

**Amendment 1**  
**to**  
**Contract #30-2021-061-DHB Primary Care Case Management Entity**  
**Between**  
**North Carolina Department of Health and Human Services, Division of Health Benefits**  
**and**  
**North Carolina Community Care Networks, Inc.**

This Amendment (Amendment) to *Contract #30-2021-061-DHB Primary Care Case Management Entity* is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Department) and North Carolina Community Care Networks, Inc. (Contractor). The Department and Contractor are each a Party and may be collectively referred to as the “Parties”

This Amendment incorporates definitions and requirements to support Integrated Care for Kids (InCK), COVID-19 Vaccination Enrollee Incentive Program, PCCM Fees and Provider Payments, and modifies the Implementation Timelines for Deliverables as stated herein.

The Parties agree as follows:

**I. Modifications to Sections II. – V.**

The following subsections are amended as follows:

**A. Section II.A. Definitions is revised to add the following defined terms:**

68. **Family Navigator:** In InCK, children assigned to SIL 2 or SIL 3 will be assigned a Family Navigator, who is part of the care management team. The Family Navigator will work directly with the child and family to help the child and family meet health, social and educational goals. The Family Navigator role may be performed by an existing care manager on the care management team and may be an RN, MSW, BSW, CHW, LPN, Population Health Specialist or equivalent. The intent is to keep the same Family Navigator while the child is enrolled in InCK but there may be cases where this is not possible. The Family Navigator will hold a specific set of InCK responsibilities for the member outlined in the Contract.
69. **InCK Integrated Care Platform:** A standardized, Internet-accessible care management tool that InCK staff and authorized personnel can use to create, store, view, update and share InCK member information, including but not limited to basic InCK member data and the SAP. This platform belongs to NC InCK.

70. **InCK Members:** Medicaid and NC Health Choice enrolled beneficiaries from birth through age 20 whose Medicaid administrative county is one of the following: Alamance, Durham, Granville, Orange or Vance.
71. **Integrated Care for Kids (InCK):** A payment and service delivery model supported by CMS cooperative agreement funding designed to improve outcomes for children.
72. **Integration Consultant:** InCK staff member who is an individual responsible for supporting InCK Family Navigators and care teams in the InCK model.
73. **North Carolina InCK (NC InCK):** The entities implementing InCK in North Carolina, led by Duke University, University of North Carolina and NC Division of Health Benefits.
74. **Partnership Council:** The governing body of NC InCK which determines strategic direction and holds staff accountable for results.
75. **Service Integration Levels (SIL):** Stratification of InCK Members calculated by NC InCK and shared with the Contractor to guide delivery of care management and InCK interventions. Members assigned to SIL 1 will indicate the lowest level of service need, while Members assigned SIL 2 and SIL 3 will indicate sequentially increasing rates of service need.
76. **Shared Action Plan (SAP):** A brief, actionable plan in a standard format set by NC InCK for improved family-centered, whole-child service coordination.

**B. Section II.B. Abbreviations and Acronyms is revised to add the following:**

72. InCK: Integrated Care for Kids
73. SAP: Shared Action Plan (used in InCK model)
74. SIL: Service Integration Levels (used in InCK model)

**C. Section III.B. General Terms and Conditions, 35. PAYMENT AND INVOICING is revised to add the following:**

**f. Payment for COVID-19 Vaccination Enrollee Incentive Program**

- i. The Department will make payments to the Contractor for up to one million dollars (\$1,000,000) in SFY22 for the administration of the COVID-19 Vaccination Enrollee Incentive Program.
- ii. The Contractor shall limit Enrollee incentives to no more than one hundred dollars (\$100) per Enrollee during SFY22.
- iii. The Department will provide reimbursement for the administration and payment of incentives in the Contractor's COVID-19 Vaccination Enrollee Incentive Program. The Department will limit reimbursement to the Contractor for the administration of the COVID-19 Vaccination Enrollee Incentive Program to no more than twenty percent (20%) of the total payments to the Contractor.
- iv. The Department will make payment to the Contractor sixty (60) Calendar Days after receipt of a clean COVID-19 Vaccination Enrollee Incentive Program Report from the Contractor for incentives paid through June 30, 2022.

**g. Payment for Integrated Care for Kids (InCK)**

- i. Department shall pay Contractor a monthly InCK management fee in accordance with *Attachment A: First Revised and Restated PCCM Fees and Provider Payments*.
- ii. The payment amount outlined in *Attachment A: First Revised and Restated PCCM Fees and Provider Payments* for monthly InCK management fee will begin April 2022 and be processed the same schedule as the monthly PCCM monthly fee payment.
- iii. If the SIL2 or SIL3 population changes by more than twenty percent (20%), Department and Contractor will mutually agree to adjustment of the fixed monthly payment accordingly via Amendment.
  - i. Beginning with the quarter ending June 30, 2022, a review of the assumed and actual SIL2 and SIL3 population will occur within forty-five (45) days of the end of each calendar quarter, within sixty (60) days of the end of the federal Public Health Emergency as defined in the Families First Coronavirus Response Act, and at least sixty (60) days prior to the Department implementing a new managed care program, but in no event will the monthly payment be adjusted more frequently than quarterly.

**D. Section IV.A. Enrollees, 3., Enrollee Engagement is revised to add the following:**

**I. COVID-19 Vaccination Enrollee Incentive Program**

- i. The Contractor may establish a COVID-19 Vaccination Enrollee Incentive Program that provides an incentive for Enrollees who receive a COVID-19 vaccine. The Contractor shall submit to the Department a COVID-19 Vaccination Enrollee Incentive Program Policy for review and approval no later than *March 31, 2022*. The Policy shall include:
  1. Type of incentive(s) offered and method(s) for administering the program;
  2. Method and timing of distributing incentive (i.e., by mail, electronic, in person);
  3. Approach to:
    - a. Focus incentives to communities within the State with low COVID-19 vaccination rates;
    - b. Focus incentives to historically marginalized group and communities;
    - c. Ensure equitable distribution of incentives in order to assure equitable outcome for Enrollees; and
    - d. Ensure incentives are not discriminatory in violation of any applicable federal or State law;
  4. Appropriate safeguards to ensure that incentives are received only by an Enrollee, or by the legal guardian of the Enrollee, who receive a COVID-19 vaccination;
  5. Adequate assurances that the program meets the requirements of 1112(a)(5) of the Social Security Act; and
  6. Appropriate safeguards to prevent abuse of the program by Enrollee and to ensure compliance with all existing federal requirements regarding payments to Enrollees.
- ii. The incentive shall not be provided in the form of cash or cash redeemable coupons. Acceptable forms of member incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may

be used only for health-related purchases, and gym memberships.

- iii. The Contractor shall maintain and share with the Department documentation of incentives provided, including Enrollee information and provider/place of vaccine through the COVID-19 Vaccination Enrollee Incentive Program using COVID-19 Vaccination Enrollee Incentive Program Report.

**E. Section IV.B. Benefits and Care Management, 3, Care Management is revised and restated as follows:**

**3. Care Management**

- a. The Contractor shall provide access to appropriate care management and coordination support across multiple settings of care, including primary care and connections to specialty care, pharmacies, and community-based resources.
  - i. Enrollees with identified high medical, behavioral, social, or resource needs and other priority populations defined below should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan.
  - ii. The Contractor shall operate a care coordination and care management program that meets the requirements of this Contract.
- b. PCCM Services
  - i. Based on risk stratification, and the findings from care needs screenings and comprehensive needs assessments as appropriate, the Contractor shall provide enrollees with care management appropriate to his or her needs.
  - ii. The Contractor shall provide the following care coordination for enrollees, as appropriate:
    - 1. Assist enrollees as they schedule medical appointments;
    - 2. Assist enrollees as they attempt to obtain proper medical equipment;
    - 3. Provide appropriate health education and health coaching; and
    - 4. Assist enrollees with obtaining appointments for age-appropriate immunizations, preventive screenings, and routine well-care visits.
  - iii. The Contractor shall assist enrollees with the following activities related to improving enrollee health:
    - 1. Managing chronic disease (i.e. disease management programs);
    - 2. Patient self-management and goal-setting;
    - 3. Addressing gaps in care (children and adults); and
    - 4. Managing medications.
  - iv. For enrollees with identified unmet health-related resource needs, the Contractor shall, as part of care coordination:
    - 1. Refer enrollees to community and social support providers to address enrollees' unmet health-related resource needs; and
    - 2. Modify their approaches based on observed outcomes.
  - v. The Contractor shall coordinate with local health departments, obstetricians, midwives, family physicians and other providers involved in the care of an enrollee who is pregnant or recently delivered.

- vi. Contractor will refer enrollees to CMARC and CMHRP for care management if they meet eligibility criteria for the programs.
- c. Integrated Care for Kids (InCK)
  - i. The Department shall implement, in coordination with the Contractor, Integrated Care for Kids (InCK), a payment and service delivery model supported by CMS grant funding designed to improve outcomes for children. The goals of NC InCK shall include:
    - a. Understand Needs: More holistically understand the needs of children and youth;
    - b. Support and Bridge Services: Integrate services across sectors for children and youth who could benefit from additional support; and
    - c. Focus Healthcare Investments: Find ways to invest resources into what matters most for children, youth, and families
  - ii. NC InCK will be focused on integrating care across ten core child services, including:
    - a. Schools;
    - b. Early Care and Education;
    - c. Food – SNAP, WIC, Food banks;
    - d. Housing;
    - e. Physical and Behavioral Healthcare;
    - f. Public Health Services – Title V;
    - g. Social Services – Child Welfare;
    - h. Mobile Crisis Response;
    - i. Juvenile Justice; and
    - j. Legal Aid.
  - ii. InCK services:
    - 1. The Contractor will receive the Service Integration Levels (SILs) for each InCK Member monthly from DHB/NC Analytics. InCK Members will be assigned to SIL 2 or SIL 3 based on their service needs
      - i. SIL 2: Children experiencing multiple, moderate-severity health, social determinants of health (SDOH), education or guardian risks.
      - ii. SIL 3:
        - i. Children who are out-of-home or have high risk of out-of-home placement.
        - ii. Children experiencing multiple, complex health and education, juvenile justice, child welfare, SDOH risks.
    - 2. The Contractor shall use SILs to refine Risk Stratification for Members assigned to InCK.
    - 3. The Contractor shall ensure that the SIL assigned to the InCK Member is reconciled each month with risk stratification for each enrollee conducted by the Contractor.

- iii. The Contractor shall consider InCK Members assigned to SIL 2 and SIL 3 as “priority populations” for the InCK integrated care model regardless of other stratification conducted by the Contractor. The Contractor shall provide Integrated Care Support to InCK members in SIL 2 and 3 who engage in care management.
- iv. The Contractor shall follow InCK protocols for all InCK members in foster care, including TP eligible children in foster care.
- v. InCK staffing:
  - 1. Family Navigators:
    - a. The Contractor shall employ Family Navigators to serve as part of the care management team for children assigned to SIL 2 and SIL 3. The Family Navigator shall work directly with children and families to help them meet health, social and educational goals.
    - b. The Contractor shall ensure that each Family Navigator uses the InCK standardized Consent Form to promote 2-way information sharing between care team members in health care and any other service providers desired by the member (e.g., behavioral health, schools, early childhood, child welfare, juvenile justice).
  - 2. Integration Consultant
    - a. The Contractor shall employ an Integration Consultant responsible for supporting InCK Family Navigators and care teams in the InCK model.
    - b. The Contractor-employed Integration Consultant shall utilize the InCK Integrated Care Platform as part of its participation in InCK to, at minimum:
      - i. Identify NC InCK Members;
      - ii. View basic data on Members in SIL 2 and 3;
      - iii. will document communications and interactions with FN and care team for Members in SIL 2 and 3;
      - iv. Store and share Shared Action Plans (SAPs) and consent documents.
- d. Identification of High-Needs Enrollees Needing Care Management
  - i. Care Needs Screening
    - 1. The Contractor shall undertake best efforts, as defined below, to conduct a Care Needs Screening (CNS) of every newly enrolled enrollee on the enrollment file provided to the Contractor from the Department, on the following time frames:
      - a. Within ninety (90) Calendar Days for all newly enrolled PCCM enrollees,
      - b. Within fourteen (14) Calendar Days for all newly enrolled enrollees in the Aged, Blind, Disabled (ABD) Category of Aid, and
      - c. Annually thereafter.
    - 2. For enrollees enrolled prior to June 4, 2021, the Contractor shall undertake best efforts to conduct a Care Needs Screening no later than June 30, 2022.

3. The Department defines “best efforts” as including at least two (2) documented follow up attempts to contact the enrollee if the first attempt is unsuccessful.
4. The Contractor’s shall establish a tool to conduct Care Needs Screening, for which the template shall be submitted to the Department for review prior to use with Members. At minimum, the tool shall identify will include screening for:
  - a. Chronic or acute conditions;
  - b. Chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
  - c. Behavioral health needs, including opioid usage and other substance use disorders, and intellectual/developmental disabilities;
  - d. Enrollees at risk of requiring long-term services and supports (LTSS);
  - e. Medications—prescribed and taken; and
  - f. Other factors or conditions the Contractor deems appropriate to inform available interventions for the enrollee.
5. For InCK Members:
  - a. The Contractor shall use best efforts to conduct a Care Needs Screening for each InCK Member assigned to SIL 1 and SIL 2 every twelve (12) months.
  - b. The Contractor shall use best efforts to conduct a Care Needs Screening for each InCK Member assigned to SIL 3 every six (6) months.
  - c. The Contractor shall aim to complete a Care Needs Screening on at least eighty percent (80%) of its overall InCK membership for each Contract Year but shall incur no penalty if the eighty percent (80%) is not reached.
- ii. The Contractor shall include unmet health-related resource need questions provided by the Department for use in all Care Needs Screenings, covering four (4) priority domains.
  1. Housing;
  2. Food;
  3. Transportation; and
  4. Interpersonal Safety/Toxic Stress.
- iii. If an enrollee appears on the monthly enrollment file more than ninety (90) Calendar Days after that enrollee is removed from the monthly enrollment file, the Contractor shall conduct the Care Needs Screening within ninety (90) Calendar Days.
- iv. The Contractor will make the results of the Care Needs Screenings available to Primary Care Providers who have signed the Contractor’s Participation Agreement via the Data Platform within seven (7) Calendar Days of the screening. If a PCP does not have a signed Participation Agreement with the Contractor, the Care Needs Screening will be made available upon request to the PCP.
- v. In the event that the Care Needs Screening identifies that a Comprehensive Needs Assessment (CNA) is needed, and the enrollee consents, the Contractor will perform a CNA to determine that enrollee’s care management needs.

- e. Identification of Priority Populations through Risk Scoring and Stratification
  - i. The Contractor shall develop and use a risk stratification tool to stratify all enrollees provided on the daily enrollment and weekly Claims files from the Department. The Contractor shall evaluate the effectiveness of its risk stratification tool at least annually.
  - ii. The Contractor shall develop and implement targeted interventions that are appropriate for each risk level and priority population. Interventions should be consistent with evidence-based or evidence-informed practices, clinical guidelines, and recommended treatments.
  - iii. The Contractor shall describe its risk stratification approach and targeted interventions in the Care Management Policy.
  - iv. The Contractor 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.
  - v. Priority populations include:
    - 1. Individuals with Long Term Services and Supports (LTSS) needs;
    - 2. Adults and children who: have HIV or AIDS; have an I/DD or SUD diagnosis; have chronic pain; have an Opioid Addiction; have TBI; are in a Neonatal Intensive Care Unit; have neonatal abstinence syndrome; all as identified on the enrollment files, the claims files, or determined through a CNS
    - 3. Enrollees identified by the Contractor as at Rising Risk;
    - 4. Enrollees who are:
      - a. Homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
      - b. Experiencing domestic violence or lack of personal safety as determined by the CNS; or
      - c. Respond to CNS social determinants of health (SDOH) questions as needing assistance in at least three SDOH areas;
    - 5. Enrollees at high risk for readmission who have been discharged from a hospital or facility;
    - 6. Enrollees in foster care;
    - 7. Enrollees transitioning out of foster care;
    - 8. Other priority populations as determined by the Contractor; and
    - 9. InCK Members assigned to SIL 2 or SIL 3 by NC InCK, regardless of other assigned stratification.
  - vi. The Contractor’s risk scoring methodology and stratification methodology shall take into account, at a minimum, the following information, as available and relevant:
    - 1. Care Needs Screening results, including the content of the screening assessing unmet health-related resource needs;
    - 2. Claims history;
    - 3. Claims analysis;
    - 4. Pharmacy data;
    - 5. Immunizations;
    - 6. Lab results;

7. Hospital utilization; and
  8. Member's zip code.
- f. Comprehensive Needs Assessments (CNA) for High-Risk Enrollees
- i. The Contractor shall make best effort to perform a CNA for consenting enrollees, who are:
    1. Identified through a Care Needs Screening or risk stratification as being within a priority population;
    2. Referred to the PCCM entity for care management by any person or entity, including the Member (self-referral).
    3. For InCK:
      - a. An InCK Member assigned to SIL 3; and
      - b. Any InCK Members who are identified as needing additional assessment based on clinical judgement based on the information provided through the Care Needs Screening.
  - ii. The Contractor's CNA must assess:
    1. What current healthcare services the enrollee is receiving;
    2. What potential healthcare services might benefit the enrollee, subject to confirmation by a healthcare provider
    3. What social services the enrollee is currently using;
    4. The current and relevant past treatment status of the enrollee's medically-identified physical health conditions, including dental conditions;
    5. The current and relevant past treatment status of medically-identified mental health and substance use disorders, including tobacco use disorders;
    6. The current and relevant past treatment status of medically-identified physical, intellectual, or developmental disabilities;
    7. The current status of any advance directives, including advance instructions for mental health treatment;
    8. The enrollee's adherence with medications prescribed for the enrollee;
    9. What informal, caregiver, or social supports, including peer support, are currently available to the enrollee
    10. The enrollee's Social Determinants of Health (SDOH) needs, using questions provided by the Department covering:
      - a. Housing
      - b. Food
      - c. Transportation
      - d. Interpersonal Violence/Toxic Stress;
        - i. At the Contractor's option, for adults only exposure to adverse childhood experiences (ACEs) or other trauma; and
        - ii. Risk factors that indicate an imminent need for LTSS.
  - iii. The Contractor shall develop methodologies and tools for conducting the Comprehensive Assessment, as appropriate for differing Member demographics and needs.

- iv. The Contractor shall conduct the CNA, whether in-person or telephonically, in a manner that respects the needs of each participant.
- v. The Contractor shall use best efforts to complete a CNA for enrollees in active care management:
  - 1. Within thirty (30) Calendar Days of consenting to care management and annually thereafter if the enrollee is still actively care managed by the Contractor;
  - 2. Upon documentation of a significant change in the enrollee's circumstances that indicate a new CNA is warranted;
  - 3. At the request of the enrollee or their provider.
- vi. The Contractor shall document and store CNA responses in its Data Platform and make it available to care team members who have executed the Contractor's participation agreement, within fourteen (14) Calendar Days of completion of the assessment.
- vii. If the CNA indicates that the enrollee does not require care management, the Contractor shall document that determination and will not be required to develop a Care Plan.
- g. Consent for InCK Members
  - i. The Contractor shall ensure that every InCK Member in SIL 2 and SIL 3 receive outreach by an InCK Family Navigator. Members who engage in care management shall receive support in completing the NC InCK consent process.
  - ii. The Contractor shall ensure that the InCK consent process is repeated when initial InCK consents expire as necessary.
  - iii. The Contractor shall ensure that completed InCK consents are transmitted to the InCK Integration Consultant within ten (10) Business Days of completion.
- h. Development of Care Plans
  - i. The Contractor shall develop person-centered Care Plans based on the responses to an enrollee's CNA and the enrollee's consent.
  - ii. The Care Plan will be developed collaboratively with appropriate input from the care team and the enrollee.
  - iii. The Contractor shall undertake best efforts to complete each Care Plan within thirty (30) Calendar Days after completion of the CNA.
  - iv. The Contractor shall ensure that each Care Plan incorporates relevant 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.
  - v. Each Care Plan shall contain:
    - 1. Measurable goals;
    - 2. Assessments of potential Medical needs including any behavioral health, intellectual/developmental disability, and/or dental needs, subject to confirmation by a healthcare provider;
    - 3. Recommended interventions to address medication adherence; and
    - 4. Recommendations for any social, educational, and other services for the enrollee.

- vi. The Contractor will update Care Plans regularly to address identified gaps in care, incorporating input from care team members and the enrollee:
  - 1. At minimum every twelve (12) months, for actively care managed enrollees;
  - 2. Upon documentation of a significant change in the enrollee's circumstances that indicate an updated Care Plan is warranted
  - 3. At the request of the enrollee or their PCP; or
  - 4. When a re-assessment occurs that indicates an updated Care Plan is warranted.
- vii. The Contractor shall document and store the Care Plan in its Data Platform and make it available to care team members who have executed the Contractor's participation agreement.
- viii. The Contractor shall share the Member Action Plan, an enrollee-facing version of the care plan, with the enrollee within thirty (30) Calendar Days of completion as appropriate.
- i. InCK Shared Action Plan
  - i. The Contractor shall attempt to complete a Shared Action Plan (SAP) using the template in Attachment J for at least thirty percent (30%) of InCK Members assigned to SIL 3 and ten (10%) of InCK members assigned to SIL 2, within thirty (30) Calendar Days of the Comprehensive Needs Assessment being completed. The aforementioned requirements for rate of SAP completion are for calendar year 2022, with benchmarks to be updated annually by the Department thereafter. The Contractor is encouraged to develop SAPs for other InCK Members, as appropriate, to the needs of the InCK Member and the InCK Members' family.
  - ii. The Contractor shall ensure that completed SAPs are stored on the NC InCK instance of Virtual Health that is accessible to the InCK family/guardian, integrated care team and complies with InCK consent for sharing; and transmitted to the InCK member's guardian, the Contractor-employed Integration Consultant, and other care team members consented to by the guardian, using a secure method which may be the InCK Integrated Care Platform or the Contractor's care management platform, within ten (10) Business Days of completion. The Contractor shall ensure that any subsequent updates shall also be shared with the member's assigned NC InCK Integration Consultant within ten (10) Business Days of the update(s).
  - iii. The Contractor shall collaborate with the family to include all care team members 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.
  - iv. The Contractor shall ensure that each InCK Member's SAP is updated at least annually as long as the child is assigned to SIL 2 or 3 and engaged in care management.
  - v. The Contractor shall ensure that all Care Plan requirements are met regardless of whether or not an SAP is developed. An individual Enrollee may have both a Care Plan and an SAP.

j. Care Management Services

i. Care Management services include:

1. Coordination of communication among care team members who provide physical health, behavioral health, intellectual/developmental disability, and social services for enrollees;
2. Medication reconciliation and encouraging medication adherence;
3. Tracking Care Plan goal progress through routine care team reviews;
4. Follow-up with the enrollee about referrals suggested by the Contractor;
5. Coordination of peer support, when available;
6. Training on self-management, as relevant;
7. Transitional care management, as needed; and
8. For InCK Members, additional coordination with school-based supports and services, child welfare, juvenile justice and/or early childhood services, as relevant.

ii. The Contractor shall assist enrollees as appropriate and as applicable in addressing the following unmet resource needs:

1. Assist enrollees who are homeless or have unstable or insecure housing with referrals to organizations that help provide securing housing.
2. Assist enrollees who indicate they need legal assistance by providing referral information to potential providers of legal assistance for Medicaid beneficiaries.
3. Assist enrollees with 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. Subject to the Contractor executing an appropriate contract with Unite USA, and subject to the continuing adherence to the conditions and requirements listed below, the Contractor will input enrollee information into NCCARE360, which application will then make enrollee referrals to various social service entities. The conditions and requirements include:

1. The Department shall ensure Unite USA obtains all necessary authorizations before any enrollee data is used for any non-HIPAA related purpose
2. The Contractor will input enrollee information into NCCARE360 once the following actions are completed:
  - a. The Contractor obtains authorization to put enrollee data into NCCARE360; and

- b. Unite USA obtains authorization from those enrollees entered into NCCARE360 to use their data for specific non-HIPAA purposes that are the community resources connected to NCCARE360.
3. The Department expressly agrees the Contractor will not be liable for any breaches of data that occur related to the Contractor using NCCARE360, and the Contractor will not indemnify the Department or any other entity against any claims that arise from the use or misuse of NCCARE360, other than claims caused by the intentional misconduct of the Contractor.
4. The Parties acknowledge that the Contractor will not receive any referrals from NCCARE360.
5. If at any time the Contractor determines that NCCARE360 or any software required to access or use NCCARE360 interferes with the operations of the Contractor or creates a risk to the security or stability of the Contractor's Data Platform, the Contractor may immediately cease using NCCARE360 and notify the Department of its decision within two (2) Business Days. If at any time the Contractor determines its contractual arrangement with Unite USA is likely to result in a significant financial risk to the company, or poses a material risk of jeopardizing the Contractor's: (i) 501(c)3 status; (ii) ability to receive federal or state funds; or (iii) ability to participate in federal or state programs or contracts, the Contractor may terminate its contract with Unite USA and will notify the Department of its decision within two (2) Business Days.
6. The Parties acknowledge the Contractor has no control over the use or transmission of enrollee data in NCCARE360. Therefore, the Department shall hold the Contractor harmless and shall not make or support any claims against the Contractor for any use or misuse of data entered into NCCARE360, and shall not impose on the Contractor any penalty or liability for any breach caused by the use or misuse of NCCARE360. This limitation will not apply to the intentional misconduct of the Contractor's employees. The Contractor agrees to notify the Department if it learns that a data breach has occurred that the Contractor reasonably believes might affect enrollee data.
7. The Parties acknowledge that the Contractor is not responsible for enforcing any rights the Department may have regarding enrollee data entered into NCCARE360. The Department will be solely responsible for enforcing its rights against the owner or any user of NCCARE360.
- iv. If Contractor determines that the enrollee's referral was not completed, Contractor will attempt to make additional referral to meet enrollee's needs.
- v. The Contractor shall use care managers to provide Care Management services to enrollees.
- vi. The Contractor shall make best effort to coordinate care management communications among the members of the multi-disciplinary care team managing care for an enrollee. These care teams may include, as appropriate:
  1. The enrollee;
  2. Caretaker(s)/legal guardians;
  3. Assigned PCP;
  4. PCCM Care Manager;
  5. Behavioral health provider(s);

6. Specialists;
  7. Nutritionists;
  8. Pharmacists and Pharmacy Techs;
  9. Natural Supports;
  10. For InCK Members assigned to SIL 2 or SIL 3 based on guardian preference:
    - 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; and
  11. Other individuals providing care to the enrollee.
- vii. The Contractor shall inform enrollees of:
1. The rationale for implementing care management services;
  2. The nature of the care management relationship; and
  3. Circumstances under which enrollee information may be disclosed to third parties.
- viii. The Contractor shall develop a Care Plan close-out process that includes notifying the enrollee. Termination of LTSS services may not be used as the sole basis for the Contractor closing out care management services for those enrollees no longer receiving LTSS services.
- ix. For InCK, the Contractor shall ensure that every InCK Member assigned to SIL 2 or SIL 3 who are engaged in care management receives the following InCK care management services, in addition to all other care management requirements in this Section.
1. The Contractor shall ensure that a dedicated, Contractor-employed Family Navigator, is assigned to the InCK Member and family.
  2. The Contractor shall ensure that at a minimum, the Family Navigator:
    - a. Serves as a consistent point of contact for the InCK Member and family;
    - b. To the greatest extent possible, communicate with the InCK Member's guardian at least quarterly for a period of a year on their integrated care needs and make referrals (but can communicate more regularly) in person, by telephone or video call;
    - c. Identifies and convenes the care team as defined together with the InCK Member's guardian for InCK members in SIL 2 and 3 who are engaged in care management,
      - i. The majority of care team members should attend each integrated care team meeting. Family Navigators should supply those not in attendance the opportunity to contribute to the coordination for the child either

prior to or after the meeting and should include all members in correspondence and action items after the meeting.

- d. Supports service referrals across InCK's 10 core child service areas; and
  - e. Ensures that an InCK Shared Action Plan is completed for at least thirty percent (30%) of SIL 3 InCK members and at least ten percent (10%) of SIL 2 InCK Members.
3. Subject to procurement of informed consent from the InCK Member's family and/or guardian, the Family Navigator shall securely share the Shared Action Plan of each InCK Member assigned to SIL 2 and SIL 3 with the InCK Member, family, care team members and assigned Integration Consultant within seven (7) Calendar Days of completion of the Shared Action Plan.
  4. If the InCK member will experience a change in Family Navigator, the Contractor shall ensure that the Family Navigator notifies the InCK 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 InCK Member during and after the transition.
- k. Transitional Care Management
- i. The Contractor shall develop a methodology for identifying enrollees being discharged from a care facility who are at risk of readmissions and other poor outcomes. This methodology may take into account:
    1. Frequency, duration and acuity of inpatient, Skilled Nursing Facility (SNF) and LTSS admissions or ED visits;
    2. Discharges and pending discharges from inpatient behavioral health services, facility-based crisis services; NICU discharges and pending discharges; and
    3. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the Contractor may prioritize.
  - ii. As part of transitional care management, the Contractor shall:
    1. Outreach to the Member's assigned PCP and other medical providers for knowledge transfer and smooth transition of care;
    2. Outreach to provider to inquire about receipt of discharge plan;
    3. Make best effort to obtain copy of discharge plan and if received, review with enrollee;
    4. Outreach to practice regarding scheduling outpatient follow-up visit within a time frame appropriate to the specific circumstances for that enrollee;
    5. Conduct medication management, including reconciliation, and support medication adherence;
    6. Ensure that a care manager is assigned to manage the transition;
    7. Encourage the enrollee to schedule a follow-up visit with their PCP, if discharged to home, within fourteen (14) Calendar Days of discharge;
    8. Ensure that the assigned care manager follows-up with the enrollee following discharge; and
    9. Develop a protocol for determining the appropriate timing and format of such outreach.

- iii. The Contractor shall ensure that Comprehensive Assessment is completed and current for all Members upon completion of transitional care management, including re-assessment for Members already assigned to care management as needed.
  - iv. The Department shall ensure the Contractor has access to an ADT data from NCHIEA that identifies when enrollees are admitted, discharged, or transferred from one care setting to another, in real time or near real time.
  - v. When the Contractor receives notice of any of the following alerts, the Contractor will respond promptly, and will attempt to follow-up with the enrollee as appropriate to discuss potential outpatient services needed:
    - 1. Same-day or next-day outreach for Contractor-designated high-risk subsets of the population with ED visit;
    - 2. Same-day or next-day outreach for Contractor-designated high-risk subsets of the population, such as children with special health care needs discharged from the hospital; and
    - 3. Additional outreach within several days after the alert to address outpatient needs (e.g. to assist with scheduling appropriate follow up visits or medication reconciliations post discharge).
  - vi. When the Contractor receives notice an enrollee has been discharged from a LTSS setting, the Contractor shall attempt to contact the LTSS care managers or healthcare providers for that enrollee to gather relevant information about the enrollee's prior care.
- I. Transition of Care
- i. Transition of Care refers to a Medicaid beneficiary 1) moving from a PHP or Tribal Option to Medicaid Direct or 2) moving from Medicaid Direct to a PHP Or Tribal Option.
  - ii. The Contractor shall perform the following Transition of Care activities:
    - 1. Establish the necessary protocols and process to identify enrollees and ensure timely and accurate information transfer and communication, including warm handoffs, with PHP or Tribal Option;
    - 2. Send and receive enrollee care plans with PHP or Tribal Option, as applicable; and
    - 3. Participate in Department-sponsored Transition of Care planning and testing activities the Department deems necessary to ensure effective development and implementation of Transition of Care requirements.
  - iii. For all enrollees transitioning to the Contractor, excluding enrollees disenrolling due to extended nursing facility stay or due to Tailored Plan eligibility and not otherwise enrolled in an LME/MCO, the Contractor shall prioritize new enrollees for care management for a minimum of sixty (60) Calendar Days after the enrollee's transition. The Contractor may then reassess the Member for continued complex care management eligibility.
  - iv. The Department shall document the policies and procedures required of the Contractor to fulfill the requirements of the Contract in the Transition of Care Policy for PCCM.
    - 1. The Department shall seek input from the Contractor prior to making any modifications, including feedback on timeline to implement changes and required system development and testing.

2. If changes are made to the Transition of Care Policy for PCCM, the Department shall provide the Contractor with at least thirty (30) Business Days before the Contractor can be obligated to comply with its terms or other mutually agreed upon timeline.
  3. The Contractor will not be required to follow any requirements revisions in the policy proposed after July 1, 2021 to which it objects, unless the parties mutually agree on changes to make it acceptable to the Contractor and the Department.
  - v. The Contractor will have ten (10) Business Days after execution of the Contract to ask questions and to object to any requirements revisions proposed after July 1, 2021 in the Transition of Care Policy for PCCM.
  - vi. The Contractor shall develop policies, processes, and procedures to fulfill the transition of care requirements and transitional care management in the Contract.
- m. Data Sharing with Providers
- i. All PCPs that execute the Contractor's participation agreement will be able to have access to the Contractor's Data Platform, enabling the PCP to see the data provided to or created by the Contractor for that PCP's enrollees, or practice in the case of quality measures.
  - ii. The Contractor shall make available practice-level quality measure performance data and gap in care information (for measures in *Attachment H: Program Performance Metrics Reporting Requirements*) with CCNC enrolled PCPs at each quarter and annually.
- n. Care Management Staffing
- i. Care Management Director
    1. The Contractor shall have a Care Management Director who is responsible for all PCCM care management activities.
    2. Appropriate care management leadership will meet with the Department on a monthly basis or as otherwise agreed between the parties to discuss progress and performance improvement opportunities.
  - ii. Care Managers
    1. The Contractor shall ensure that the clinician leading the care team has the minimum credentials of RN or LCSW.
    2. Care managers must have competency in:
      - a. Comprehensive Needs Assessments and care planning;
      - b. Motivational interviewing;
      - c. Self-management;
      - d. Trauma informed care;
      - e. Cultural competency;
      - f. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
      - g. Understanding and assessing for Adverse Childhood Experiences (ACEs) and trauma.

- h. Best practices for integrated care for children and families, including supports from child welfare, juvenile justice, early child care and education, and schools.
  - 3. The Contractor will train its care managers on:
    - a. Strategies to promote enrollee self-management;
    - b. Strategies to encourage medication adherence;
    - c. Motivational interviewing;
    - d. Completing CNAs and person-centered Care Plans;
    - e. Strategies for communicating across the care team;
    - f. Strategies for addressing current or potential LTSS needs;
    - g. Execution of Comprehensive Assessments of Members;
    - h. Waiver services available only through BH I/DD TPs, BH I/DD TP eligibility criteria, and the process for a Member who needs a waiver service that is available only through LME/MCOs to transfer to a LME/MCO Strategies for enrollees who have identified behavioral health issues;
    - i. Transitional care management;
    - j. Cultural competency and implicit bias;
    - k. Strategies specific to care managing dually-eligible enrollees;
    - l. Strategies for care managing children in foster care;
    - m. Strategies for Trauma-Informed Care and care managing enrollees with ACEs and Trauma; and
    - n. Strategies for understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level.
  - 4. The Contractor shall ensure that care managers remain conflict-free, which shall be defined as not providing care management services or oversight for enrollees with whom they are related by blood or marriage, financially responsible, or legally allowed to make financial or health related decisions for.
- iii. InCK Family Navigators
  - 1. The Contractor 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. Family-centered completion of Shared Action Plan
    - b. Beneficiary Transition Support
  - 2. The Contractor shall ensure that Family Navigators attend at least sixty percent (60%) of InCK's monthly Family Navigator capacity building events organized by NC InCK each year. InCK will host a total of twelve (12) events annually, lasting 1.5 hours each.

- o. Care Management Policies and Processes
  - i. The Contractor shall develop comprehensive Care Management Policies, and other documents including procedures, workflows, or another other documents that demonstrate the Contract's approach to meeting all the Care Management requirements of the Contract. The Contractor shall submit the Policies for review by the Department ninety (90) Calendar Days after Contract effective date and annually thereafter.
  - ii. The Care Management Policies and other documents shall include:
    - 1. How to conduct a Care Needs Screening (CNS), including:
      - a. What questions comprise a CNS;
      - b. How to perform a CNS;
      - c. Strategies to encourage complete enrollee responses;
      - d. Timelines for completing and readministering the CNS;
    - 2. How to identify an enrollee as in need of care management services:
      - a. A definition of the Contractor's priority populations, including description of population, how they are identified;
      - b. A description of claims analysis and risk stratification;
      - c. A description of the ways an enrollee may be referred for care management; and
      - d. A description of how to communicate with the care team and the enrollee about the Contractor's care management services.
    - 3. A description of Risk scoring and stratification:
      - a. What data is used to create risk scores;
      - b. How are risk scores calculated;
      - c. Methodology for identifying members of priority populations;
      - d. What is the risk score range for each stratification;
    - 4. A description of the Comprehensive Needs Assessment (CNA), including:
      - a. What questions are asked;
      - b. How are CNAs conducted;
      - c. Approach to determining when high-need Members will receive face-to-face interactions;
    - 5. Care Plans, including:
      - a. Approaches for involving and communicating with the care team;
      - b. Strategies for developing Care Plans to achieve the enrollee's Care Plan goals and
      - c. Process for and frequency of Care Plan updates;
    - 6. Processes specific to children in Foster Care;
    - 7. Processes specific to TCLI;
    - 8. Processes specific to transitional care management and transition of care;

9. Training and Qualification of care managers and other multidisciplinary team members including timing/frequency of training and ongoing continuing education;
10. Linkages with community resources for Members as needed, including for those identified as having unmet health-related resource needs;
11. Providing information and navigation regarding community providers of social services. Transitional care management, including the approach to working with Members with LTSS needs; and
12. Processes specific to InCK members.

**F. Section IV.I. PCCM Technical Specifications is revised and restated as follows:**

**I. PCCM Technical Specifications**

1. The Contractor will implement data exchanges as defined by the Department.
2. The Department anticipates changes to its Information Technology Systems. The Contractor will update its data exchanges to conform with any changes to data exchanges, file formats, data exchange frequencies, data exchange protocols and transports, and file size. The Department will provide test environments to allow adequate testing time.
3. The Contractor shall provide a testing point of contact to participate in test planning, discuss status of testing, attend status meetings, and escalate issues to the Department as needed.
4. Electronic Data Submission
  - a. End to End Testing
    - i. The Contractor shall complete as appropriate development, Unit/Assembly Testing, System Integration/Regression Testing, and Performance/Security Testing prior to the commencement of End to End testing.
    - ii. The Contractor shall participate in End to End testing, including attending sessions to review End to End test cases.
    - iii. The Contractor will perform end to end testing and show the Department the results. The Contractor will use the Department-defined scripts and Test Management Tool for tracking and reporting.
    - iv. The Contractor shall use the Department's instance of HP Application Lifecycle Management (HPALM) to track End to End test execution and defect resolution.
  - b. Electronic Data Interchange (EDI)
    - i. The Contractor will create interfaces as necessary to exchange data between the Contractor and the Department or the Department's chosen vendors managing data required under this Contract. The Contractor's interfaces must be compatible with the Department's requirements for data infrastructure for data used pursuant to this Contract.
    - ii. The Contractor shall transmit protected health information (PHI) in accordance with the HIPAA Privacy and Security rules for the transmission of electronic PHI (45 CFR 164.312(e)).
    - iii. Failures in data exchanges and interfaces that are not resolved through normal operations must be reported to the Department or the Department's vendor promptly, and not to exceed four (4) hours during normal business hours. If the failure substantially affects the Contractor's ability to deliver enrollee services, it must be reported as soon as practical.

The Contractor will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than three (3) Business Days after the resolution of the failure. The Department may request additional information if the initial RCA does not include adequate information.

- c. Retransmissions
  - i. If the Contractor receives a transmission from the Department or the Department's vendor that the Contractor cannot process correctly, the Contractor will notify the Department within 4 business hours and the Department shall ensure a corrected file is retransmitted to the Contractor within four (4) business hours.
  - ii. If the Department or the Department's vendor cannot process a file received from the Contractor, due to errors on the part of Contractor, the Department will notify the Contractor and the Contractor shall retransmit as soon as the errors are remediated.
  - iii. For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the specified format for the data exchange, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparseable xml, etc.), or is incomplete.
- d. Test Data Transmission

The Contractor will test all data transmissions with all data exchange partners to validate connectivity, format, and data fields. Examples of data exchanges may include, but are not limited to, data exchanges between the Department and the Contractor, or between the Contractor and other Department vendors such as other Managed Care Entities, Fiscal Agent, or NC FAST. The Department will oversee any testing and review results. If the testing is not successful, the Department will ensure the entity causing the test failure remediates the failure.
- e. Test Environments
  - i. The Contractor shall have at least two (2) testing environments – one for Systems Integration Testing, and one for End to End testing. The environments shall use the appropriate data sets defined by the Department.
  - ii. The Contractor shall use test environments are compliant with all security requirements defined by North Carolina State and the Department's Privacy and Security Office to support testing with production data.
  - iii. The Contractor shall have test environments available prior to conducting Systems Integration Testing.
  - iv. The Contractor's test environments must, as appropriate, be able to refresh test environments and ingest files the same size as would be required in a production environment and must be able to use data that would appear in a production environment.
  - v. The Contractor's test environment must, as appropriate, be able to simulate date and duration dependent processes.
- 5. Enrollment and Reconciliation
  - a. Enrollment and Reconciliation
    - i. Enrollment:
      - 1. The Contractor shall accept an 834 or other eligibility file daily from the Department with new, modified, and terminated Member records for Members enrolled in the PCCM entity.

2. The Contractor shall add, modify, or terminate Members daily based on 834 or other eligibility file.
  3. At the Department's request, the Contractor shall provide a full roster of Members currently enrolled in the PCCM entity in the Department's preferred format within seventy-two (72) hours. The file format of this request must be provided to the Contractor at least thirty (30) Calendar Days prior to any such request.
  4. The Contractor shall accept InCK SIL stratification file from the Department with all InCK Member and SIL level monthly.
- ii. Reconciliation:
1. The Contractor shall accept a weekly and monthly 834 or other eligibility file from the Department, with all enrollees that were added, modified, and terminated for the period.
  2. The Contractor shall compare the Contractor's loaded enrollee data with the Department's monthly enrollee data sent, to ensure accuracy.
  3. The Contractor will notify the Department of any differences in the comparison between the monthly enrollee records received and the monthly enrollee records loaded, on a monthly basis.
  4. The Department shall determine if corrections are needed to the enrollment data to address discrepancies identified by the Contractor during reconciliation.
  5. The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the Contractor.
  6. The Contractor shall use corrected files sent by the Department.
6. Technology Documents
- a. The Contractor shall provide the following documents to the Department for review and approval within ninety (90) Calendar Days after execution of the Contract, unless otherwise approved by the Department. The Department may request additional information be made available or developed if the documentation is not satisfactory.
    - i. System Security Plan: The Contractor shall complete the State's System Security Plan template within ninety (90) Calendar Days after execution of the Contract. After approval by the Department, the Plan shall be updated annually and resubmitted to the Department for review. (Link to DHHS template: <https://files.nc.gov/ncdit/documents/files/NC%20DIT%20SSP%20Template.20180112.docx>)
    - ii. Context Diagram. The Contractor shall update its context Diagram and provide it to the Department within ninety (90) Calendar Days after execution of the Contract. The Contractor will maintain this document throughout the Term of the Contract.
    - iii. Relevant summary findings of SOC 2 Type 2 Reports, to the extent the Contractor will store any Department owned-data on its servers. These findings shall be provided to the Department annually.
    - iv. Summary findings of any system penetration tests performed on the Data Platform; and
    - v. Business Associate Agreement between the Contractor and Subcontractors, if applicable.

7. PCCM Data Management
  - a. The Contractor shall maintain a Data Platform that collects, analyzes, integrates, and provides operational reporting that satisfies the requirements detailed in this Contract. The Data Platform shall house state-owned data provided by the Department to the Contractor.
  - b. To the extent the Contractor subcontracts administration and operation of the Data Platform to any third party, the Contractor shall execute with such third parties all necessary documentation to ensure the obligations in this Contract to protect State-owned data are applied to those third parties.
  - c. The Contractor shall require all third-party entities to execute its Participation Agreement and Business Associate Agreement before accessing the Data Platform and State-owned data.
  - d. The Contractor shall monitor access and use of the Data Platform and the Data at a location owned, leased, or controlled by the Contractor and through the use of equipment that is under the ownership or control of the Contractor, to ensure access and use are consistent with the permitted purposes and Applicable Law.
  - e. The Department has the right to request information from the Contractor.
  - f. All reports submitted by the Contractor shall be validated by the Contractor prior to submission.
  - g. The Department shall have access to the Data Platform and the data in it used to perform under this Contract.
8. InCK Integrated Care Platform
  - a. The Integration Consultant shall use the InCK Integrated Care Platform for sharing data on InCK members including:
    - i. Care Manager and Integration Consultant Collaboration Notes for InCK Members in SIL 2 and SIL 3
    - ii. Storage of InCK Shared Action Plan and Consent Form
    - iii. Sharing SAP and other documents with care team members w/ consent.

## **II. Modifications to Attachments**

The following attachments are modified as stated herein.

- A.** *Attachment A: PCCM Fees and Provider Payments* is revised and restated as *Attachment A: First Revised and Restated PCCM Fees and Provider Payments*.
- B.** *Attachment B: Deliverables and Reporting Requirement* is revised and restated as *Attachment B: First Revised and Restated Deliverables and Reporting Requirements*.
- C.** *Attachment I: Implementation Timeline* is revised and restated as *Attachment I: First Revised and Restated Implementation Timeline*.

**III. Effective Date**

This Amendment is effective upon the later of the execution dates of the Parties.

**IV. Unchanged Provisions:**

All other terms and conditions of the Contract remain in full force and effect.

**IN WITNESS WHEREOF**, the Parties have executed this Amendment in their official capacities as of the dates provided.

**North Carolina Community Care Networks, Inc.**

DocuSigned by:

*Christopher Woodfin*

ADA65FA6DA364B9

Chris Woodfin, CFO and EVP

Date: 03/02/22 | 1:36 PM EST

**North Carolina Department of Health and Human Services,  
Division of Health Benefits**

DocuSigned by:

*Dave Richard*

11395D232A054A2

Dave Richard, Deputy Secretary

Date: 03/02/22 | 8:21 AM PST

**Attachment A: First Revised and Restated PCCM Fees and Provider Payments****1) PCCM Fees Paid to the Contractor**

Table 1: Payment to the Contractor	
Monthly Payment	\$3,873,778
InCK Payment	\$138, 894
Total Enrollment Assumption	418,299
Care Management Population Assumption	109,545

**2) Payment for Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP)**

Table 2: Payment to the Local Health Departments (LHD)	
Program	PMPM Paid to LHD
CMARC	\$4.56
CMHRP	\$4.96

**3) Primary Care Provider Fees to be Paid by the Department**

Table 3: Primary Care Provider Fees to be Paid by the Department	
Provider Type	PMPM Paid to PCP
Carolina Access: Non-ABD and Health Choice	\$2.50
Carolina Access: ABD	\$5.00
CIHA as of July 1, 2019	\$61.65

**Attachment B: First Revised and Restated Deliverables and Reporting Requirements**

First Revised and Restated Table 1: Reports from N3CN					
Report Name	Frequency	Due Date (in Calendar days unless otherwise indicated)	Initial Reporting Period	Initial Due Date	DHB Sign Off Date (in Calendar days unless otherwise indicated)
1. Change in Member Circumstance (MEM009-B)	Monthly	15 Days after month end	January 2022	February 15, 2022	30 Days after Received
2. Member Grievance Log	Quarterly	15 days after quarter end	July 1, 2021 to September 30, 2021	October 15, 2021	30 Days after Received
3. Care Needs Screening Report (BCM026)	Quarterly	60 days after the end of the quarter	February – March 2022	May 1, 2022	30 Days after Received
4. Annual Quality Measures Report (QAV007)	Annual	120 days after measurement period (Calendar Year)	Calendar Year 2021	April 30, 2022	30 Days after Received
5. Care Management Interaction Beneficiary Report (BCM051)	Monthly	30 days after the end of the month	July 2021 August 2021 September 2021  April 2022 will be the first reporting period that includes InCK updates	October 15, 2021  First report with InCK updates is due May 31, 2022	30 Days after Received
6. CCNC Enrolled PCP	Monthly (changes only)	5 business day before the end of the month	July 2021	July 26, 2021	30 Days after Received
7. Cumulative Quarterly Financial Report	Quarterly	45 Calendar Days after the end of the quarter	July 2021 to September 2021	November 15, 2021	30 Days after Received
8. Quality Assurance and Performance Improvement Plan (QAPI)	Annual	90 days after contract effective date and annually thereafter on March 1	7/1/21 to 6/30/22	9/27/2021	60 days after Received
9. Performance Improvement Projects: Quarterly report	Quarterly	30 days after end of quarter	December 2021	1/30/22	30 days after Received

First Revised and Restated Table 1: Reports from N3CN					
Report Name	Frequency	Due Date (in Calendar days unless otherwise indicated)	Initial Reporting Period	Initial Due Date	DHB Sign Off Date (in Calendar days unless otherwise indicated)
10. N3CN Audited Financial Statement	Annual	December 31	Fiscal Year 2021	December 31, 2021	30 Days after Received
11. State Grant Certification No Overdue Tax Debts	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
12. Federal Certifications & Disclosures	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
13. IRS Tax Exemption Verification Form	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
14. State Certifications	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
15. Conflict of Interest Verification	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
16. COVID-19 Vaccination Enrollee Incentive Program Report	Monthly	30 days after the end of the month	March 2022	April 30, 2022	30 Days after Received
17. State Data Resource Center (SDRC) Report	Quarterly & Annually	15 days after the Worksheet is sent to CCNC by State	January 2022 to March 2022	April 30, 2022	30 Days after Received

First Revised and Restated Table 2: Deliverables from N3CN	
Deliverable Name	Delivery Time Frame
1. Business Continuity Plan	One hundred twenty-Hundred Twenty (120) days of Contract Execution
2. Care Management Policy	Ninety (90) of Contract Execution and annually thereafter
3. Conflict of Interest Policy	ninety (90) days of Contract Execution
4. Enrollee Grievance Policy	ninety (90) days of Contract Execution
5. Enrollee Handbook	One hundred five days (105) of Contract Execution
6. Enrollee Welcome Letter	Ninety (90) days prior to use with Members and annually thereafter

7. Fraud, Waste and Abuse Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
8. Key PCCM Role - Care Management Director	Thirty (30) days of Contract Execution
9. Key PCCM Role - Chief Medical Director	Thirty (30) days of Contract Execution
10. Key PCCM Role - Quality Management Director	Thirty (30) days of Contract Execution
11. Member Educational and Outreach Materials Policy	Sixty (60) of Contract Execution and annually thereafter
12. Provider Participation Agreement	Upon the effective date of the Contract
13. Service Line Operational Prior to Launch.	Ninety (90) of Contract Execution
14. Supplemented Call Scripts	Thirty (30) days prior to use with audience
15. System Security Plan	Ninety (90) days of Contract Execution and annually thereafter
16. System Context Diagram	Ninety (90) days of Contract Execution
17. Summary SOC 2, Type 2	Ninety (90) days of Contract Execution and annually thereafter
18. Whistleblower Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
19. Workplace Harassment and Discrimination Policy	Ninety (90) days of Contract Execution

First Revised and Restated Table 3: Deliverables from DHB	
Deliverable Name	Delivery Time Frame
1. Call Scripts (at least six)	Within thirty (30) days of Contract Execution
2. Enrollee Handbook	Within forty-five (45) days of Contract Execution
3. Approve PCP Participation Agreement	Within thirty (30) days of Contract Execution

**G. Attachment I: First Revised and Restated Implementation Timelines:**

- a. The Parties acknowledge the following performance obligations will not begin upon execution of the Contract.
- b. **Call Center.** Contractor will not have a call center capable of receiving inbound calls and incorporating the automated processes described in the Contract in place as of the date of execution of the Contract. After the Department has provided the final scripts and routing information for inbound call activities, the Department and Contractor will set a timeline for implementation of the inbound call center functionality. The Parties anticipate the inbound call center functionality will begin to be used on March 1, 2022 or other mutually agreed upon date.
- c. **Care Needs Screenings.** Contractor will not have the Care Needs Screening tool or process in place as of the date of execution of the Contract. The Parties anticipate Care Needs Screenings will begin on February 8, 2022, or other mutually agreed upon date.
- d. **Enrollee Handbook.** Contractor will not have its version of the Enrollee Handbook finalized as of the date of execution of the Contract. After the Department has approved the final wording for Contractor's version of the Enrollee Handbook, the Department and Contractor will set a timeline for publication and potential delivery of the Enrollee Handbook. The Parties anticipate Contractor's version of the Enrollee Handbook will begin to be used on March 1, 2022, or other mutually agreed upon date.
- e. **Foster Care Exit Outreach.** Contractor will not have in place as of the date of execution of the Contract the programming necessary to identify enrollees in Foster Care who are within six months of turning twenty-six years of age. The Parties anticipate Contractor will implement this functionality on January 4, 2022, or other mutually agreed upon date.
- f. **Participation Agreements.** After the Department has reviewed and accepted Contractor's new participation agreement, the Department and Contractor will prioritize PCCM participating entities for receipt and execution of the new participation agreement and will set a timeline for delivery and receipt of executed participation agreements. Entities with existing participation agreements in place as of the date of execution of the Contract will be allowed to access the Data Platform under that participation agreement for up to one hundred thirty-five (135) days. Entities that do not execute a new participation agreement on the established timeline will not have access to the Data Platform until they do. Contractor will notify the Department of all PCCM participating entities that do not execute a participation agreement as of the timeline established by the Department and Contractor.
- g. **Revised Risk Stratification Algorithm.** Contractor will not have a revised risk stratification algorithm incorporating new parameters from the Department in place as of the date of execution of the Contract. The Parties anticipate the revised risk stratification algorithm will begin to be used on January 4, 2022, or other mutually agreed upon date.
- h. **Revised Risk Stratification Algorithm for Foster Children.** Contractor will not have a revised risk stratification algorithm incorporating new parameters from the Department in place as of the date of execution of the Contract. The Parties anticipate the revised risk stratification algorithm will begin to be used on January 4, 2022, or other mutually agreed upon date.
- i. **Subcontractors.** Contractor will not have executed Subcontractor agreements in place with all approved Subcontractors as of the date of execution of the Contract. After the Department has reviewed and accepted Contractor's new Subcontractor agreement, the Department and Contractor

will set a timeline for delivery and receipt of executed Subcontractor agreements. Contractor will notify the Department of all Subcontractors that do not execute a Subcontractor agreement as of the timeline established by the Department and Contractor. Contractor may choose not to use any Subcontractor that does not sign the Subcontractor agreement. Contractor will use a Memorandum of Agreement or similar document with the approved Subcontractors to enable Subcontractors to perform under the Contract until the Subcontractor agreements are executed.

- j. **Welcome Letters.** Contractor will not have Welcome letters in place as of the date of execution of the Contract. After the Department has approved the final wording for the Welcome letters, the Department and Contractor will set a timeline for delivery of those letters. The Parties anticipate Welcome letters will begin to be sent on January 4, 2022, on or other mutually agreed upon date.
- k. **Transition of Care Prioritization Logic.** Contractor will not have a technical solution in place for automatically triggering priority logic in VirtualHealth for members disenrolling into Medicaid Direct from Standard Plans or Tribal Option as of the date of execution of the Contract. The Parties anticipate Transition of Care Prioritization Logic will be in place on April 1, 2022 or other mutually agreed upon date. Contractor will be able to receive all warm handoffs and outreach to members identified via warm handoff by date of execution of the Contract.
- l. **InCK.** Contractor will receive first InCK SIL Stratification File in February 2022 and should begin InCK care management, Integration consultation services as of April 1, 2022. NC InCK reporting new fields on existing report (BCM051) should begin for service provided in April 2022.

# Attachment J: NC InCK Shared Action Plan Template



## SHARED ACTION PLAN FOR:

### CHILD & FAMILY BACKGROUND

*Please fill in the child & family background. Current caregivers may include birth parent(s), foster parent(s), or other family members. If applicable, natural supports may include essential family members, friends, or neighbors who play an important role in supporting the child's health and well-being.*

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

DOB: \_\_\_\_\_ County: \_\_\_\_\_  
(mm/dd/yyyy)

Preferred written & spoken language: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Primary Caregiver Name: \_\_\_\_\_ Legal Guardian  
Relationship to Child: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Other Caregiver/Natural Support Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Other Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Family Navigator Name: \_\_\_\_\_ Date completed: \_\_\_\_\_  
(mm/dd/yyyy)

*Your family's concerns and priorities related to your child's health and wellbeing are the focus of your Shared Action Plan. The information you choose to provide is helpful as we all work together to achieve your desired outcomes for your child and family.*

Child's & Family's Strengths, Interests, and Activities:

Family's Area of Concern: What are you most worried about? What challenges does your child and/or family face every day? What challenges do not happen often, but are of concern?



## ACTION PLAN

Choose 3 priority goals (and up to 5) that you would like to prioritize to ensure the health and well-being of the child.

GOAL	WHO (Name of the person supporting goal)	IS DOING WHAT (Will take this action)	PROGRESS
			Date: _____ (mm/dd/yyyy) Start date: _____ (mm/dd/yyyy) Check in date: _____ (mm/dd/yyyy) Completion date: _____ (mm/dd/yyyy)
			Date: _____ (mm/dd/yyyy) Start date: _____ (mm/dd/yyyy) Check in date: _____ (mm/dd/yyyy) Completion date: _____ (mm/dd/yyyy)
			Date: _____ (mm/dd/yyyy) Start date: _____ (mm/dd/yyyy) Check in date: _____ (mm/dd/yyyy) Completion date: _____ (mm/dd/yyyy)
			Date: _____ (mm/dd/yyyy) Start date: _____ (mm/dd/yyyy) Check in date: _____ (mm/dd/yyyy) Completion date: _____ (mm/dd/yyyy)
			Date: _____ (mm/dd/yyyy) Start date: _____ (mm/dd/yyyy) Check in date: _____ (mm/dd/yyyy) Completion date: _____ (mm/dd/yyyy)

SAP Follow Up Date: \_\_\_\_\_  
 (mm/dd/yyyy)



*Please use this page to ask the family if they have used any of the services listed in the last year. If they say yes, please check the corresponding box. If you identify an area of need, please check the "support needed" box and consider helping the family develop a goal to meet that need. If there is a referral needed (examples include food, housing, etc.), the Family Navigator should make arrangements with the family to submit referrals in order to assist the family in meeting that need.*

Service Area	Current Services Received and/or Care Plans Completed in the Last Year	
Physical Health	Primary care Specialty care Dental Physical health care plan created with health professional (list name of plan & organization of provider): _____	PT/OT/Speech Home Health/Medical Equipment Support Needed
Mental Health & Intellectual Disabilities	Outpatient Behavioral Health Services In-home Services Person-Centered Plan of Care (PCP) Comprehensive CrisisPlan (CCP) School-based Psychological Services	Residential or In-patient Psychiatric Services Individual Service Plan (ISP) Utilization of Mobile Crisis Response Service Support Needed
Education & Schools	Care Coordination for Children (CC4C) Exceptional Children's Program Individual Family Service Plan (IFSP) In- or out- of school suspension Behavior Plan Individual Health Plan Other accommodations/equipment needs at school	Early Intervention (Infant-Toddler Program) School counseling Individualized Education Plan (IEP) 504 Plan Emergency Action Plan Support Needed
Food	Supplemental Nutrition Assistance Program (SNAP) Women, Infants, & Children (WIC) program Food Pantry	Other Food Program Support Needed
Housing	Section 8 Housing Voucher Stay in shelter Needs help to pay utilities and water	County Housing Authority Experiencing homelessness Support Needed
Juvenile Justice	Diversion plan/contract Probation Individualized Service Plan (ISP)	Child and Family Team (CFT) plan Post Supervision Release (PRS) Plan Support Needed
Legal Services	Has requested assistance from Legal Aid of NC or Disability Rights of NC Support Needed	
Child Welfare	In-home Services Foster Care Therapeutic Placement	Kinship Care Support Needed