member of another PHP.
120. **Pregnancy Management Program:** A care program that encourages adoption of best prenatal, pregnancy, and perinatal care for Medicaid Managed Care Members.
121. **Prepaid Health Plan (PHP):** Has the same meaning as Prepaid Health Plan, as defined in Section 4. (2) of Session Law 2015-245, as amended by Session Law 2018-48. A PHP is a Managed Care Organization (MCO).

122. **Primary Care Kindergarten Readiness Promoting Bundle:** A set of interventions that primary care practices can provide in the office or connect children and families to that help prepare children for Kindergarten
123. **Primary Care Provider (PCP):** The participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the Member to provide and coordinate all the Member's health care needs and to initiate and monitor referrals for specialized services, when required.
124. **Program Integrity (PI):** Has the same meaning as described in 42 C.F.R. Part 455.
125. **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age fifty-five (55) and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.
126. **Protected Health Information (PHI):** Has the same meaning as PHI as defined by 45 C.F.R. § 160.103.
127. **Provider:** Except as it relates to credentialing, has the same meaning as Provider as defined in 42 C.F.R. § 438.2.
128. **Provider (For the purposes of credentialing):** Individual practitioners and facilities, entities, organizations, atypical organizations/providers, and institutions, unless otherwise noted.
129. **Provider Contracting:** The process by which the PHP negotiates and secures a contractual agreement with providers who are active, Medicaid Enrolled providers and are to be included in the PHP's Provider Network.
130. **Provider Enrollment:** The process by which a provider is enrolled in North Carolina's Medicaid or NC Health Choice programs, with credentialing as a component of enrollment. A provider who has enrolled in North Carolina's Medicaid or NC Health Choice programs (or both) shall be referred to as a "Medicaid Enrolled provider" or an "Enrolled Medicaid provider".
131. **Provider Grievance:** Any oral or written complaint or dispute by a Provider over any aspects of the operations, activities, or behavior of the PHP except for any dispute over for which the provider has appeal rights.
132. **Provider-Led Entity (PLE):** Means, as defined in Section 4.(2)b. of Session Law 2015-245, as amended by Session Law 2016-121. A PLE is a PHP and is a Managed Care Organization (MCO).
133. **Qualified Health Plan (QHP):** Means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of Article 45 of the Code of Federal Regulations issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 of Article 45 of the Code of Federal Regulations. 45 C.F.R. § 155.20.
134. **Qualified Interpreter:** Has the same meaning as described in 45 C.F.R. § 92.4.
135. **Readily Accessible:** Has the same meaning as Readily Accessible as defined in 42 C.F.R. § 438.10(a).
136. **Readiness Review:** Has the same meaning as described in 42 C.F.R. § 438.66(d).
137. **Redeterminations:** The annual review of beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and NC Health Choice.
138. **Remote Patient Monitoring:** The use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital

signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring.

- a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
 - b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.
139. **Reprocess:** For the purposes of claims and encounters, the activities completed by a payer to reconsider the outcome of a previously adjudicated claim.
 140. **Rising Risk:** Population group that has not yet become high-risk but who may become high-risk if certain risk factors and behaviors are not addressed.
 141. **Security Assertion Markup Language (SAML):** This is the State's preferred standard for the implementation of identity and access management.
 142. **Service Integration Levels (SIL):** Stratification of InCK-attributed Members calculated by NC InCK and shared with PHPs to guide delivery of care management and InCK interventions. SIL 1 will indicate the lowest level of service need, while SIL 2 and 3 will indicate sequentially increasing rates of service need.
 143. **Shared Action Plan (SAP):** Standardized plan on an NC InCK-provided template for improved family-centered, whole-child service coordination.
 144. **Significant Change:** Means any change in the services offered by PHPs, the benefits covered under the contract, the geographic service area, and the composition of or payments to the PHP's provider network, and the enrollment of a new population in the PHP.
 145. **Standard Plan:** A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most North Carolina Medicaid and NC Health Choice beneficiaries and that are not BH IDD Tailored Plans as described in in Section 4.(10) of SL 2015-245, as amended by SL 2018-48.
 146. **State:** The State of North Carolina, the NC Department of Health and Human Services as an agency or in its capacity as the Using Agency.
 147. **State Business Day:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, except for North Carolina State holidays as defined by the Office of State Human Resources. <https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays>.
 148. **State Fair Hearing:** The hearing or hearings conducted at the Office of Administrative Hearings (OAH) under N.C. Gen. Stat. § 108D-15 to resolve a dispute between a Member and a PHP about an Adverse Benefit Determination.
 149. **Subcontractor:** An entity having an arrangement with the PHP, where the PHP uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the subcontractor and the Department, only the Contractor. Network providers are not considered Subcontractors for the Contract.
 150. **Telehealth:** Telehealth is 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. Telehealth may be referred to as "telemedicine" within this Contract.
 151. **Transition Entity:** Department-designated entity responsible for coordinating transition of care activities and supporting members through the transition between service delivery

systems. Transition entities include other PHPs, LME/MCOs, CCNC, Tribal Option and other designated entities.

152. **Transition Notice Date:** The date a transitioning member's anticipated enrollment change is reflected on a PHP's eligibility file (834).
153. **Transitions of Care:** The Process of assisting a Member to transition between PHPs; between payment delivery systems; including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between providers upon a provider's termination from the PHP network.
154. **Value-Added Services:** Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the PHP's discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.
155. **Value-Based Payment (VBP):** Payment arrangements between PHPs and providers that fall within Levels 2 and 4 of the multi-payer Health Care Payment (HCP) and Action Network (LAN) Alternative Payment Model (APM) framework.
156. **Vendor:** A companies, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.
157. **Video Remote Interpreting:** Has the same meaning as described in 28 C.F.R. § 35.104.
158. **Virtual Patient Communications:** Virtual patient communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).
159. **Warm transfer:** Defined as a beneficiary or provider call is transferred directly from the original call center to the appropriate party without requiring the caller to make an additional call and without the PHP abandoning the call until the other party answers.
160. **X12 Transactions:** —Any EDI transaction included in the x12.org standard. This includes but is not limited to the 834 Benefit Enrollment and Maintenance, the 837 Health Care Claim, and the 277 Health Care Information Status Notification. The entire transaction set can be found at <http://www.x12.org>.

b. Section III.B. Acronyms is revised and restated in its entirety to add newly defined acronyms and renumber Section III.B Acronyms as follows:

B. Acronyms

1. AAP: American Academy of Pediatrics
2. ACD: Automated Call Distribution System
3. ADL: Activities of Daily Living
4. ADT: Admission, Discharge, Transfer
5. AMH: Advanced Medical Home
6. API: Administrative Provider Identification
7. APM: Alternative Payment Method
8. ASAM: American Society for Addiction Medicine
9. ASC: Accredited Standards Committee
10. AVRS: Automated Voice Response System

11. BAA: Business Associate Agreement
12. BAHA: Bone Conduction Hearing Aids
13. BCCCP: Breast and Cervical Cancer Control Program
14. BH: Behavioral Health
15. BIP: Behavioral Intervention Plan
16. CAH: Critical Access Hospital
17. CAHPS: Consumer Assessment of Healthcare Providers and Systems Plan Survey
18. CANS: Children and Adolescents Needs and Strengths
19. CAP: Corrective Action Plan
20. CAP/C: Community Alternatives Program for Children
21. CAP/DA: Community Alternatives Program for Disabled Adults
22. CBO: Community Based Organization
23. CCHN: Carolina Complete Health Network
24. CCO: Chief Compliance Officer
25. CDSA: Children's Developmental Services Agency
26. CEO: Chief Executive Officer
27. CFO: Chief Financial Officer
28. CHIP: Children's Health Insurance Program
29. CIN: Clinically Integrated Network
30. CIO: Chief Information Officer
31. CMO: Chief Medical Officer
32. CMS: Centers for Medicare & Medicaid Services
33. COD: Cost of Dispensing
34. CP: Commercial Plan
35. CPT: Current Procedural Terminology
36. CVMS: Covid Vaccine Management System
37. CVO: Credentialing Verification Organization
38. DHB: Department of Health Benefits
39. DHHS: Department of Health and Human Services
40. DHSR: Division of Health Service Regulation
41. DIT: Department of Information Technology
42. DLP: Desk Level Procedures
43. DME: Durable Medical Equipment
44. DMVA: Department of Military and Veterans Affairs
45. DOI: Department of Insurance
46. DOS: Date of Service
47. DSOHF: Division of State Operated Healthcare Facilities
48. DSS: Division of Social Services
49. DUR: Drug Utilization Review
50. EB: Enrollment Broker
51. ECBI: Eastern Band of Cherokee Indians
52. ECSII: Early Childhood Services Intensity Instrument
53. EDI: Electronic Data Interchange
54. EFT: Electronic Funds Transfer
55. EN: Enteral Nutrition
56. EPS: Episodic Payment System
57. EPSDT: Early and Periodic Screening, Diagnostic and Treatment
58. EQRO: External Quality Review Organization
59. ESB: Enterprise Service Bus

60. ESRD: End Stage Renal Disease
61. EUP: End User Procedures
62. EVV: Electronic Visit Verification
63. FAR: Federal Acquisition Regulation
64. FDA: Food and Drug Administration
65. FFS: Fee-for-service
66. FFY: Federal Fiscal Year
67. FQHC: Federally Qualified Health Center
68. HCPCS: Healthcare Common Procedure Coding System
69. HHS: U.S. Department of Health and Human Services
70. HIPAA: Health Insurance Portability and Accountability Act
71. HIPP: Health Insurance Premium Payment
72. HITECH: Health Information Technology for Economic and Clinical Health Act
73. HIV: Human Immunodeficiency Virus
74. HOH: Head of Household
75. HRSA: Health Resources and Services Administration
76. HSO: Human Service Organization
77. I/DD: Intellectually/Developmental Disability
78. IADL: Instrumental Activities of Daily Living
79. ICF: Intermediate Care Facility
80. IDG: Interdisciplinary Group
81. IDM: Identity Management
82. IEM: Inborn Errors of Metabolism
83. IEP: Individualized Education Program
84. IFSP: Individual Family Service Plan
85. IHCP: Indian Health Care Provider
86. IHP: Individual Health Plan
87. IID: Individuals with Intellectual Disabilities
88. ILOS: In Lieu of Services
89. IMB: Into the Mouth of Babies
90. IMCE: Indian Managed Care Entities
91. IMD: Institution for Mental Disease
92. InCK: Integrated Care for Kids
93. IP: Independent Practitioners
94. IPS: Interactive Purchasing System
95. IRF: Inpatient Rehabilitation Facility
96. IRS: Internal Revenue Service
97. ISP: Individualized Service Plan
98. ITD: Information Technology Department (DHHS)
99. LAN: Learning and Action Network
100. LCSW: Licensed Clinical Social Worker
101. LEA: Local Education Agencies
102. LEIE: List of Excluded Individuals/Entities
103. LEP: Limited English Proficient
104. LHD: Local Health Department
105. LME/MCO: Local Management Entities-Managed Care Organizations
106. LPE: Lead Pilot Entity
107. LPN: Licensed Practical Nurse
108. LTSS: Long Term Service and Supports

109. MAC: Maximum Allowable Cost
110. MAO: Medicare Advantage Organization
111. MCAC: Medical Care Advisory Committee
112. MES: Medicaid Enterprise System
113. MHPAEA: Mental Health Parity and Addiction Equity Act
114. MID: North Carolina Department of Justice Medicaid Investigations Division
115. MIMS: Medicaid Integrated Modular Solution
116. MIPS: Master Integrated Project Schedule
117. MIS: Management Information Systems
118. MITA: Medicaid Information Technology Architecture
119. MLR: Medical Loss Ratio
120. MMDB: Medicaid Master Database
121. MME: Morphine Milligram Equivalent
122. MMIS: Medicaid Management Information Systems
123. NADAC: National Average Drug Acquisition Cost
124. NC: North Carolina
125. NC FAST: North Carolina Families Accessing Services through Technology
126. NCAC: North Carolina Administrative Code
127. NCCI: National Correct Coding Initiative
128. NCDPH: North Carolina Division of Public Health
129. NCEDB: North Carolina Medicare Enrollment Database
130. NCGA: North Carolina General Assembly
131. NCHC: North Carolina Health Choice
132. NCID: North Carolina Identity Management Service
133. NCIR: North Carolina Immunization Registry
134. NCPDP: National Council for Prescription Drug Programs
135. NCQA: National Committee for Quality Assurance
136. NDC: National Drug Code
137. NEMT: Non- Emergency Medical Transportation
138. NIEM: National Information Exchange Model
139. NPI: National Provider Identifier
140. NPPES: National Plan and Provider Enumeration System
141. OAH: Office of Administrative Hearings
142. OCR: Office of Civil Rights
143. OFAC: Office of Foreign Assets Control
144. PA: Prior Authorization
145. PACE: Program of All-Inclusive Care
146. PBM: Pharmacy Benefit Managers
147. PCP: Primary Care Provider
148. PCS: Personal Care Services
149. PDL: Preferred Drug List
150. PDM: Provider Data Management
151. PDN: Private Duty Nursing
152. PHHS: Public Health and Human Services
153. PHI: Personal Health Information
154. PHP: Prepaid Health Plan
155. PI: Program Integrity
156. PIHP: Prepaid Inpatient Health Plans
157. PIP: Performance Improvement Program

158. PLE: Provider-Led Entities
159. PMPM: Per Member Per Month
160. PRC: Purchased/Referred Care
161. PSO: North Carolina Department of Health and Human Services Privacy and Security Office
162. PTA: Privacy Threshold Analysis
163. QAPI: Quality Assurance and Performance Improvement
164. QHP: Qualified Health Plan
165. REOMB: Recipient Explanation of Medical Benefit
166. RFP: Request for Proposal
167. RHC: Rural Health Clinic
168. RN: Registered Nurse
169. ROI: Return on Investment
170. SAM: System of Award Management
171. SAML: Security Assertion Markup Language
172. SAP: Shared Action Plan
173. SBI: North Carolina State Bureau of Investigation
174. SBIRT: Screening, Brief Intervention, and Referral to Treatment
175. SED: Serious Emotional Disturbance
176. SFTP: Secure File Transfer Protocol
177. SID: System Integration Design
178. SIL: Service Integration Levels
179. SIP: System Integration Plan
180. SIS: Supports Intensity Scale
181. SIU: Special Investigations Unit
182. SLA: Service Level Agreements
183. SLPA: Speech/Language Pathology Assistant
184. SMA: State Medicaid Agency
185. SMAC: State Maximum Allowable Cost
186. SMI: Serious Mental Illness
187. SNF: Skilled Nursing Facility
188. SOC: Service Organization Control
189. SP: Standard Plan
190. SSA: Social Security Act
191. SSADMF: Social Security Administration Death Master File
192. SUD: Substance Use Disorder
193. TBI: Traumatic Brain Injury
194. TCLI: Transition to Community Living Initiative
195. TCM: Targeted Case Management
196. TDD: Telecommunications Device for the Deaf
197. TP: Tailored Plan
198. TPA: Third Part Administrator
199. TPL: Third party liability
200. TPN: Total Parenteral Nutrition
201. TTY: Text Telephone
202. UM: Utilization Management
203. VBP: Value-based payments
204. VEO: Visual Evoked Potential
205. VFC: Vaccines for Children
206. WCA: Web Content Accessibility Guidelines

- 207. WHCRA: Women's Health and Cancer Rights Act of 1998
- 208. WIC: Women, Infants and Children

c. Section III.D. Terms and Conditions, 11. CONTRACT ADMINISTRATORS for the Department are revised and restated as follows:

For the Department

Contract Administrator for all contractual issues listed herein:

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

Contract Administrator regarding day to day activities herein:

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

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

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

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

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

d. Section III.D. Terms and Conditions 32. PAYMENT AND REIMBURSEMENT, I. is revised and restated as follows:

I. COVID-19 Vaccination Incentive Program:

i. Incentive Program for Members

- a. The Department will make payments to the Contractor for fifty percent (50%) of expenditures on the COVID-19 Vaccination Member Incentive Program up to \$1,000,000 in Contract Year 1.
 1. The PHP shall limit Member Incentives to no more than two hundred dollars (\$200) per Member during Contract Year 1.
 2. The Department will provide reimbursement for the administration and payment of incentives in the Contractor’s COVID-19 Vaccination Member Incentive Program. The Department will limit reimbursement to the Contractor for the administration of the COVID-19 Vaccination Member Incentive Program to no more than twenty percent (20%) of the total payments to the Contractor.
- b. The Department will make payment to the Contractor sixty (60) Calendar Days after receipt of a complete COVID-19 Member Incentive Program Expenditure Report for Contract Year 1.

ii. Incentive Program for PHPs

- a. The Department will establish a COVID-19 Vaccination Incentive Program.
- b. As provided in *Section V.I.7. COVID-19 Vaccination Incentive Program Payments*, the Contractor will be eligible to receive a separate incentive payment for each Member over the age of 11 who becomes fully vaccinated for COVID-19 after the Gating Target is met. Fully vaccinated shall be defined as receiving one (1) Johnson & Johnson shot; two (2) Moderna, or two (2) Pfizer shots. Payment will be made after the Contractor meets the Department’s defined Gating Target.
 1. In order to be eligible for the COVID-19 Vaccination Incentive Program, all Prepaid Health Plans awarded a Standard Plan Contract, must meet a Gating Target, 30% of all Standard Plan Members over eleven (11) years old must be fully vaccinated based on COVID-19 Vaccine Management System (CVMS) records.

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

Specific subsections are modified as stated herein.

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

- h. Compliance with Department Policies
 - i. The PHP shall comply with Department policies as identified and required by the Department, including the following:
 - a) Medicaid Managed Care Enrollment Policy
 - b) Department Clinical Coverage Policies;
 - c) Transition of Care Policy;
 - d) Care Management Policy;
 - e) Advanced Medical Home Program Policy;
 - f) Care Management for High-Risk Pregnancy Policy;
 - g) Care Management for At-Risk Children Policy;
 - h) Management of Inborn Errors of Metabolism Policy;
 - i) Uniform Credentialing and Recredentialing Policy;
 - j) NC Non-Emergency Medical Transportation Managed Care Policy;
 - k) Advanced Medical Home Provider Manual;
 - l) Healthy Opportunities Pilot Care Management Protocol;
 - m) Healthy Opportunities Pilot Payment Protocol;
 - n) Healthy Opportunities Pilot Transitions of Care Protocol; and
 - o) Healthy Opportunities Standard Plan Implementation Period Incentive Payments Milestone Guide.
 - ii. The Department may amend policies and shall provide updated versions to the PHP at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The PHP shall have the opportunity to review and provide feedback prior to finalization.

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

- ii. Additionally, the following personnel, at a minimum, shall be located in and operate from within the State of North Carolina:
 - a) Behavioral Health (BH) Managers;
 - b) Care Management Managers, Supervisors and Staff;
 - c) Member Complaint, Grievance, and Appeal Coordinator;
 - d) Member Services and Service Line Staff;
 - e) Provider Relations and Service Line Staff;
 - f) Quality Assessment and Improvement and Utilization Management Coordinator;
 - g) Tribal Provider Contracting Specialist;
 - h) Liaison to the Division of Mental Health;
 - i) Liaison to the Division of Social Services;
 - j) Liaison between the Department and the North Carolina Attorney General's Medicaid Investigation Division;
 - k) Care Management Housing Specialist;
 - l) Utilization Management Managers;
 - m) Pharmacy and Service Line Staff; and
 - n) InCK Family Navigators and Integration Consultants.

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

- g) If the PHP denies the request for an expedited plan appeal, it shall do the following:
 - i. Immediately transfer the appeal to the timeframes for standard resolution; and
 - ii. Make reasonable efforts to give the Member or an authorized representative oral notice of the denial and follow up with a written notice of the denial of the expedited resolution request within two (2) Calendar Days of the denial of the expedited appeal. 42 C.F.R. §§ 438.410(c) and 438.408 (c)(2)(ii).

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

- ix. Consistent with 42 C.F.R. § 438.210(a)(5)(ii), the PHP shall provide medically necessary services that address:
 - a) The prevention, diagnosis, and treatment of a Member’s disease, condition, and/or disorder that results in health impairments and/or disability.
 - b) The ability for a Member to achieve age-appropriate growth and development.
 - c) The ability for a Member to attain, maintain, or regain functional capacity.
 - d) The opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

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

- ii. The Clinical Practice Guidelines shall:
 - a) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
 - b) Consider the needs of Members;
 - c) Be adopted in consultation with contracting health professionals;
 - d) Be reviewed and updated periodically as appropriate;
 - e) Be utilized for decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply; and
 - f) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. § 438.236.

f. Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, i. Dispensing Fees is revised to add the following:

- f) For 340B and Non-340B Hemophilia drugs, the dispensing fee is paid based on the quantity of units dispensed, utilizing a multiplier at \$0.04 for Hemophilia Treatment Center (HTC) pharmacies and \$0.025 for all other Non-Hemophilia pharmacies.
- g) The PHP shall not reimburse pharmacy professional dispensing fees to drug reimbursement under the all-inclusive rate “AIR” or bundle payment.

g. Section V.C. Benefits and Care Management, 4. Transition of Care, c. vii. is revised and restated as follows:

- vii. The PHP shall bear the financial responsibility for diagnosis-related group based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the PHP (or prior in the case of a beneficiary who is inpatient on their first day of enrollment in the PHP if there is no prior Medicaid managed care or NC Medicaid Direct coverage for inpatient) through the date

of discharge from such facility. The PHP shall send Diagnosis-related group (DRG) codes on encounter data. Post discharge care may be coordinated prior to discharge.

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

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

i. Section V.C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination iv. – vi. is revised and restated as follows:

iv. Integrated Care for Kids (InCK)

- a) Integrated Care for Kids (InCK) is a national care delivery and payment reform model initiated by CMS. InCK aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid by incorporating the primary determinants of health into care available to children. Information on the national model is at <https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model>.
- b) North Carolina's InCK model shall be known as InCK. The goals of InCK are to:
 - 1. Improve priority outcomes of child health and well-being;
 - 2. Reduce avoidable inpatient stays and out of home placements; and
 - 3. Create sustainable, alternative ways of paying for care.
- c) InCK will be implemented between 2022 and 2026 for Members, birth through age 20, whose Medicaid administrative county is Alamance, Durham, Granville, Orange or Vance County. All Members who reside in the participating counties will be eligible for InCK, regardless of the location of their health care providers.
- d) The PHP shall work with the Department, InCK and Advanced Medical Homes to implement InCK for participating InCK Members.
- e) InCK will attribute InCK eligible Members to the PHP and assign each InCK Member into one of three (3) Service Integration Levels (SILs), based on clinical and non-clinical data, and will transmit Member-level SILs to each PHP.
- f) InCK will be focused on integrating care across ten core child services:
 - 1. Schools;
 - 2. Early care and education;
 - 3. Food – SNAP, WIC, food banks;
 - 4. Housing;
 - 5. Physical and behavioral healthcare;
 - 6. Public health services – Title V of Social Security Act;
 - 7. Social services – child welfare;
 - 8. Mobile crisis response;
 - 9. Juvenile Justice; and
 - 10. Legal services.
- g) The PHP-employed Integration Consultant shall utilize the InCK Integrated Care Platform as part of its participation in InCK to, at minimum:
 - 1. Identify InCK attributed Members;
 - 2. View basic data on Members assigned to SIL 2 and 3;
 - 3. Integrate care panel management and notes for Members assigned to SIL 2 and 3; and
 - 4. Store and share Shared Action Plans (SAPs) and consent documents.

- h) The PHP shall ensure that an InCK Family Navigator is designated for all InCK Members assigned to SIL 2 or SIL 3 to support the InCK Member’s care integration needs.
 - i) The PHP shall submit timely, complete and accurate data to InCK and the Department for inclusion in the InCK Program Evaluation.
 - j) The PHP shall support Kindergarten readiness promotion actions in InCK participating practices by ensuring that each component of the InCK Primary Care Kindergarten Readiness Bundle can be ordered, coded, and recorded by health care providers during well child visits.
 - k) The PHP shall provide training and coaching to InCK participating practices regarding the components of the Kindergarten Readiness Promotion Bundle, including added coding and billing requirements, in accordance with details laid out in the InCK Quality Measurement Technical Specifications Manual.
- v. Identification of High-Need Members Needing Care Management
- a) Care Needs Screening
 1. The PHP shall undertake best efforts to conduct a Care Needs Screening of every member within ninety (90) calendar days of the effective date of enrollment. The PHP shall expedite this screening process for all newly enrolled members in the Aged, Blind, Disabled (ABD) Category of Aid who have not otherwise been identified as a High Need members. 42 CFR 438.208(b)(3).
 - i. The purpose of the Care Needs Screening shall be to provide the PHP with general information about Members’ health and to identify Members with unmet health-related resource needs who may require a Comprehensive Assessment, as defined by the Contract, for care management.
 - ii. The Department defines “best efforts” as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful. The PHP shall develop processes and procedures to maximize rate of response on the screening.
 2. Each PHP shall establish an evidence-based or evidenced-supported tool to conduct the Care Needs Screening. At a minimum, the tool shall identify:
 - i. Chronic or acute conditions;
 - ii. Chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
 - iii. Behavioral health needs, including opioid usage and other substance use disorders;
 - iv. Members at risk of requiring LTSS;
 - v. Medications—prescribed and taken; and
 - vi. Other factors or conditions (e.g., pregnancy) about which the PHP would need to be aware to arrange available interventions for the Member.
 3. The PHP shall include the Department’s standardized Healthy Opportunities screening questions provided in *Attachment M. 9. Healthy Opportunities Screening Questions* in all Care Needs Screenings, covering four (4) priority domains:
 - i. Housing;
 - ii. Food;
 - iii. Transportation; and
 - iv. Interpersonal Safety/toxic stress.
 4. The PHP shall verify that any Care Needs Screenings conducted by designated care management entities are completed in a timely manner and results of the screenings are routed back to the PHP.
 5. The PHP shall share the results of the Care Needs Screening with each Member’s assigned AMH/PCP within seven (7) calendar days of screening, or within seven (7) calendar days of assignment of a new AMH/PCP, whichever is earlier.

6. The PHP shall share with any other Designated Care Management Entity who may be serving the Member the results of the Care Needs Screening within seven (7) calendar days of screening.
 7. If a Member's eligibility is reinstated to Medicaid and it has been more than ninety (90) days from the Member's previous eligibility, the PHP shall conduct the Care Needs Screening again within ninety (90) days.
 8. In the event that the Care Needs Screening identifies a Member as part of a priority population for care management, a Comprehensive Assessment shall be conducted to determine that Member's care management needs.
 9. The PHP must attempt a Care Needs Screening at least annually for individuals not engaged in care management.
 10. For Members enrolled in InCK:
 - i. The PHP shall use best efforts to conduct a Care Needs Screening for each InCK attributed Member assigned to SIL 3 every six (6) months.
 - ii. The PHP shall use best efforts to conduct a Care Needs Screening for each InCK attributed Member assigned to SIL 1 and SIL 2 every twelve (12) months.
 - iii. The PHP shall use best efforts to conduct Care Needs Screenings on at least eighty percent (80%) of its overall InCK attributed Membership annually.
- b) Identification of Priority Populations through Risk Scoring and Stratification
1. The PHP shall use risk scoring and stratification to identify Members who are part of priority populations for care management and should receive a Comprehensive Assessment to determine their care management needs.
 2. The Department defines "priority populations" as populations likely to have care management needs and benefit from care management, including the following:
 - i. Individuals with Long Term Services and Supports (LTSS) needs;
 - ii. Adults and children with Special Health Care Needs;
 - iii. Individuals identified by the PHP as at Rising Risk;
 - iv. Individuals with high unmet health-related resource needs, as defined at a minimum to include:
 - a) Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
 - b) Members experiencing or witnessing domestic violence or lack of personal safety; and
 - c) Members showing unmet health-related needs in three or more Opportunities for Health domains on the Care Needs Screening.
 - v. At-Risk Children (age 0-5);
 - vi. High-Risk Pregnant Women;
 - vii. Other priority populations as determined by the PHP (i.e. Members with complex conditions like HIV, Hepatitis C, or Sickle Cell); and
 - viii. InCK attributed Members assigned to SIL 2 or 3 by NC InCK.
 3. Each PHP's risk scoring methodology and stratification methodology shall take into account, at a minimum, the following information:
 - i. Care Needs Screening results, including the content of the screening assessing unmet health-related resource needs;
 - ii. Claims history;
 - iii. Claims analysis;
 - iv. Pharmacy data;
 - v. Immunizations;
 - vi. Lab results;

- vii. Admission, Discharge, Transfer (ADT) feed information;
 - viii. Provider referrals;
 - ix. Referrals from social services
 - x. Member's zip code
 - xi. Member's race and ethnicity; and
 - xii. Member or caretaker self-referral.
4. In the event that the PHP identifies a Member as part of a priority population for care management, the PHP shall conduct a Comprehensive Assessment to determine that Member's care management needs.
 5. For a Member enrolled in InCK, the PHP shall proceed with a Comprehensive Assessment if the Member is identified as part of any other priority population, even if the Member is not identified as SIL 2 or 3.
- c) Comprehensive Assessment to Identify High-Need Members
1. The PHP shall perform a Comprehensive Assessment for every Member who is:
 - i. Identified through Care Needs Screening and/or risk stratification as being within a priority population, including members at risk of requiring LTSS;
 - ii. Referred to the PHP for care management by a provider, Member (self-referral), family member, or other person or entity, including social services;
 - iii. An InCK attributed Member assigned to SIL 3; and
 - iv. Those InCK attributed Members assigned to SIL 2 who are identified through the Care Needs Screening and/or additional data analysis of InCK-provided data as being within a priority population.
 2. The Comprehensive Assessment shall identify ongoing special conditions that require a course of treatment or regular care monitoring.
 3. The Comprehensive Assessment shall be a person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive care management and will inform the Member's ongoing care plan and treatment.
 4. The PHP shall develop and deploy Comprehensive Assessments tailored to Members that include, at a minimum, the following content:
 - i. Member's immediate care needs;
 - ii. Member's current services;
 - iii. Other state or local services currently used;
 - iv. Physical health conditions, including dental conditions;
 - v. Current and past mental health and substance use status and/or disorders;
 - vi. Physical, intellectual, or developmental disabilities;
 - vii. Medications – prescribed and taken;
 - viii. Available informal, caregiver, or social supports, including peer support
 - ix. Current and past mental health and substance use status and/or disorders;
 - x. Four priority unmet health-related resource domains;
 - xi. Any other ongoing special conditions that require a course of treatment or regular care monitoring;
 - xii. At the PHP's option, for adults only exposure to adverse childhood experiences (ACEs) or other trauma;
 - xiii. Risk factors that indicate an imminent need for LTSS;
 - xiv. Care giving-related needs of member's unpaid, information caregiver; and
 - xv. For InCK, educational needs.
 5. The PHP shall develop methodologies and tools for conducting the Comprehensive Assessment, as appropriate for differing Member demographics and needs.

6. The PHP shall undertake best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more priority populations or having received a referral for care management. For InCK, the PHP shall undertake best efforts to complete the Comprehensive Assessment within thirty (30) Calendar Days of an InCK attributed Member becoming assigned to SIL 3.
 7. The PHP shall conduct the Comprehensive Assessment in a location that meets the Member's needs.
 8. The PHP shall not withhold necessary services for Members while awaiting completion of the Comprehensive Assessment.
 9. The PHP shall ensure that a Comprehensive Assessment is completed or re-completed for all Members, including re-assessment for Members already assigned to care management:
 - i. At least annually;
 - ii. When the Member's circumstances or needs change significantly; and/or
 - iii. At the Member's request.
 10. The PHP shall share the results of the Comprehensive Assessment with the Member, Member's AMH/PCP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law.
 11. Reserved.
 12. If the Comprehensive Assessment determines that the Member does not require care management, the PHP shall document that determination and will not be required to develop a Care Plan.
 13. The PHP's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.
- d) Treatment of Members needing LTSS: All Members identified as needing LTSS or at risk of requiring LTSS, shall be categorized as high-need Members and shall therefore receive care management.
- vi. Provision of Care Management for High-Need Members
- a) Development of Care Plan
 1. Using the findings of the Comprehensive Assessment, the PHP shall develop a Care Plan for each high-needs Member. 42 C.F.R. § 438.208(c)(3).
 2. The PHP shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.
 3. The PHP shall undertake best efforts to complete each Care Plan within thirty (30) calendar days of completion of the Comprehensive Assessment and in accordance with any applicable state quality assurance and utilization review standards.
 4. The PHP shall ensure that development of the Care Plan does not delay the provision of needed services to a Member in a timely manner, even if that Member is waiting for a Care Plan to be developed.
 5. The PHP shall ensure that each Care Plan incorporates findings of the Care Needs Screening (including unmet health-related resource need questions), claims analysis and risk scoring, the Comprehensive Assessment, any available medical records, and other sources as needed.
 6. Each Care Plan shall contain, at a minimum:
 - i. Measurable goals;
 - ii. Medical needs including any behavioral health or dental needs;
 - iii. Interventions including addressing medication management, including adherence;
 - iv. Intended outcomes;
 - v. Social, educational, and other services needed by the Member.

7. The PHP shall ensure that the Care Plan is regularly updated to address gaps in care, incorporating input from care team Members and Member, as part of care management; and that the Care Plan will be comprehensively updated:
 - i. At minimum every twelve (12) months;
 - ii. When a Member's circumstances or needs change significantly;
 - iii. At the Member's request; and/or
 - iv. When a re-assessment occurs.
 8. The PHP shall ensure that each Care Plan is documented and stored and made available to the Member and care team members, including the Member's AMH/PCP.
- b) InCK Consent and Development of Shared Action Plan (SAP)
1. The PHP shall ensure that every InCK attributed Member assigned to SIL 2 and 3 is informed of their eligibility for InCK and shall complete the InCK consent process. The PHP shall enable care team collaboration supported by the InCK model in accordance with the InCK consent process set out in the InCK Performance Measure Technical Specifications Manual.
 2. The PHP shall ensure that the InCK consent process is repeated when initial InCK consents expire and at least every twelve (12) months thereafter for continuing InCK attributed Members assigned to SIL 2 and SIL 3.
 3. The PHP shall ensure that completed InCK consents are transmitted to InCK Integration Consultants via the InCK Integrated Care Platform within seven (7) Calendar Days of completion.
 4. The PHP shall complete a SAP for at least thirty percent (30%) of InCK attributed Members assigned to SIL 3 and ten percent (10%) of InCK attributed Members assigned to SIL 2 for calendar year 2022, with benchmarks to be updated annually by the Department thereafter. The PHP is encouraged to develop SAPs for other Members enrolled in InCK as appropriate to the needs of the Member and the Members' family.
 5. The PHP shall ensure that the SAPs are completed using the standardized format provided by NC InCK, as set out in the InCK Performance Measure Technical Specifications Manual.
 6. The PHP shall ensure that all Care Plan requirements are met regardless of whether or not a SAP is developed. An individual Member may have both a Care Plan and a SAP.
 7. The PHP shall ensure that completed SAPs are transmitted to the Integration Consultant and other care team members consented to by the guardian, using a secure method which may be the InCK Integrated Care Platform, within seven (7) Calendar Days of completion. The PHP shall ensure that any subsequent updates shall also be shared with Integration Consultant and other care team members consented to by the guardian within seven (7) Calendar Days of the update(s).
 8. The PHP shall ensure that all care team members be included on the SAP roster and the SAP roster should be updated and securely distributed based on consent to the guardian and care team by the Family Navigator when changes occur to the care team members.
 9. The PHP shall ensure that the SAP is stored on an electronic platform that is accessible to the Member, family/guardian and care team members and complies with consent for sharing, which could be an Electronic Health Record, the InCK Care Management platform or other care management system. Accessibility to the guardian must include capability for the guardian to print copies of records that can be distributed to the member and/or family as appropriate.
 10. The PHP shall ensure that each InCK attributed Member's SAP is updated at least annually as long as the InCK attributed Member is assigned to SIL 3.

c) Care Management Services

1. The PHP shall provide care management, according to the Care Plan developed, to each high-need Member or through a contracted AMH, consistent with local care management requirements.
2. The PHP shall ensure that care management includes:
 - i. Coordination of physical, behavioral health and social services;
 - ii. Medication management, including regular medication reconciliation and support of medication adherence;
 - iii. Progress tracking through routine care team reviews;
 - iv. Referral follow up;
 - v. Peer support;
 - vi. Training on self-management, as relevant;
 - vii. Transitional care management (as described below), as needed; and
 - viii. For InCK-enrolled Members, additional coordination with school-based supports and services, child welfare, juvenile justice and/or early childhood services, as relevant.
3. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum:
 - i. Use the “NC Resource Platform” to identify community-based resources and connect Members to such resources, to the extent the “NC Resource Platform” is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1.
 - a) The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources.
 - b) The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.
 - ii. Provide in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, at a minimum to:
 - a) Food and Nutrition Services;
 - b) Temporary Assistance for Needy Families;
 - c) Child Care Subsidy;
 - d) Low Income Energy Assistance Program-;
 - e) Women, Infants and Children (WIC);
 - f) Free and Reduced Lunch (FRL); and
 - g) School-based services for children with exceptional needs.
 - iii. Have a housing specialist on staff or on contract who can assist individuals who are homeless in securing housing; and
 - iv. Provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.
4. The PHP shall provide every high-need Member with a designated care manager.
5. The PHP shall establish a multi-disciplinary care team for each high-need Member that consists of, where applicable depending on Member needs:
 - i. The Member;
 - ii. Caretaker(s)/legal guardians;

- iii. AMH/PCP;
 - iv. Behavioral health provider(s);
 - v. Specialists;
 - vi. Nutritionists;
 - vii. Pharmacists and Pharmacy Techs;
 - viii. Community Health Workers;
 - ix. Natural Supports; and
 - x. For InCK-eligible Members assigned to SIL 2 or 3 based on guardian preferences:
 - a) Family Navigator (mandatory);
 - b) School personnel;
 - c) Early childcare and education personnel;
 - d) Child welfare personnel;
 - e) Juvenile Justice personnel; and
 - f) Other service providers or supports designated by the guardian or Member.
6. The PHP shall ensure timely communication across the care team.
 7. The PHP shall ensure that each high-need Member is informed of:
 - i. The nature of the care management relationship;
 - ii. Circumstances under which information will be disclosed to third parties;
 - iii. The availability of the grievance and appeals process as described in Section V.B.6. Member Grievances and Appeals; and
 - iv. The rationale for implementing care management services.
 8. The PHP shall ensure that care managers assist in coordinating access to naloxone for members with an opioid use disorder (e.g., referrals to pharmacy or community organization).
 9. The PHP shall provide the Department with a weekly report on members utilizing IMD-SUD services as defined in *Section VII. Attachment J. Third Revised and Restated Reporting Requirements*. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.
 10. The PHP shall develop policies and procedures to close out the Care Plan process, should the care team determine that the Member no longer requires an ongoing Care Plan. Policies and procedures for closeout shall include Member notification processes.
 - i. Upon termination of an LTSS service that results in the member no longer meeting the LTSS definition, a PHP shall continue to provide care management to the member for a time determined by individual circumstance and documented in the care plan to minimize disruption and ensure continuity of care after the service termination.
 11. For InCK, the PHP shall ensure that every InCK attributed Member assigned to SIL 2 or 3 receives the following InCK care management services, in addition to all other care management requirements in this Section:
 - i. The PHP shall ensure that a dedicated Family Navigator from the Member's AMH/CIN care team, or from the PHP's own staff, as applicable, is assigned to the Member and family.
 - ii. The Family Navigator shall be responsible for:
 - a) Serving as a consistent point of contact for the Member and family;
 - b) Fostering long term support for the Member and family;
 - c) Convening and communication with professionals serving the Member within and beyond healthcare (e.g., education, Child Welfare) on at least a quarterly basis and engaging them in the care team;
 - d) Supporting the Member's care needs including InCK's core child service areas;
 - e) Supporting the development of Shared Action Plans;

- f) Obtaining informed consent from InCK attributed Members and families (including guardian, when appropriate) assigned to SIL 2 and 3 for the following functions:
 - 1) Sharing the SAP with others, if applicable;
 - 2) Ongoing care team coordination to support the Member; and
 - 3) Access to InCK's platform and Member's profile and adhering to the InCK consent process set out in the InCK Performance Measure Technical Specifications Manual.
 - iii. The PHP shall ensure that the Family Navigator serves each Member and family continuously for a full twelve (12) month period, to the greatest extent possible.
 - iv. The PHP shall ensure that the Family Navigator checks in with each InCK-enrolled Member and family at least quarterly, in person or by telephone or video call.
 - v. If the Family Navigator is a different person from the care team member who conducted the Care Needs Screening, Comprehensive Assessment or other Care Management steps, the PHP shall ensure that the Member and Family are clearly introduced to all care team members and their roles, and are introduced to the Family Navigator as the single continuous point of contact.
 - vi. Subject to procurement of informed consent from the Member's family and/or guardian, the Family Navigator shall securely share each InCK Member's (assigned to SIL 2 and 3) Shared Action Plan with the Member, family, care team members and assigned Integration Consultant within seven (7) Calendar Days of completion of the Shared Action Plan.
- d) Transitional Care Management
1. The PHP shall manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. 42 C.F.R. § 438.208(b)(2)(i).
 2. As specified in the Department's Transitions of Care Policy, the PHP shall manage transitions of care for identified Members transitioning between PHPs or between payment delivery systems.
 3. The PHP shall develop policies and procedures for transitional care management consistent with the requirements provider here and in the Department's Transitions of Care Policy.
 4. The PHP shall develop a methodology for identifying Members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:
 - 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; and
 - iv. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the PHP may prioritize.
 5. As part of transitional care management, the PHP shall:
 - i. Outreach to the Member's AMH/PCP and all other medical providers;
 - ii. Facilitate clinical handoffs;
 - iii. Obtain a copy of the discharge plan and verify that the care manager of the Member receives and reviews the discharge plan with the Member and the facility;
 - iv. Ensure that a follow up outpatient and/or home visit is scheduled within a clinically appropriate time window;
 - v. Conduct medication management, including reconciliation, and support medication adherence;

- vi. Ensure that a care manager is assigned to manage the transition;
 - vii. Ensure that the assigned care manager rapidly follows up with the Member following discharge; and
 - viii. Develop a protocol for determining the appropriate timing and format of such outreach.
6. The PHP shall ensure that Comprehensive Assessment is completed and current for all enrollees upon completion of transitional care management, including re-assessment for enrollees already assigned to care management.
 7. The PHP shall have access to an ADT data source that correctly identifies when Members are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.
 8. As part of transitional care management, the PHP shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
 - i. Real time (minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
 - ii. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted to the hospital;
 - iii. Additional outreach within several day days after the alert to address outpatient needs or prevent future problems for other 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).
 9. For InCK attributed Members working with a Family Navigator and experiencing a transition, the PHP shall ensure that the Family Navigator notifies the Member's care team and Integration Consultant of the transition in their role and support the team in continuing to meet the needs of the Member during and after the transition.
- e) HIV Case Management Providers
1. The PHP may contract with existing HIV Case Management providers, at their discretion.
- f) Care Management for individuals receiving or at risk of requiring Long Term Services and Support (LTSS)
1. The PHP shall meet all general care management requirements for Members with LTSS needs and shall meet additional requirements for Members with LTSS needs as described in this subsection and in accordance with 42 C.F.R. § 438.208.
 2. The PHP shall conduct a Comprehensive Assessment for all Members identified as needing LTSS. The PHP shall use a Comprehensive Assessment tool to conduct such assessments that meets all requirements for Comprehensive Assessments given above.
 3. The PHP shall ensure that the care manager may elect to put an interim plan in place to ensure that the Member's needs are met while the Care Plan is developed.
 4. The PHP shall provide transitional care management for Members with LTSS from a nursing facility or other institution that includes outreach to a Member's prior care managers, Member's PCP and all other medical providers. The PHP shall define transition out of an institution as a change in Member circumstance and cause for re-assessment.
 5. The PHP's transitional housing specialist shall ensure that Members using LTSS transitioning from nursing facilities to the community are connected to appropriate housing options as needed.
 6. The PHP shall re-assess Member needs for Members with LTSS needs, and review and revise a Member's care accordingly, at least every twelve (12) months, at the request of the Member, or when the Member's circumstances change. A change in Member circumstances could include an increased need for care, decreased need for care, transition into or out of

an institution, loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance. The PHP shall participate in Department sponsored webinars, trainings and continuing education opportunities about LTSS-related practices and requirements as identified by the Department.

vii. Care Manager Qualifications and Training

- a) The PHP shall ensure that the clinician leading the care team has the minimum credentials of RN or LCSW.
- b) The PHP shall engage appropriate staff on the care team to meet the needs of the Members including medical and behavioral health specialists, pharmacists and pharmacy technicians, peer specialists, navigators, and community health workers.
- c) The PHP shall require that care management staff show competency in areas including:
 1. Person-centered needs assessments and care planning;
 2. Motivational interviewing;
 3. Self-management;
 4. Trauma informed care;
 5. Cultural competency;
 6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
 7. Understanding and addressing Adverse Childhood Experiences (ACEs) and trauma.
- d) Qualifications for care managers for Members with LTSS needs shall meet the minimum requirements defined within this Contract for all other care managers herein and shall additionally include, at a minimum:
 1. Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience;
 2. Prior experience with social work, geriatrics, gerontology, pediatrics, or human services.
- e) The PHP shall ensure that care manager training include at a minimum:
 1. Self-management, including medication adherence strategies;
 2. Motivational interviewing or comparable training;
 3. Person-centered needs assessments and care planning;
 4. Integrated and coordinated physical and behavioral health care;
 5. Execution of Comprehensive Assessments of Members;
 6. Services available only through BH I/DD TPs, BH I/DD TP eligibility criteria, and the process for a Member who needs a service that is available only through BH/IDD Tailored Plans to transfer to a BH I/DD Tailored Plans;
 7. BH crisis response (for care managers with assigned Members with BH needs);
 8. Transitional care management;
 9. Cultural competency, including considerations for Tribal population for PHPs that enroll Tribal members;
 10. Understanding and addressing ACEs, Trauma, and Trauma Informed Care;
 11. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level;
 12. Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children;
 13. Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications) and

14. The State "System of Care" training curriculum (for care managers with assigned Members age three (3) up to age eighteen (18) with BH needs). Request any newly added training requirements identified in amendment 3 be completed within the first year of operation.
 15. Best practices for integrated care for children and families, including supports from child welfare, juvenile justice, early child care and education, and schools.
- f) The PHP shall train care managers for Members with LTSS needs in the training listed herein and additionally in LTSS care management including:
1. Person-centered needs assessment and care planning related to populations with LTSS needs;
 2. Cultural competency for populations with LTSS needs;
 3. Independent living;
 4. Methods for supporting applicable Member to prepare for pending Medicare eligibility and enrollment;
 5. Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission; and
 6. Methods for effectively coordinating with school-related programming and transition-planning activities.
 7. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment, and training Members on proper practices, particularly for Members receiving care in the home or community-based settings, or as Members transition across care settings.
 8. General understanding of virtual (e.g., Telehealth) applications in order to assist Members in using the tools.
- g) The PHP shall ensure that care managers remain conflict-free, which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.
- viii. InCK Family Navigators: The PHP shall train Family Navigators in the training listed herein and additionally in the InCK model, using materials provided by NC InCK, when available, including:
- a) Training for family-centered complete of Shared Action Plan;
 - b) Beneficiary Transition Support;
 1. Health plan changes;
 2. Coverage Lapse;
 3. Aging Out;
 - c) Other training as identified by the Integration Consultant or NC InCK.
 - d) The PHP shall ensure the Family Navigators attend at least sixty percent (60%) of all Family Navigator capacity building events organized by NC InCK each Contract Year.
- j. Section V.C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, ii. General Requirements for Local Care Management is revised to add the following:**
- i) InCK attributed Members assigned to SIL 2 and 3, the PHP shall coordinate with the Member's assigned AMH to ensure assignment of a care manager who undertakes InCK-specific care management practices and care team practices as described herein.

k. Section V.C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, c. Revised Data and Information Sharing to Support Care Management, 2. is revised to add the following:

- vi. For AMH practices participating in InCK, the PHP shall provide InCK participating practices with data as defined in the Advanced Medical Home Provider Manual and Advanced Medical Home Data Specification Guidance, including but not limited to:
 - a) Patient Risk Data:
 - i. The PHP shall use the patient risk interface layout for sharing risk data with AMHs/CINs and include SIL information for InCK beneficiaries.
 - ii. The PHP shall have capability to ingest the patient risk interface from the AMHs/CINs with and without SIL information for InCK beneficiaries.
 - b) InCK Member attribution;
 - c) InCK Member Service Level Integration (SIL) levels; and
 - d) Data related to performance on InCK measures, as applicable.

l. Section V.D. Providers, 1. Provider Network, d. Furnishing of Services (42 C.F.R. § 438.206(c)), i. b) is revised and restated as follows:

- b) The Department may adopt new or amend the Network time and travel distance, appointment wait time, or other adequacy standards from time-to-time through an amendment to the Contract or through formal notice to the PHP from the Department. The PHP shall comply with the new standards as directed by the Department, but the PHP shall have no less than ninety (90) Calendar Days to comply with any new or amended network adequacy standards adopted by the Department.

m. Section V.D. Providers, 1. Provider Network, f. Exception to Network Requirements, iii. is revised and restated as follows:

- iii. In accordance with 42 C.F.R. § 438.68(d)(1), the PHP may request Department approval for an exception to meeting the Department's Network Adequacy Standards in a specific county for a specific provider type and member age (adult or pediatric, as applicable). Requests must:
 - a) Be made in writing;
 - b) Describe efforts to negotiate in good faith;
 - c) Include justification for the exception and a description of how Medicaid Member needs for the specific county and provider type will be met; and
 - d) Include the PHP's plan to address Member needs and remedy the network deficiency, including an estimated timeline to close the network gap.

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

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

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

- iii. Factors used to build the Network, including a description of the Network and how PHP uses the Medicaid Enrolled Provider data supplied by the Department, or the Department's vendor, in its network development and provider contracting process.

p. Section V.D. Providers 1. Provider Network g. Assurances of Adequacy Capacity and Services (42 C.F.R. § 438.207) iv. is revised and restated as follows:

- iv. Ongoing Monitoring and Significant Changes in the Provider Network
 - a) At least once a calendar quarter, the PHP shall monitor its Provider Network for a significant change that would affect adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *Attachment F. Second Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards*.
 - b) The PHP shall report the results of the monitoring for significant change performed during a calendar quarter in the quarterly submission for that calendar quarter of the Network Data Details Extract Report described in *Attachment J. Third Revised and Restated Reporting Requirements*.
 - c) If the PHP determines a significant change has occurred that negatively affects adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards, the PHP shall prepare and concurrently submit the following information to the Department when the PHP submits the quarterly Network Data Details Extract Report that documents the significant change:
 - 1. An updated Network Access Plan, including an updated attestation indicating compliance with or how the PHP will come into compliance with the time/ distance and/or appointment wait time standards established by the Department; and
 - 2. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.

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

- iii. The PHP shall not include any provider (including ordering, prescribing, or referring only providers) in its Medicaid Managed Care Provider Network that is not enrolled in North Carolina Medicaid. If the PHP is made aware of providers included in their network file that are not actively enrolled in NC Medicaid, the PHP shall remove the provider from the PHP network File within one (1) Business Day of notification. The PHP shall remove any provider from the PHP Network File and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider.
 - a. The PHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract.

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

- ii. The PHP shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval (30) days after the Contract Award.
- iii. The PHP shall review and update the Credentialing and Re-credentialing Policy annually, with submission due on October 1st, to reflect changes to applicable federal and state laws, rules and regulations, Department or PHP policies, procedures, bulletins, guidelines or manuals, or PHP business processes as necessary.
- iv. The PHP shall make updates outside of the annual review, if there are substantive updates or revisions that impact provider or PHP business, as determined by the Department or PHP. Updates outside of the annual review are not counted towards the annual review. Only those specific

substantive updates or revisions will be reviewed by the Department outside of the annual review. The PHP shall submit any significant changes to the PHP's Credentialing and Re-credentialing Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.

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

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

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

- a) The first five (5) Contract Years for critical access hospitals and hospitals in economically depressed counties, defined as counties designated in November 2020 as Tier 1 or Tier 2 by the North Carolina Department of Commerce.

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

bb. Provider Hardship Payments

- i. The PHP shall have the capability to process Hardship Payment requests from a provider within seven (7) Business Days of receipt of a hardship request or three (3) Business Days of receipt of an urgent hardship request.
- ii. The PHP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval thirty (30) Calendar Days after amendment execution. The Provider Hardship Payment Policy shall include:
 - a) Method for providers to submit Hardship Payment requests,
 - b) Description of timeline for payment for standard and urgent requests, including integration into check write schedule,
 - c) Criteria for requests to be reviewed and approved by the PHP, and
 - d) Description of how providers and the Department will be notified of status of the request and payment, if applicable.
- iii. The PHP shall recoup Hardship Payments by offsetting the provider's future claim payments or through a one-time repayment by the provider.

cc. InCK Alternative Payment Model (APM)

- i. In Contract Year 2, the PHP shall pay incentive payments to AMHs participating in InCK. Such payments shall be exclusively based on each AMH's performance on the InCK APM measure set forth in the InCK Performance Measure Technical Specifications Manual.
- ii. The PHP shall determine the weighting and dollar amounts to be paid associated with each measure, within guardrails as may be set by the InCK Performance Measure Technical Specifications Manual.

v. Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, e. ii. c) 9-11 is revised and restated as follows:

- 9. Mechanisms to assess and address health disparities;
- 10. The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy; and

11. Mechanisms to assess and address health equity including access to culturally and linguistically appropriate services and a diverse provider pool.

w. Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, e. ii. is revised to add the following:

- d) The Quality Assessment and Improvement Program (QAPI) reporting shall also include Member Advisory Committee (MAC) activity, result summaries, and program assessments of the following:
 1. Mechanisms to collect and assess feedback from the PHP’s Member Advisory Committee;
 2. The PHP’s actions/initiative taken based on Member Advisory Committee’s feedback in alignment with improvement and appropriateness of care provided to Members;
 3. Mechanisms to review member satisfaction and feedback on the member experience with PHP responsiveness to member issues/comments/concerns; and
 4. The PHP shall submit an updated MAC roster of committee members when there are modifications made to the MAC representatives (reference PHP MAC Guidance for MAC member composition requirements). This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUS), etc.

x. Section V.G. Program Operations, 1. Service Lines, b. is revised to add the following:

- vi. **Non-Emergency Medical Transportation (NEMT) Member and Provider Service Lines:** To assist callers in scheduling coordinated, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid enrolled Providers.

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

Second Revised and Restated Section V.G. Table 1: Member and Provider Support Call Center Operations				
Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
i. Member Service Line	1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch) 2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week 3. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
ii. Provider Support Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
iii. Pharmacy Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Prescriber prior authorization services available to meet 24-hour	Yes	Yes	At least thirty (30) Calendar Days prior to Medicaid

	review requirements as defined in Section V. C. 3. Pharmacy Benefits 3. Open all State holidays			Managed Care launch
iv. Nurse Line	1. Twenty-four (24) hours per day / seven (7) days per week / 365 days per year	No	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
v. Behavioral Health Crisis Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	Yes	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
vi. Non-Emergency Medical Transportation (NEMT) Member Service Line	1. Monday - Saturday: 7AM - 6PM ET 2. Open all state holidays	No	No	No later than July 1, 2021
vii. Non-Emergency Medical Transportation (NEMT) Provider Service Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	No	No	No later than July 1, 2021

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

- h. All PHP services lines, with the exception of the NEMT Member and Provider service lines and secondary call centers, shall be able to transfer calls via warm transfer to the Department’s Fee-for-Service Provider and Medicaid call centers, Enrollment Broker, Ombudsman, county DSS or EBCI PHHS offices, and all participating PHPs or LME/MCOs when appropriate and without impacting the capacity to handle in-bound calls simultaneously.
 - i. The warm transfer is required only during the operational hours of the entities listed above in *Second Revised and Restated Section V.G. Table 1: Member and Provider Support Call Center Operations*.
 - ii. If the service line is attempting to connect a Member to another entity that is closed, the PHP shall provide the information on how the caller may contact the entity directly during their operating hours.

aa. Section V.G. Program Operations, 1. Service Lines, m. i. is revised and restated as follows:

- i. The PHP shall relinquish ownership of the toll-free number(s), with the exception of the NEMT Member and Provider and secondary call centers service line numbers, upon Contract termination or expiration, at which time the Department shall take title of these telephone numbers.

bb. Section V.G. Program Operations, 1. Service Lines, n. iii. is revised and restated as follows:

- iii. All service line scripts shall be made available to the Department upon request, and all Member Service Line, Nurse Line, NEMT Member Service Line, and Behavioral Health Crisis Line scripts shall be approved by the Department prior to use or when significant changes are made.

cc. Section V.G. Program Operations, 1. Service Lines is revised to add the following:

- v. Non-Emergency Medical Transportation (NEMT) Member and Provider Service Lines:
 - i. The NEMT Member and Provider service lines shall adhere to logistical, informational, and accessibility requirements as defined in *Section V.C.5. Non-Emergency Medical Transportation*.
- w. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers. The PHP is required to submit a request to the Department for review and approval for a call center used by the PHP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract. The PHP shall not be allowed to request, for Department review and approval, any exceptions for overflow call centers.
 - i. Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the five (5) service lines specified in the Contract.
- x. Gross Customer Abuse
 - i. The PHP shall prohibit gross customer abuse by call center agents across its service lines. Gross customer abuse includes any of the following actions performed by a call center agent, as determined by the Department:
 - a) Use of profanity or vulgar language;
 - b) Yelling or screaming at callers;
 - c) Intentional disconnection with the caller; and
 - d) Negligent or willful misconduct.
 - ii. As part of its call center quality assurance and monitoring approach, the PHP shall monitor its service lines for gross customer abuse and report any identified incidents to the Department. Any complaints received by the PHP from a caller claiming gross customer abuse shall be reported to the Department. The PHP shall report incidents of gross customer abuse to the Department within two (2) Business Days after the incident is reported to or discovered by the PHP, in a format and manner defined by the Department.
 - iii. The Department will monitor service lines for gross customer abuse during call center quality assurance procedures such as call listening observations or investigating external complaints.

dd. Section V.G. Program Operations, 5. Business Continuity, b. xxi. a) 1. ii) is revised and restated as follows:

- ii) Reserved

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

- vii. The Date of Receipt for medical and pharmacy claims shall be the date the PHP receives the claim, as indicated by its date stamp on the claim, and the date of payment for a claim is the date of the check or other form of payment from the PHP to the provider. 42 C.F.R. §§ 447.45(d)(5) and (d)(6).
- viii. A PHP is presumed to have received a written claim in accordance with N.C. Gen. Stat. § 58-3-225(b).

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

- i. National Correct Coding Initiative (NCCI)
 - i. The Department has opted to use the Compatible Medicaid NCCI Methodologies in the Medicaid Managed Care program and share the Non-public Medicaid NCCI Edit Files with the PHPs for processing claims that are paid by the PHP on a Fee-for-Service basis.
 - ii. The PHP shall follow NCCI policies to control improper coding that may lead to inappropriate payments to providers by the PHP.
 - a) The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with the PHP on a quarterly basis, when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
 - 1. Within three (3) Calendar Days of receipt of the edit files, the PHP shall provide written notice to the Department confirming receipt of the files.
 - b) The PHP shall incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the PHP pays on a Fee-for-Service basis. The NCCI editing shall occur prior to current procedure code review and any other editing by the PHP's claims payment systems.
 - c) The PHP shall load the Non-public Medicaid NCCI Edit Files into its claims payment systems upon receipt of the edit files from the Department.
 - 1. The edit files shall be loaded and ready for use by the PHP by no later than 12:00 am on the first day of the calendar quarter in which the edit files are effective.
 - 2. If the PHP experiences issues loading the edit files into its claims payment systems or any other issues with the edit files that prevents the PHP from properly loading the files into its systems, the PHP shall notify the Department within twenty-four (24) hours of identifying the issue.
 - 3. The PHP shall provide written notice to the Department no later than two (2) Calendar Days after the start of each calendar quarter acknowledging that the new Non-public Medicaid NCCI Edit Files in effect for that quarter were properly loaded into its claims payment systems.
 - 4. If the edit files are not properly loaded and ready for use by 12:00 am on the first day of the calendar quarter, the PHP shall reprocess any claim processed without using the Non-public Medicaid NCCI Edits in effect for that quarter. All reprocessed claims are subject to the prompt pay standards, including interest and penalties, specified in the Contract.
 - 5. The PHP shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
 - iii. The PHP and its Subcontractors are subject to the terms and conditions of *Attachment M.11. National Correct Coding Initiative Confidentiality Agreement*.

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

- i. The PHP shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP developed by the Department or its vendor(s) to be provided at Contract Award.

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

- iii. The PHP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Data Submission Guide and Companion Guides – 837I, 837P, and NCPDP.

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

vii. Specifications

- a) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.
- b) Encounters are defined in two (2) groups:
 - 1. Medical, including ILOS, value added services and ECM pilot services
 - 2. Pharmacy, including outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.
- c) The PHP shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
 - 1. The PHP shall have the capability to submit to the Department encounter data from:
 - i. Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
 - ii. Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
- d) The PHP shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.
- e) The PHP, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.
- f) The PHP shall reference the same edit codes as the Department's system, which are defined in the Department's Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.

jj. Section V.H. Claims and Encounter Management, 2. Encounters, e. ix. a) is revised and restated as follows:

a) Timeliness

- 1. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.
- 2. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) calendar days from the claim payment date.

kk. Section V.H. Claims and Encounter Management, 2. Encounters, i. Testing, ii. is revised and restated as follows:

- ii. The PHP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.

II. Section V.I. Financial Requirements is revised to add the following:

7. COVID-19 Vaccination Incentive Program Payments

- a. The Department will establish a COVID-19 Vaccination Incentive Program in accordance with 42 C.F.R. § 438.6(b)(2) and make payments to the PHP in accordance with *Section III.D.32. PAYMENT AND REIMBURSEMENT*. As required by 42 C.F.R. § 438.6(b)(2), the COVID-19 Vaccination Incentive Program is:
 - i. For a fixed period of time and performance is measured during the Contract Year in which the incentive arrangement is applied, as specified in this Section.
 - ii. Not to be renewed automatically.
 - iii. Made available to both public and private PHPs under the same terms of performance.
 - iv. Not conditioned on the PHP entering into or adhering to intergovernmental transfer agreements.
 - v. Necessary for the specified activities and targets outlined in this Section that align with the Department's quality strategy.
- b. The COVID-19 Vaccination Incentive Program will run from when the Gating Target is reached through June 30, 2022.
- c. Once the Gating Target is reached, the PHP will be eligible for the following incentive payments for Members over age eleven (11) that become fully vaccinated after the Gating Target was met:
 - i. One hundred dollars (\$100) for each Member who is from a county where the average vaccination rate for Standard Plan Members is above the state average for Standard Plan Members.
 - ii. One hundred twenty dollars (\$120) for each Member who is from a county where the average vaccination rate for Standard Plan Members is below the state average for Standard Plan Members.
- d. Payments shall be made as follows:
 - i. Payments will be made for any Member who was enrolled with the PHP at the end of the month in which they were fully vaccinated.
 - ii. Payment will be based on the county's Medicaid vaccination rate for Standard Plan Members at the end of the month in which the Member was fully vaccinated.
 - iii. Payments will not exceed \$2,000,000 per PHP during COVID-19 Vaccination Incentive Program period.
 - iv. Payments will be made according to beneficiary vaccination records as documented in the NCIR.
 - v. The Department shall make one (1) payment to the PHP in FY23Q1 for performance through June 30, 2022.
- e. The PHP shall develop and submit to the Department a COVID-19 Vaccination Targeted Improvement Strategy, no later than April 1, 2022, to define the PHP's approach to increasing COVID-19 Vaccination rates. The Strategy shall include:
 - i. Key drivers, planned and data-driven interventions (including Provider Incentives if used), and indicators tracked to increase vaccination rates.
 - ii. Planned interventions address historically marginalized groups and communities and promote equitable outcomes for members.
 - iii. Assurances that provider penalties and withholds will not be part of the strategy.
- f. The Department may adjust COVID-19 Vaccination Incentive Program Gating Target and payment approach based on changes in vaccination rates and updated or new evidenced-based guidance for booster vaccinations and vaccinations for children under the age of 12. The Department will

notify the PHP at least thirty (30) Calendar Days in advance of adjusting program Gating Target and payment approach.

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

- c) The PHP shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law, or criminal justice, or have at least three (3) years of relevant experience.

nn. Section V.K. Technical Specifications, 5. Provider Directory, b. ii. is revised and restated as follows:

- ii. The PHP will, at a frequency defined by the Department, create a full provider directory file including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The PHP will deliver the file to NCTracks based on the defined technical process.

oo. Section V.K. Technical Specifications, 7. PHP Data Management and Health Information Systems, b. is revised and restated as follows:

- b. North Carolina's Health Information Exchange
 - i. The PHP shall submit encounters and claims to North Carolina's Health Information Exchange, known as NC HealthConnex, as required by Article 29B of Chapter 90 of the NC General Statutes, the Statewide Health Information Exchange Act.
 - ii. Pursuant to N.C. Gen. Stat. § 90-414.4(a1)(3), the PHP may authorize the Department to submit the required data to NC HealthConnex on behalf of the PHP.

3. Modifications to Section VI. Contract Performance of the Contract

Specific subsections are modified as stated herein.

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

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
1.	Failure to meet plan readiness review deadlines as set by the Department.	\$5,000 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in <i>Section V.A.9. Staffing and Facilities</i> and <i>Attachment O. 10. Disclosure of Conflicts of Interest</i> .	\$10,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by <i>Attachment O.9. Disclosure of Litigation and Criminal Conviction</i> .	\$1,000 per Calendar Day

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages

No.	PROGRAM ISSUES	DAMAGES
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in <i>Attachment O.9. Disclosure of Ownership Interest.</i>	\$2,500 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in <i>Section V.B.4. Marketing</i>	\$5,000 per occurrence
6.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in <i>Section V.B.2. Medicaid Managed Care Enrolment and Disenrollment.</i>	\$500 per occurrence per Member
7.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in <i>Section V.B.3. Member Engagement.</i>	\$250 per occurrence per Member
8.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in <i>Section V.B.6. Member Grievances and Appeals.</i>	\$500 per occurrence
9.	Reserved.	Reserved.
10.	Failure to comply with all orders and final decisions relating to claim disputes, appeals and/or State Fair Hearing as issued or as directed by the Department.	\$5,000 per occurrence
11.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in <i>Section V.B.6. Member Grievances and Appeals.</i>	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND \$500 per Calendar Day for each day the PHP fails to provide continuation or restoration as required by the Department.
12.	Failure to attend mediations and hearings as scheduled as specified in <i>Section V.B.6. Member Grievances and Appeals.</i>	\$1,000 for each mediation or hearing that the PHP fails to attend as required
13.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	\$5,000 per occurrence per Member

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages

No.	PROGRAM ISSUES	DAMAGES
14.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified <i>Section V.C.1. Medical and Behavioral Health Benefits Package and V.C.3. Pharmacy Benefits.</i>	\$5,000 per standard authorization request \$7,500 per expedited authorization request
15.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified <i>Section V.D.1. Provider Network.</i>	\$1,000 per occurrence
16.	Failure to follow Department required Clinical Coverage Policies as specified <i>Section V.C.1. Medical and Behavioral Health Benefits Package.</i>	\$2,500 per occurrence
17.	Failure to timely update pharmacy reimbursement schedules as required by as specified <i>Section V.C.3. Pharmacy Benefits.</i>	\$2,500 per Calendar Day per occurrence
18.	Failure to comply with Transition of Care requirements as specified <i>Section V.C.4. Transition of Care.</i>	\$100 per Calendar Day, per Member AND The value of the services the PHP failed to cover during the applicable transition of care period, as determined by the Department.
19.	Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified <i>Section V.C.5. Non-Emergency Transportation.</i>	\$500 per occurrence per Member
20.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	\$1,500 per occurrence per driver
21.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	\$250 per occurrence per Member
22.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	\$1,500 per Calendar Day per vehicle
23.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	\$250 per Calendar Day
24.	Reserved.	Reserved.
25.	Reserved.	Reserved.
		Reserved.
		Reserved.
26.	Reserved.	Reserved.
27.	Reserved.	Reserved.
28.	Reserved.	Reserved.
29.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with a LHD.	\$500 per Calendar Day

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages

No.	PROGRAM ISSUES	DAMAGES
30.	Failure to implement and maintain an Opioid Misuse Prevention Program as described in <i>Section V.C.7. Prevention and Population Health Management Program.</i>	\$2,000 per Calendar Day for each day the Department determines the PHP is not in compliance with the Opioid Misuse Prevention Program requirements
31.	Failure to update online and printed provider directory as required by <i>Section V.D.2. Provider Network Management.</i>	\$1,000 per provider, per Calendar Day
32.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by <i>Section V.D.2. Provider Network Management.</i>	\$100 per Calendar Day per Member for failure to timely notify the affected Member
33.	Reserved.	Reserved.
34.	Failure to notify a provider of the network contracting decision within five (5) Business Days of verification of the provider's status as a Medicaid Enrolled provider.	\$50 per Calendar Day per provider
35.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in <i>Section V.D.1. Provider Network</i> (excludes Department approved exceptions to the network adequacy standards).	\$2,500 per month for failure to meet any of the listed standards, either individually or in combination
36.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	\$250 per Calendar Day
37.	Failure to maintain accurate provider directory information as required by <i>Section V.D.2. Provider Network Management.</i>	\$100 per confirmed incident
38.	Failure to timely provide notice to the Department of capacity to serve the PHP's expected enrollment as described in <i>Section V.D.1. Provider Network.</i>	\$2,500 per Calendar Day
39.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$5,000 per Calendar Day
40.	Failure to timely submit appropriate PIPs to the Department as described in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$1,000 per Calendar Day
41.	Failure to timely submit QAPI to the Department as described in <i>Section V.E.1. Quality Management and Quality Improvement.</i>	\$1,000 per Calendar Day

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
42.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in <i>Section V.A.3. National Committee for Quality Assurance (NCQA) Association.</i>	\$100,000 per month for every month beyond the month NCQA accreditation must be obtained
43.	Failure to timely submit monthly encounter data set certification.	\$1,000 per Calendar Day
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Attachment J: Third Revised and Restated Reporting Requirements.</i>	\$2,000 per Calendar Day
45.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in <i>Section V.I.2 Medical Loss Ratio</i> and <i>Attachment J. Third Revised and Restated Reporting Requirements.</i>	\$2,000 per Calendar Day
46.	Failure to timely and accurately submit monthly financial reports in accordance with <i>Attachment J: Third Revised and Restated Reporting Requirements</i> or comply with any other ad-hoc request for financial reporting as directed by the Department.	\$1,000 per Calendar Day
47.	Failure to establish and maintain a Special Investigative Unit as described in <i>Section V.J.3. Fraud, Waste and Abuse Prevention.</i>	\$5,000 per Calendar Day that the Department determines the PHP is not in compliance
48.	Failure to timely submit on an annual basis the Compliance Program report as described in <i>Section V.J.1. Compliance Program</i> and <i>Attachment J: Third Revised and Restated Reporting Requirements.</i>	\$1,000 per Calendar Day
49.	Failure to timely submit the Recoveries from Third Party Resources Report described in <i>Section V.J.4. Third Party Liability</i> and <i>Attachment J: Third Revised and Restated Reporting Requirements</i>	\$250 per Calendar Day
50.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$2,500 per incident for failure to fully cooperate during an investigation
51.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	\$250 per Calendar Day

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages

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

Third Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	PROGRAM ISSUES	DAMAGES
60.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	\$500 per Calendar Day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action
61.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	\$500 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
62.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	\$1,000 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
63.	Failure to implement and maintain a Member Lock-In Program as described in <i>Section V.C.7. Prevention and Population Health Management Program</i> .	\$500 per calendar day per member that the PHP is not meeting Lock-In Requirements outlined in <i>Section V.C.7 Prevention and Population Health Management Program</i> and N.C. Gen. Stat. § 108A-68.2.
64.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PHP Network File within one (1) Business Day as specified in <i>Section V.D.2. Provider Network Management</i> .	\$1,000 per provider per business day
65.	Engaging in gross customer abuse of Members by PHP service line agents as prohibited by <i>Section V.G.1. Service Lines</i> .	\$1,000 per occurrence
66.	Failure to timely report incidents of gross customer abuse to the Department in accordance with <i>Section V.G.1. Service Lines</i> .	\$250 per Business Day the PHP fails to timely report to the Department.

b. Section VI.A. Technical Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, vi. Payment of Liquidated Damages and other Monetary Sanctions, a) is revised and restated as follows:

- vi. Payment of Liquidated Damages and other Monetary Sanctions
 - a) If the Contractor elects not to appeal the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within fifteen (15) Calendar Days of the date on the written notice assessing the liquidated damages or other monetary sanctions.

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

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Monthly	\$1,000 per eligibility file that does not meet the submission guidelines of the eligibility file.
2.	Member Appeals Resolution -Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	\$10,000 per month
3.	Member Appeals Resolution - Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	\$10,000 per month
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	\$5,000 per month
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	\$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls	Monthly	\$5,000 per service line per month
7.	Call Response Time/Call Answer Timeliness -Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
8.	Call Wait/Hold Times - Member Services line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
9.	Call Abandonment Rate – Member Services line	The abandonment call rate shall not exceed five percent (5%)	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$10,000 per month
10.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	\$15,000 per month
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The PHP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$15,000 per month
12.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	\$15,000 per month
13.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	\$10,000 per month
14.	Call Wait/Hold Times - Nurse Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$10,000 per month
16.	Call Response Time/Call Answer Timeliness -Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$5,000 per month
19.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
20.	Call Wait/Hold Times - Pharmacy Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
21.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	\$10,000 per month

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
22.	Encounter Data Timeliness/ Completeness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	\$50 per claim per Calendar Day
23.	Encounter Data Timeliness/ Completeness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	\$100 per claim per Calendar Day
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	\$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	\$50,000 per week
26.	Encounter Data Reconciliation - Pharmacy	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within thirty (30) Calendar Days or at least ninety-nine point eight (99.8%) of paid claim amounts reported on financial reports within sixty (60) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	\$100,000 per month
27.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	\$2,500 per occurrence
28.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	\$2,500 per month

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
29.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	\$100 per occurrence (each communication outside of the standard for the month)
30.	Encounter Data Reconciliation - Medical	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine point eight (99.8%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	\$10,000 per month
31.	Call Response Time/Call Answer Timeliness – NEMT Member Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
32.	Call Wait/Hold Times – NEMT Member Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
33.	Call Abandonment Rate – NEMT Member Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$10,000 per month
34.	Call Response Time/Call Answer Timeliness – NEMT Provider Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
35.	Call Wait/Hold Times – NEMT Provider Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Third Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
36.	Call Abandonment Rate – NEMT Provider Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$10,000 per month

4. Modifications to Section VII. Attachments A-N of the Contract

Specific attachments and subsections are modified as stated herein.

- a. **Attachment 1: Section VII. Attachment A. Table 1: PHP Organization Roles and Positions** is revised and restated in its entirety to incorporate educational requirements for SUI and add defined roles and requirements for InCK as set forth in Attachment 1, *Attachment A. First Revised and Restated PHP Organization Roles and Positions* to this Amendment.
- b. **Attachment 2: Section VII. Attachment G. Second Revised and Restated Required Standard Provisions for PHP and Provider Contracts** is revised and restated in its entirety to incorporate InCK and Healthy Opportunities requirements as set forth in Attachment 2, *Attachment G. Third Revised and Restated Required Standard Provisions for PHP and Provider Contracts* to this Amendment.
- c. **Attachment 3: Section VII. Attachment H. Second Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers** is revised and restated in its entirety incorporate DHHS reimbursement requirements as set forth in Attachment 3, *Attachment H. Third Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers. Medicaid Managed Care Addendum for Indian Health Care Providers* to this Amendment.
- d. **Attachment 4: Section VII. Attachment I. First Revised and Restated Provider Appeals** is revised and restated in its entirety to incorporate single case agreement requirements as set forth in Attachment 4, *Attachment I. Second Revised and Restated Provider Appeals* to this Amendment.
- e. **Attachment 5: Section VII. Attachment J. Second Revised and Restated Reporting Requirements** is revised and restated in its entirety to address Healthy Opportunities, NEMT, quality and finance reporting requirements as set forth in Attachment 5, *Attachment J. Third Revised and Restated Reporting Requirements* to this Amendment.
- f. **Attachment 6: Section VII. Attachment M.11. National Correct Coding Initiative Confidentiality Agreement** is added to the Contract to incorporate the requirements for National Correct Coding Initiative Confidentiality as set forth in Attachment 6, *Section VII. Attachment M.11. National Correct Coding Initiative Confidentiality Agreement* to this Amendment.
- g. **Attachment 7: Section X. Summary of Contractual Payment and Risk Sharing Terms** is revised and restated in its entirety to incorporate rates effective November 1, 2021, as set forth in Attachment 7, *Second Revised and Restated Summary of Contractual Payment and Risk Sharing Terms* to this Amendment.

5. Effective Date

This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

6. Other Requirements

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

Execution:

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

Department of Health and Human Services

Dave Richard, Deputy Secretary

Date: _____

PHP Name

PHP Authorized Signature

Date: _____

Attachment 1

Attachment A: First Revised and Restated Table 1: PHP Organization Roles and Positions

The Department requires that the PHP also staff the following roles to fulfill the requirements of in the North Carolina Medicaid Managed Care Program.

First Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1. Implementation and Readiness Review Staff	These individuals will carry out the implementation and readiness review terms of the contract.	<ul style="list-style-type: none"> • N/A
2. Full-Time Member Services Staff	These individuals will coordinate communication with Members.	<ul style="list-style-type: none"> • Must reside in North Carolina
3. Member Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates Member complaints, grievances and appeals in a timely manner.	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program
4. Full-Time Member Complaint, Grievance, and Appeal Staff	These individuals will work to resolve Member complaints, grievances and appeals in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> • Must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals for
5. Full-Time Utilization Management Staff	These individuals will conduct utilization management activities, including but not limited to prior authorization, concurrent review and retrospective review.	<ul style="list-style-type: none"> • Shall be NC-licensed nurses and/or licensed behavioral health professionals in good standing
6. PBM Liaison	If the PHP partners with a third-party PBM, this individual will serve as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	<ul style="list-style-type: none"> • N/A
7. Care Management Supervisor	This individual shall be responsible for all staff and activities related to the care management program, and shall be responsible for ensuring the functioning of care management activities across the continuum of care.	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program • Care Manager for behavioral health services is NC-licensed LCSW in good standing

First Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<ul style="list-style-type: none"> Care Manager for medical services is a NC-licensed registered nurse in good- standing
8. Full-Time Care Managers	This individual shall be responsible for conducting all functions and activities of the care management program and serve as the lead for each care management teams.	<ul style="list-style-type: none"> Must reside in North Carolina Must be licensed practitioners Must be supervised by an RN, LCSW, or psychologist with trauma-based experience and training
9. Care Management Staff	As part of the care management team, these individuals shall be responsible for conducting all functions and activities of the care management program.	<ul style="list-style-type: none"> Must reside in North Carolina Care management staff may include social workers, community health workers and peers
10. Behavioral Health (BH) Managers and Full-Time BH Staff	These individuals shall be responsible for integrating into the clinical and care management teams to ensure Member’s behavioral health needs are fully integrated into the service delivery system.	<ul style="list-style-type: none"> Must reside in North Carolina Experience working in behavioral health managed care and clinical setting Licensed behavioral health professional practicing within their scope
11. Full-Time Care Management Housing Specialist	This individual(s) will assist Members who are homeless in securing housing.	<ul style="list-style-type: none"> Must reside in North Carolina
12. Full-Time Care Management Transition Staff	These individuals will assist Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.	<ul style="list-style-type: none"> Must reside in North Carolina
13. Provider Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	<ul style="list-style-type: none"> Must reside in North Carolina Fully dedicated to the North Carolina Medicaid Managed Care program

First Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
14. Provider Relations and Call Center Staff	These individuals will coordinate communications between the PHP and providers.	<ul style="list-style-type: none"> • Must reside in North Carolina
15. Pharmacy Director for the Pharmacy Service Line	This individual will oversee all Pharmacy Service Line staff management and ensure the team meets the requirements of the Contract.	<ul style="list-style-type: none"> • NC registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
16. Pharmacy Technician Supervisor for the Pharmacy Service Line	This individual will ensure Pharmacy Service Line staff are trained on and compliant with pharmacy clinical coverage policies, prior authorization (PA) requirements, and drug formularies/preferred drug lists.	<ul style="list-style-type: none"> • Certified Pharmacy Technician registered with the NC Board of Pharmacy • Minimum of three (3) years of pharmacy benefits call center experience
17. Liaison between the Department and the North Carolina Attorney General's Medicaid Investigation Division	This individual will serve as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	<ul style="list-style-type: none"> • Must reside in North Carolina
18. Special Investigations Unit (SIU) Lead	This individual shall lead the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate the Department and OCPI, as well as ensure timely resolution of investigation.	<ul style="list-style-type: none"> • Fully dedicated to the North Carolina Medicaid Managed Care Program Funded from the North Carolina Medicaid budget
19. Special Investigations Unit (SIU)	These individuals will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	<ul style="list-style-type: none"> • Associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice or have at least three (3) years of relevant experience.

First Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
20. Tribal Provider Contracting Specialists	These individuals shall be trained in IHCP requirements and accountable to developing necessary tribal networks.	<ul style="list-style-type: none"> • Must reside in North Carolina
21. Liaison to the Division of Social Services	This individual will serve as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serve as a primary contact to triage and escalate Member specific or PHP questions.	<ul style="list-style-type: none"> • Must reside in North Carolina
22. InCK Integration Consultant	This individual will support care teams in implementing InCK by providing consultations to support Family Navigators on topics including but not limited to resource navigation across core child service areas, trainings, and connections to help InCK participant meet goals of Shared Action Plan. The Integration Consultant also advises InCK leadership on key components of the model.	<ul style="list-style-type: none"> • Must reside in North Carolina • 1.0 FTE required per PHP • Must have clinical experience (e.g. Care Manager, RN, BSW, LPN, MSW). • Must be selected through collaborative process with NC InCK Managing Director and Operations and Strategy Director
23. InCK Family Navigator	This individual will be a designated care team member assigned to support an InCK member's (assigned to SIL 2 and SIL 3) care integration needs.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must have clinical experience (e.g. Care Manager, RN, MSW, LPN, BSW)

Attachment 2

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

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

1. Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following:

- a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
- b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
 - i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
- c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
- e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the PHP's insolvency the contract must address:
 1. Transition of administrative duties and records; and
 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

- f. **Credentialing:** The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
 - i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
 - ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 - 1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
 - 2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. **Liability Insurance:** The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.
- h. **Member Billing:** The contract must address the following:
 - i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and
 - ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- i. **Provider Accessibility.** The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.
- j. **Eligibility Verification.** The contract must address the PHP's obligation to provide a mechanism that allows providers to verify Member eligibility, based on current information held by the PHP, before rendering health care services.

- k. Medical Records. The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
 - i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;
 - ii. Maintain adequate medical and other health records according to industry and PHP standards; and
 - iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
- l. Member Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.
- m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).
- n. Data to the Provider: The contract must address the PHP's obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.
- o. Utilization Management: The contract must address the provider's obligations to comply with the PHP's utilization management programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- p. Provider Directory: The provider's authorization and the PHP's obligation to include the name of the provider or the provider group in the provider directory distributed to Members.

- q. Dispute Resolution: Any process to be followed to resolve contractual differences between the PHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.D.5. Provider Grievances and Appeals*.
- r. Assignment: Provisions on assignment of the contract must include that:
 - i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.
 - ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
- s. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- t. Interpreting and Translation Services: The contract must have provisions that indicate:
 - i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
 - ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
 - iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.
- u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
- v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.
- w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care

Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

- x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- y. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in Section V.D.4. of the PHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PHP shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Attachment H. Third Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the PHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.
- z. Clinical Records Requests for Claims Processing: the contract shall indicate that the PHP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.
- aa. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PHP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for

authorization within three (3) business days of concluding the authorized outpatient procedure.

- bb. Physician Advisor Use in Claims Dispute: The contract must indicate that the PHP shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.
- cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:
 - i. The Designated Pilot Care Management Entity shall:
 - a) Utilize NCCARE360 for functions outlined in *PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.*
 - b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*
 - c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.
 - d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot.*
 - e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals, i. Provider Complaints related to the Healthy Opportunities Pilot.*
 - f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*
 - ii. The PHP shall:
 - a) Make fixed Per Member Per Month (PMPM) Pilot care management payments to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined *PHP Contract Section V.D.4 Provider Payments, w. Healthy Opportunities Pilot Payments, ii. Care Management Payments.*
 - b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.
 - iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.

- dd. Healthy Opportunities Network Leads: The PHP must contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as noted in Section V.D.1.c.vi, using a Department-standardized PHP-Network Lead model contract, to access the Network Lead's network of Pilot providers, also referred to as Human Service Organizations (HSOs).
- ee. Advanced Medical Home InCK: For all Advanced Medical Homes participating in the InCK program, a provision that outlines the InCK model and requirements that is consistent with the Advanced Medical Home Manual. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's InCK Program.

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

- a. Attachment M. 2. Advanced Medical Home Program Policy
- b. Attachment M. 3. Pregnancy Management Program Policy
- c. Attachment M. 4. Care Management for High-Risk Pregnancy Policy
- d. Attachment M. 5. Care Management for At-Risk Children Policy
- e. Advanced Medical Home Manual

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

- a. Compliance with State and Federal Laws

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

- b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to provider records

The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [PHP and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [PHP and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

- i. The United States Department of Health and Human Services or its designee;*
- ii. The Comptroller General of the United States or its designee;*
- iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee*
- iv. The Office of Inspector General*

- v. *North Carolina Department of Justice Medicaid Investigations Division*
- vi. *Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;*
- vii. *The North Carolina Office of State Auditor, or its designee*
- viii. *A state or federal law enforcement agency.*
- ix. *And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.*

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

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

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

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

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

- x. *For Medical claims (including behavioral health):*

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

3. *A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.*
- xi. *For Pharmacy Claims:*
 1. *The [Company] shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.*
 2. *A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.*
 - xii. *If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).*
 1. *The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).*
 - xiii. *If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.*
 - xiv. *Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.*
 - xv. *The [Company] shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require the [Provider] to request the interest or the penalty.*

h. **Contract Effective Date.**

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

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

Attachment 3

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

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.¹

2. Definitions.

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

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

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

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

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

(c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R.

¹ Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

§ 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.

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

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

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

(h) “Urban Indian organization” has the meaning given in the IHCA 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 IHCA.

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

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

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

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

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

6. Agreement to Pay IHCP.

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

(b) The State shall make a supplemental payment to the IHCP to make up the difference between the amount the PHP pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the PHP is less than the amount they would have received under FFS or the applicable encounter rate.

7. Persons Eligible for Items and Services from IHCP.

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

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

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

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

9. Non-Taxable Entity.

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

10. Insurance and Indemnification.

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

(b) **Indian Tribes and Tribal Organizations.** A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means

the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

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

11. Licensure and Accreditation.

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

12. Dispute Resolution.

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

13. Governing Law.

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

14. Medical Quality Assurance Requirements.

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

15. Claims Format.

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the 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.

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

17. Hours and Days of Service.

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

18. Coordination of Care/Referral Requirements.

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

19. Sovereign Immunity.

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

20. Endorsement.

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

APPROVALS

For the Managed Care Plan:

For the IHCP:

Date: _____

Date: _____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS that is an IHCP:

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

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

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

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

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

Attachment 4

Attachment I. Second Revised and Restated Provider Appeals

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

Section VII. Attachment I. Second Revised and Restated Table 1: Provider Appeals	
Reference Number	Appeal Criteria
For Network Providers	
1	<p>A network provider has the right to appeal certain actions taken by the PHP. Appeals to the PHP shall be available to a network provider for the following reasons:</p> <ul style="list-style-type: none">a) Program Integrity related findings or activities;b) Finding of fraud, waste, or abuse by the PHP;c) Finding of or recovery of an overpayment by the PHP;d) Withhold or suspension of a payment related to fraud, waste, or abuse concerns;e) Termination of, or determination not to renew, an existing contract for LHD care/case management services;f) Determination to lower an AMH provider's Tier Status; andg) Violation of terms between the PHP and provider.
For Out-of-network Providers	
2	<p>An out-of-network provider may appeal certain actions taken by the PHP. Appeals to the PHP shall be available to an out-of-network provider for the following reasons:</p> <ul style="list-style-type: none">a) An out-of-network payment arrangement such as a single-case agreement;b) Finding of waste or abuse by the PHP; andc) Finding of or recovery of an overpayment by the PHP.

Attachment 5

Attachment J. Third Revised and Restated Reporting Requirements

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

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

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

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

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

m. Monthly PHP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems.
n. COVID-19 Vaccine Incentive Program Report	Monthly report to include cumulative Member level details on COVID-19 Vaccination Member Incentive Program, including Member information, vaccine provider data, incentives provided and expenditures.
3. Benefits and Care Management	
a. Institute of Mental Disease (IMD) Report	Alternate-week report providing the prior two calendar weeks' summary of members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provide NPI, facility admission date and facility discharge date.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.
c. ProDUR Alert Report	Quarterly report highlighting prospective alerts and responses for pharmacy claims.
d. Top GSNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.
e. Ad Hoc and Trigger Report	Quarterly report containing activities and adhoc report, summary of total paid claims, and trigger report with comparison of top 200 GC3s by claim count.
f. EPSDT Report	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.
g. Non-Emergency Medical Transportation (NEMT) Report	Monthly report highlighting the NEMT utilization, monthly requests received, processed, denied and open where the date of service falls within the reporting range.
h. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.
i. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs.
j. Healthy Opportunities Pilot Key Metrics Report	Quarterly report of Healthy Opportunities Pilot key metrics including, at a minimum, Members served, services used, total service delivery costs, and member cost and utilization metrics related to the Healthy Opportunities Pilots.

k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management payments.
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. AMH Integration Contracting Report	Monthly AMH Tier 3 practices contracting and integration status report
p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. High Needs Members Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members.
s. Crossover-Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.
t. Quarterly Admission and Readmission Report	Quarterly summary report of admission and readmission trends.
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
y. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PHP may submit if the Department notifies the PHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PHP's anticipated spending through the remainder of the Pilot service delivery year.
z. Healthy Opportunities Pilot Service Delivery Report	Monthly report of PHP Pilot service delivery spending.

aa. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
bb. Healthy Opportunities Pilot Care Management Payment Report	Monthly report of PHP spending on care management payments.
cc. Designated Care Management Entity NCCARE360 Onboarding Report	Quarterly report of NCCARE360 onboarding status of Designated Care Management Entities and Designated Pilot Care Management Entities.
dd. Healthy Opportunities Pilot Directing Pilot Services to High-Priority Populations Report	Quarterly report beginning in Pilot Service Delivery Year 2 on Pilot enrollment and how the PHP has directed Pilot services to high-priority populations.
ee. Healthy Opportunities Pilot Compliance Report	Quarterly report on Healthy Opportunities Pilot compliance activities.
4. Providers	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.
c. Network Adequacy Exceptions Narrative Report	Quarterly narrative report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with PRV001-J Network Adequacy Exceptions Report
d. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy.
e. Provider Contracting Determinations and Activities Report	Quarterly and ad hoc report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods.

f. Provider Contracting Determinations and Activities Narrative Report	Quarterly and ad hoc narrative report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with PRV005-J: Provider Contracting Determinations and Activities Narrative Report.
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Essential Provider Alternate Arrangements Narrative Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy. To be submitted with the Essential Alternate Arrangements Report.
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. RESERVED	Reserved.
n. Provider Grievances, Appeals, and Litigated Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.

p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Suspended and Terminated Providers Report	Monthly report showing suspended claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. PHP shall reinstate payment to the provider upon notice that

	the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Referenced in V.D.2.j.i.a / V.D.2.j.i.b.
y. UNC Vidant Hospital Directed Payment Report Data – Outpatient	Quarterly report to collect claims data to support outpatient directed payments to UNC / Vidant Hospitals.
z. UNC Vidant Hospital Directed Payment Report Data – Inpatient	Quarterly report to collect claims data to support inpatient directed payments to UNC / Vidant Hospitals.
aa. NEMT Annual Review Report	Annual report confirming that the vendor has completed the annual review of all Non-Emergency Medical Transportation providers and they are in compliance with the requirements outlined in the NEMT policy. The report identifies findings and any actions taken by the responsible agency.
5. Quality and Value	
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. VBP Assessment	Annual retrospective report documenting VBP contracts in place and payments made under VBP arrangements.
d. VBP Strategy Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming Contract Year. These templates should be included in PHPs’ VBP Strategies submitted to the Department annually.
e. VBP Strategy Narrative Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming year. These templates should be included in PHPs’ VBP Strategies submitted to the Department annually. To be submitted with VBP Strategy Templates.
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Eligible Mothers for Low Birth Weight Extract	Eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.
6. Stakeholder engagement	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.

b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. Program Administration	
a. Service Line Report	Quarterly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
d. Secondary Call Center Service Line Report	Monthly secondary call center service line utilization and statistics.
8. Compliance	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
g. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint,

	description of allegation/complaint, how complaint identified, issues, and resolution.
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. IV.4.d.
9. Financial Requirements	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template.
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.
d. NC PHP Claims Monitoring Report	Weekly summary of claims that have been received, paid, pending, rejected, and denied by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount.
e. PHP Mass Adjustment Supplemental Information Report	Ad hoc report required in the event that a provider escalates a complaint or grievance related to PHP Mass Adjustment processing. The PHP must complete required information within the report for the Department to validate appropriate Mass Adjustment of Claims was completed

Attachment 6

Attachment M.11. National Correct Coding Initiative Confidentiality Agreement

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL CORRECT CODING INITIATIVE EDITS CONFIDENTIALITY AGREEMENT

This Agreement is made effective the 25th of February, 2022, by and between the North Carolina Department of Health and Human Services, Division of Health Benefits (“Department”) and **Plan Name** (“Contractor”). The Department and Contractor may be collectively referred to as the “Parties.”

I. BACKGROUND

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and is intended to reduce improper coding that may result in inappropriate payments of Medicare Part B claims and Medicaid claims. In 2010, Section 6507 of the Patient Protection and Affordable Care Act amended Section 1903(r) of the Social Security Act and required CMS to notify state Medicaid agencies of the NCCI Methodologies used in the Medicare Part B program that were compatible with Medicaid. As of October 2010, state Medicaid agencies have been required to incorporate the Compatible Medicaid NCCI Methodologies in their systems for processing applicable Medicaid Fee-for-Service (FFS) claims which are submitted with, and reimbursed on the basis of, Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes from the following types of providers: (1) practitioners and ambulatory surgical centers; (2) services provided to outpatients in hospitals (including services rendered in emergency rooms, observation units, laboratories, and radiology departments, and other diagnostic and therapeutic services); and (3) providers of durable and home medical equipment.

The implementation of the NCCI Edits is mandatory for all Medicaid FFS programs, but the application of the Compatible Medicaid NCCI Methodologies to FFS claims processed by managed care organizations within states’ Medicaid managed care programs is optional. In accordance with federal law, the Department has implemented the Compatible Medicaid NCCI Methodologies into its FFS program, NC Medicaid Direct, and has opted to use the Compatible Medicaid NCCI Methodologies its Medicaid Managed Care program and share the Non-public State Medicaid NCCI Edit Files, provided by CMS to the Department, with the Prepaid Health Plans (PHPs) for processing claims that are paid by the PHPs on a FFS basis.

II. PURPOSE

This Agreement sets forth the terms and conditions under which the Department will share with Contractor the Non-public State Medicaid NCCI Edit Files posted by CMS on a quarterly basis to the secure Regional Information Sharing Systems (RISSNET) portal that is only accessible to state Medicaid agencies. The Agreement further specifies Contractor’s obligations for use and disclosure of the Non-public State Medicaid NCCI Edit Files once provided to Contractor by the Department.

III. DEFINITIONS

1. **Compatible Medicaid NCCI Methodologies.** The six NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for

practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology with medically unlikely edits for durable medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.

2. **Contracted Parties.** Any contractor or subcontractor (including Commercial Off-the-Shelf (COTS) software vendors) which assist Contractor with implementation of claims processing or encounter data, and who must use the Non-public Medicaid NCCI Edit Files for processing purposes.
3. **National Correct Coding Initiative (NCCI).** The CMS-developed coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
4. **NCCI Edits.** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) MUEs, or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
5. **NCCI Methodologies.** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
6. **Non-public Medicaid NCCI Edit Files.** The quarterly Medicaid NCCI edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure RISSNET portal.

VI. AGREEMENT

The Parties agree to the following provisions of this Agreement:

1. **USE AND DISCLOSURE**

- a. The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with Contractor when available, but no later than ten (10) calendar days after the files have been made available by CMS.
- b. Contractor is required to incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the Contractor pays on an FFS basis. The NCCI editing should occur prior to current procedure code review and any other editing by the Contractor's claims payment systems.
- c. Contractor agrees to use any non-public information from the Non-public Medicaid NCCI Edit Files only for business purposes directly related to the implementation of the Compatible Medicaid NCCI Methodologies in the State of North Carolina.
- d. Except as otherwise permitted in this Agreement, after the start of the calendar quarter, Contractor may disclose only nonconfidential information that is also available to the general public about the Non-public Medicaid NCCI Edit Files found on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
- e. Contractor may share the Non-public Medicaid NCCI Edit Files with a Contracted Party assisting with the implementation of the State's Medicaid NCCI program in the processing of claims or encounter data, only after execution of the appropriate confidentiality agreements that include

the same restrictions on use and disclosure as contained herein. Such agreements with any Contracted Party shall be provided to the Department upon request.

2. RESTRICTIONS ON USE AND DISCLOSURE

- a. Except as permitted by this Agreement, Contractor shall not disclose, publish, or share with any party, not involved in the implementation of the Compatible Medicaid NCCI Methodologies covered by this Agreement, the Non-public Medicaid NCCI Edit Files.
 - b. Contractor shall not publish or otherwise share new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edits Files with individuals, medical societies, or any other entities, unless it is a Contracted Party, prior to the posting of the Medicaid NCCI Edits on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
 - c. Contractor shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
 - d. Contractor shall not release to the public any non-public information contained in the Non-public Medicaid NCCI Edit Files, at any time. Only the Department shall have the discretion to release additional information for selected individual edits or limited ranges of edits from the files posted on the secure RISSNET portal.
 - e. Contractor shall not use the Non-public Medicaid NCCI Edit Files for any non-Medicaid purpose, at any time.
- 3. REPORTING.** Contractor shall report in writing to the Department any unauthorized access, uses, or disclosures of the Non-public Medicaid NCCI Edit Files by Contractor, or by its Contracted Party, within twenty-four (24) hours after it becomes aware of the unauthorized access, use, or disclosure. Notice shall be provided to the Department Contract Administrators in accordance with the terms and conditions of *Section III.D.11. Contract Administrators* of the Contract which are incorporated herein by reference. In addition, Contractor shall reasonably cooperate with the Department to mitigate the damage or harm of any such incidents of unauthorized access, use, or disclosure of the Non-public Medicaid NCCI Edit Files.

4. GENERAL TERMS AND CONDITIONS.

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. The Department may impose remedial actions, intermediate sanctions, liquidated damages and/or terminate the Contract in accordance with the terms and conditions of *Section III.D.46. Termination* and *Section VI. Contract Performance* of the Contract, which are incorporated herein by reference, for violations of this Agreement.

5. TERM AND TERMINATION:

- a. **Term.** This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract expires or terminates, whichever occurs first.
- b. **Termination Without Cause.** The Department may terminate this Agreement without cause by providing thirty (30) calendar days written notice of the termination to Contractor.

- c. **Termination for Cause.** Any use of the Non-public Medicaid NCCI Edit Files, except as contemplated under this Agreement or approved in writing by the Department, shall be a violation of the Agreement and any such violation shall be considered a material breach of the Agreement. A material breach of this Agreement by Contractor shall be considered sufficient basis for the Department to terminate this Agreement for cause. Upon the Department’s knowledge of a material breach by Contractor, the Department may, at its discretion:
 - i. Provide an opportunity for Contractor to cure the breach or end the violation, and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department; or
 - ii. Immediately terminate this Agreement and/or the Contract as specified in Section VI.4. *GENERAL TERMS AND CONDITIONS* of this Agreement.
- d. **Effect of Termination.** Upon termination of this Agreement, for any reason, all the following shall occur:
 - i. The Department shall cease sharing the Non-public Medicaid NCCI Edit Files covered by this Agreement with Contractor; and
 - ii. Contractor shall only be allowed to continue using any Non-public Medicaid NCCI Edit Files shared by the Department prior to the termination of this Agreement for the remainder of the calendar quarter in which the edits are effective.
- e. **Survival.** All terms and conditions regarding the restrictions on use and disclosure of the Non-public Medicaid NCCI Edit Files set forth in this Agreement shall survive the termination of this Agreement and shall remain fully enforceable by Department against Contractor.

PHP Contact Name, Title Date
 PHP Name

Attachment 7

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

A. This Section summarizes November 1, 2021 – December 31, 2021 capitation payment and risk sharing terms and figures included the Standard Plan Rate Book for State Fiscal Year 2022 dated December 10, 2021. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$1,638.69	\$1,568.54	\$1,805.36	\$1,651.78	\$1,508.27	\$1,482.06
TANF, Newborns (<1)	\$979.21	\$814.62	\$901.66	\$842.13	\$805.08	\$843.07
TANF, Children (1–20)	\$181.70	\$160.32	\$169.46	\$155.08	\$159.47	\$155.19
TANF, Adults (21+)	\$406.17	\$412.71	\$417.29	\$403.51	\$423.37	\$403.99
Maternity Event	\$11,174.86	\$10,737.45	\$12,097.22	\$10,996.25	\$10,547.38	\$11,544.12

PMPM Add-on for Legislative Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$14.25	\$13.94	\$16.08	\$14.93	\$14.02	\$14.55
TANF, Newborns (<1)	\$6.91	\$7.26	\$8.02	\$7.52	\$8.33	\$7.88
TANF, Children (1–20)	\$2.79	\$2.48	\$2.72	\$2.42	\$2.53	\$2.41
TANF, Adults (21+)	\$5.03	\$5.70	\$5.76	\$5.85	\$6.28	\$5.61
Maternity Event	\$104.73	\$113.68	\$120.26	\$107.08	\$118.37	\$119.99

PMPM Add-on for DHHS Authorized Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$22.63	\$36.19	\$53.26	\$41.21	\$36.02	\$39.14
TANF, Newborns (<1)	\$4.81	\$5.01	\$5.02	\$5.01	\$4.62	\$4.71
TANF, Children (1–20)	\$3.29	\$3.14	\$3.11	\$3.30	\$3.25	\$3.13

TANF, Adults (21+)	\$2.16	\$2.32	\$2.63	\$2.39	\$2.74	\$2.73
Maternity Event	\$12.00	\$3.21	\$7.15	\$14.88	\$7.30	\$16.93

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.5%	91.8%	92.3%	91.8%	92.1%	92.1%
TANF, Newborns (<1)	91.8%	91.1%	91.6%	91.0%	91.3%	91.4%
TANF, Children (1–20)	89.0%	88.5%	88.6%	87.8%	88.1%	88.6%
TANF, Adults (21+)	90.7%	90.2%	90.5%	90.0%	90.4%	90.4%
Maternity Event	95.1%	94.6%	94.9%	94.6%	94.8%	94.9%

Target Service Ratios Underlying COVID-19 Add-Ons

COA/Region	DHHS Rate Action	
	Legislative Add-Ons	Add-Ons
All COA, All Regions	98.75%	98.75%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.4%	4.9%	4.7%	4.6%	5.3%	4.8%
TANF, Newborns (<1)	11.5%	15.2%	14.1%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.6%	18.9%	18.5%	18.1%	18.3%	17.5%
TANF, Adults (21+)	8.6%	8.8%	9.1%	9.1%	10.3%	8.9%
Maternity Event	15.4%	15.9%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.1%	88.7%	85.8%	88.0%	91.9%	88.0%

B. This Section summarizes January 1, 2022 – January 31, 2022 capitation payment and risk sharing terms and figures. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$1,638.74	\$1,568.59	\$1,805.41	\$1,652.18	\$1,508.33	\$1,482.11
TANF, Newborns (<1)	\$979.21	\$814.61	\$901.65	\$843.39	\$805.07	\$843.07
TANF, Children (1–20)	\$181.73	\$160.34	\$169.48	\$156.36	\$159.49	\$155.20
TANF, Adults (21+)	\$406.19	\$412.73	\$417.31	\$403.53	\$423.39	\$404.00
Maternity Event	\$11,174.84	\$10,737.43	\$12,097.20	\$10,996.22	\$10,547.36	\$11,544.11

PMPM Add-on for Legislative Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$0.16	\$0.19	\$0.31	\$1.01	\$0.21	\$0.34
TANF, Newborns (<1)	\$0.00	\$0.00	\$0.01	\$0.01	\$0.01	\$0.00
TANF, Children (1–20)	\$0.10	\$0.04	\$0.07	\$0.09	\$0.05	\$0.08
TANF, Adults (21+)	\$0.09	\$0.06	\$0.14	\$0.52	\$0.14	\$0.13
Maternity Event	\$0.00	\$0.00	\$0.00	\$0.01	\$0.00	\$0.00

PMPM Add-on for DHHS Authorized Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$12.88	\$24.05	\$37.87	\$28.12	\$24.47	\$26.54
TANF, Newborns (<1)	\$0.90	\$0.81	\$0.71	\$0.80	\$0.51	\$0.45
TANF, Children (1–20)	\$0.30	\$0.21	\$0.11	\$0.18	\$0.11	\$0.15
TANF, Adults (21+)	\$0.45	\$0.56	\$0.79	\$0.70	\$0.83	\$0.78
Maternity Event	\$6.73	\$0.70	\$0.83	\$3.95	\$3.00	\$6.85

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.5%	91.8%	92.3%	91.8%	92.1%	92.1%
TANF, Newborns (<1)	91.8%	91.1%	91.6%	90.9%	91.3%	91.4%
TANF, Children (1–20)	89.0%	88.5%	88.6%	87.1%	88.1%	88.6%
TANF, Adults (21+)	90.7%	90.2%	90.5%	90.0%	90.4%	90.4%
Maternity Event	95.1%	94.6%	94.9%	94.6%	94.8%	94.9%

Target Service Ratios Underlying COVID-19 Add-Ons

COA/Region	Legislative Add-Ons	DHHS Rate Action Add-Ons
All COA, All Regions	98.75%	98.75%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.4%	4.9%	4.7%	4.6%	5.3%	4.8%
TANF, Newborns (<1)	11.5%	15.2%	14.1%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.6%	18.9%	18.5%	18.0%	18.3%	17.5%
TANF, Adults (21+)	8.6%	8.8%	9.1%	9.1%	10.3%	8.9%
Maternity Event	15.4%	15.9%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard	Plan
89.1%	88.7%	85.7%	88.0%	91.9%	88.0%	

C. This Section summarizes February 1, 2022 – June 30, 2022 capitation payment and risk sharing terms and figures. Beginning in August 2021, the ABD, TANF and Other Related Children ages 1–20, and TANF and Other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$1,638.74	\$1,568.59	\$1,805.41	\$1,652.18	\$1,508.33	\$1,482.11
TANF, Newborns (<1)	\$979.21	\$814.61	\$901.65	\$843.39	\$805.07	\$843.07
TANF, Children (1–20)	\$181.73	\$160.34	\$169.48	\$156.36	\$159.49	\$155.20
TANF, Adults (21+)	\$406.19	\$412.73	\$417.31	\$403.53	\$423.39	\$404.00
Maternity Event	\$11,174.84	\$10,737.43	\$12,097.20	\$10,996.22	\$10,547.36	\$11,544.11

PMPM Add-on for Legislative Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$0.16	\$0.19	\$0.31	\$1.01	\$0.21	\$0.34
TANF, Newborns (<1)	\$0.00	\$0.00	\$0.01	\$0.01	\$0.01	\$0.00
TANF, Children (1–20)	\$0.10	\$0.04	\$0.07	\$0.09	\$0.05	\$0.08
TANF, Adults (21+)	\$0.09	\$0.06	\$0.14	\$0.52	\$0.14	\$0.13
Maternity Event	\$0.00	\$0.00	\$0.00	\$0.01	\$0.00	\$0.00

PMPM Add-on for DHHS Authorized Rate Increases by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	\$12.09	\$23.88	\$37.63	\$27.68	\$24.10	\$26.09
TANF, Newborns (<1)	\$0.47	\$0.41	\$0.63	\$0.35	\$0.33	\$0.15
TANF, Children (1–20)	\$0.06	\$0.06	\$0.06	\$0.04	\$0.02	\$0.04
TANF, Adults (21+)	\$0.11	\$0.50	\$0.70	\$0.51	\$0.64	\$0.56
Maternity Event	\$0.12	\$0.06	\$0.23	\$0.13	\$1.14	\$0.12

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	92.5%	91.8%	92.3%	91.8%	92.1%	92.1%
TANF, Newborns (<1)	91.8%	91.1%	91.6%	90.9%	91.3%	91.4%
TANF, Children (1–20)	89.0%	88.5%	88.6%	87.1%	88.1%	88.6%
TANF, Adults (21+)	90.7%	90.2%	90.5%	90.0%	90.4%	90.4%
Maternity Event	95.1%	94.6%	94.9%	94.6%	94.8%	94.9%

Target Service Ratios Underlying COVID-19 Add-Ons

COA/Region	DHHS Rate Action	
	Legislative Add-Ons	Add-Ons
<i>All COA, All Regions</i>	98.75%	98.75%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
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TANF, Adults (21+)	8.6%	8.8%	9.1%	9.1%	10.3%	8.9%
Maternity Event	15.4%	15.9%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard	Plan
89.1%	88.7%	85.7%	88.0%	91.9%	88.0%	