AMENDMENT NUMBER 1

CONTRACT #30-2024-001-DHB
CHILDREN AND FAMILIES SPECIALITY PLAN

BETWEEN

THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

AND

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

This Amendment to Contract #30-2024-001-DHB (Contract), made effective August 15, 2024, is between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Department"), and Blue Cross and Blue Shield of North Carolina ("Contractor"). Department and Contractor may be individually referred to as "Party" and collectively as the "Parties."

Background

In June 2018, the North Carolina General Assembly enacted North Carolina Session Law 2018-48, which amended Session Law 2015-245, directing the Department to provide a plan to the General Assembly about the future of serving children and youth currently and formerly in the child welfare system under Medicaid Managed Care.

The Children and Families Specialty Plan (CFSP) is an integrated Medicaid Managed Care plan that covers services specified to address a spectrum of Member needs, including those related to physical health, behavioral Health, I/DD, LTSS, and pharmacy services and unmet health-related resource needs. Intended to meet the unique health care needs of children, youth and families currently and formerly served by the child welfare system, the CFSP operates statewide, enabling Members to access a broad range of physical health and behavioral health services and maintain treatment plans when their geographic locations change.

The purpose of this Amendment is to modify existing requirements and incorporate new requirements into the Contract.

The Parties agree as follows:

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

   Specific subsections of the Contact are modified as follows:

a. *Section III.A. Definitions, 55. Contract Award Date* is revised and restated in its entirety as follows:

55. **Contract Award Date:** August 15, 2024.

b. *Section III.A. Definitions, 56. Contract Effective Date* is revised and restated in its entirety as follows:

56. **Contract Effective Date:** August 15, 2024.

c. *Section III.A. Definitions, 126. Medicaid Managed Care* is revised and restated in its entirety as follows:

126**. Medicaid Managed Care:** A NC Medicaid Managed Care plan that will serve members as described in Section 9E.22 of Session Law 2023-134.

d. *Section III.C. Contract Term*, is revised and restated in its entirety as follows:

C. Contract Term

1. The initial Contract Term will be August 15, 2024, through June 30, 2029, and shall include an Implementation Period and Contract Years 1 through 4, revised in First Revised and Restated Section III. C. Table 1: Contract Term, as follows:

First Revised and Restated Section III. C. Table 1: Contract Term	
Contract Period	**Effective Dates**
Implementation Period	August 15, 2024 through November 30, 2025
Contract Year 1	December 1, 2025 through June 30, 2026
Contract Year 2	July 1, 2026 through June 30, 2027
Contract Year 3	July 1, 2027 through June 30, 2028
Contract Year 4	July 1, 2028 through June 30, 2029

2. The Department reserves the option, in its sole discretion, to extend the Contract for one (1) additional Contract Year or a shorter period as required by the Department. The Department shall notify Contractor in writing if it is exercising its option to extend at least ninety (90) Calendar Days prior to the expected renewal date.

3. The Contractor shall notify the Department in writing at least nine (9) months prior to the renewal date if the Contractor does not wish to renew. The Contractor may be responsible for damages for failure to notify the Department of the intent not to renew within this timeframe.

4. The initial Contract Term and any renewal terms together constitute the "Contract Term."

e. *Section III. D. Terms and Conditions, 1. ACCESS TO PERSONS AND RECORDS* is revised and restated in its entirety as follows:

1. **ACCESS TO PERSONS AND RECORDS:**
   a. Pursuant to NCGS § 147-64.7 and NCGS § 143-49(9), the Department, the State Auditor, appropriate State or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, systems, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with *Paragraph 44.* ***RECORDS RETENTION*** of this *Section III.D.* of the Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such changes or additions.
   b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered by State agencies or political subdepartments in accordance with NCGS § 147-64.7.
   c. The financial auditors of the Department shall also have full access to all of Contractor's financial records and other information determined by the Department to be necessary for the Department's substantiation of the monthly payment(s). These audit rights are in addition to any audit rights any federal agency may have regarding the use of federally allocated funds.
   d. The following entities may audit the records of this Contract during and after the term of the Contract to verify accounts and data affecting fees or performance:
      i. The State Auditor;
      ii. The internal auditors of the affected department, or agency, to the extent authorized by law; and
      iii. The Joint Legislative Commission on Governmental Operations (Commission) and Commission Staff, as defined in NCGS § 120-72(3), whose primary responsibility is to provide professional or administrative services to the Commission.
   e. Nothing in this section is intended to limit or restrict the State Auditor's rights.
   f. This provision shall survive termination or expiration of this Contract.

f. *Section III. E. Confidentiality, Privacy and Security Protections, 9. Privacy and Security Related Deliverables, a.* is revised and restated in its entirety as follows:

   a. The following shall be submitted in response to this RFP:
      i. Vendor Readiness Assessment Report (VRAR) https://it.nc.gov/documents/vendor-readiness-assessment-report;
      ii. System Security Plan (SSP); The CFSP must request the System Security Plan Template from medicaid.contractadministrator@dhhs.nc.gov.
      iii. Vendor SOC 2 or ISO 27001 or FedRamp or equivalent compliance certificates;
      iv. Network Architecture Diagram; and
      v. Data Flow Diagram and Description.

2. Modifications to *Section V. Scope of Services*

Specific subsections of the Contract are modified as follows:

a. *Section V.A. Administration and Management, 9. Staffing and Facilities, e. The CFSP Shall, iii.* is revised and restated in its entirety as follows:

iii. Ensure all key personnel positions are filled no later than May 9, 2025.

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

ii. The CFSP shall establish call center(s) and staff in North Carolina no later than May 9, 2025.

c. *Section V. D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, i. Co-Location, 1)* is revised and restated in its entirety as follows:

1) Subject to agreement by County DSS, the CFSP shall be required to co-locate a share of care managers at a level to be determined in collaboration across the Department, County DSS, and the CFSP.

d. *Section V.D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, i. Co-Location* is revised to add the following requirement:

5) The CFSP shall submit its policies and procedures for co-location as part of its Care Management Policy (Section V.D.5. Care Management Policy).

e. *Section V.D. Care Management, 2. CFSP Care Management, u. CFSP Care Management Payments, i.* is revised and restated in its entirety as follows:

i. The CFSP shall make payments to providers to support the delivery of the CFSP Care Management model according to the requirements in Section V.E.4.p. Payments of Medical Home Fees to AMH.

f. *Section V.D. Care Management, 5. Care Management Policy, d. The Care Management Policy shall describe in detail the CFSP's, i. Processes for determining CFSP Care Management eligibility*, is revised to add the following requirement:

32) Policies and procedures for co-location services as described in Section V.D.2.f.i. Co-Location.

g. *Section V.E. Providers, 4. Provider Payments, f. Hospital Payments for BH Claims, i.* is revised and restated in its entirety as follows:

i. The CFSP shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims in accordance with Department guidance related to hospital rate floor methodology.

h. *Section V.L. Technical Specifications, 1. Data Exchange Model, d.* is revised and restated in its entirety as follows:

d. The Department anticipates that an integration platform would be implemented at the time the CFSP is being developed and some/all interfaces could be routed through this integration platform at go live. The Department will provide technical designs and test environments to allow adequate development and testing time.

i. *Section V.L. Technical Specifications, 8. Testing, a.* is revised and restated in its entirety as follows:

a. System Test Plan. The CFSP shall develop and maintain a System Test Plan inclusive of the CFSP's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. The Test Plan shall be submitted to the Department no later than January 12, 2025 and otherwise upon request by the Department and shall include:

i. High level description of the scope of each testing phase;
ii. Applications or Systems that are part of the testing;
iii. Integrations that are part of the testing;
iv. Testing techniques or tools that will be used for testing;
v. Test Environment; and
vi. Test Metrics and Reporting of Defects.

3. Modifications to *Attachments A-R*

Specific Contract Attachments are modified as follows:

a. *Section VII. Attachments A – R* is revised and renamed *Section VII. Attachments*.
b. *Section VII. Attachment C: Anticipated Contract Implementation Schedule* is revised and restated in its entirety and renamed Section VII. First Revised and Restated Attachment C: Anticipated Contract Implementation Schedule and attached to this Amendment.
c. *Section VII. Attachment I. Reporting Requirements* is revised and restated in its entirety and renamed Section VII. First Revised and Restated Attachment I: Reporting Requirements and attached to this Amendment.
d. *Section VII. Attachment L. Policies* is revised and restated in its entirety and renamed Section VII. First Revised and Restated Attachment L. Policies and attached to this Amendment.

4. <u>Effective Date:</u> This Amendment is effective upon the later of the execution dates by the Parties ("Effective Date"), subject to approval by CMS.

5. <u>Other Requirements</u>: Unless expressly amended herein, all other terms and conditions of the Contract, as previously amended, shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties have executed this Amendment in their official capacities as of the Effective Date.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

Angela Boykin
Angela Boykin (Nov 27, 2024 10:04 EST)
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Date: 11/27/2024

Angela Boykin, Chief Executive Officer (CEO)

THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

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Jay Ludlam
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Date: 11/26/24 | 4:23 PM EST

Jay Ludlam, Deputy Secretary
NC Medicaid

First Revised and Restated Attachment C: Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of CFSP services beginning on December 1, 2025[1]. The Department may make adjustments after Contract Award.

First Revised and Restated Attachment C. Table 1: Anticipated Contract Implementation Dates

Milestone Reference Number	Key Milestone	Description	Tentative Date
1.	Contract Award	The date the Department will award the CFSP Contract for CFSP	August 15, 2024
2.	Commencement of CFSP Implementation Planning	The date the CFSP Implementation Team must be ready to commence Implementation Planning activities	August 15, 2024
3.	Identification of additional resources for Implementation Team	The date the CFSP must identify any additional resources needed to support the implementation activities	Contract Award + thirty (30) days
4.	Submission of CFSP Operating Plan	The date the CFSP's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
5.	Submission of key technology deliverables	The date the CFSP submits to the Department: • System Security Plan • Encounter Implementation Approach • System Interface Design • SOC 2 Type 2 Report • Vendor Readiness Assessment (VRAR)	Contract Award + thirty (30) days
6.	Submission of Business Continuity Plan	The date the CFSP's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
7.	Submission of key provider materials	The date the CFSP submits to the Department: • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual	Contract Award + thirty (30) days
8.	Value-Added Services	The date the CFSP submits to the Department submit to the Department for approval, in the Department developed standardized template, required information as	Contract Award + thirty (30) days

[1] As defined in SL XYZ, CFSP will launch on December 1, 2024. Upon Contract award and based on the Offeror's responses, the Department will work with NCGA to establish an appropriate launch date.

First Revised and Restated Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
		described in *Section V.C.1.h.Value-Added Services.*	
9.	ILOS Service Request Form	The date the CFSP submits to the Department the standardized ILOS Service Request Form for approval	Contract Award + thirty (30) days
10.	Draft Implementation Plan	The date the CFSP's Implementation Plan Draft must be submitted to the Department	Contract Award + forty-five (45) days
11.	Submission of Member education efforts	The date the CFSP submits its planned Member education efforts to the Department	Contract Award + sixty (60) days
12.	Acquisition of service line phone numbers	The date the CFSP must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days
13.	Submission of key Member materials	The date the CFSP submits to the Department: • Enrollment and Disenrollment Policy • Member ID Card • Welcome Packet • Mailing Policy • Rights and Responsibilities Policy	Contract Award + sixty (60) days
14.	Submission of Tobacco Cessation Plan	The date the CFSP must submit a Tobacco Cessation Plan to the Department	Contract Award + ninety (90) days
15.	Submission of Fraud Prevention Plan	The date the CFSP must submit a Fraud Prevention Plan to the Department for review and approval	Contract Award + ninety (90) days
16.	Establishment of CFSP Office and Call Center(s) in NC	The date the CFSP must begin implementing call center(s) and staff in North Carolina	Contract Award + ninety (90) days
17.	Submission of Locum Tenens Policy	The date the CFSP submits to the Department the Locum Tenens Policy	Contract Award + ninety (90) days
18.	Tribal Engagement Strategy	The date the CFSP's Tribal Engagement Strategy must be submitted to the Department for review	Contract Award + ninety (90) days
19.	Pharmacy Provider Network Audit Program	The date the CFSP's Pharmacy Provider Network Audit Program must be submitted to the Department	Contract Award + ninety (90) days

First Revised and Restated Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
20.	Mail Order Program Policy	The date the CFSP's Mail Order Program Policy, including a sample of all Member mail order-related correspondence, must be submitted to the Department	Contract Award + ninety (90) days
21.	Critical Incident Response Policy	The date the CFSP submits to the Critical Incident Response Policy	Contract Award + ninety (90) days
22.	Good Faith Provider Contracting Policy	The date the CFSP shall develop and submit Good Faith Provider Contracting Policy that includes a description of how the CFSP will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions	Contract Award + ninety (90) days
23.	Submission of Third Party Liability Policy	The date the CFSP submits to the Department the Third Party Liability Policy	Contract Award + ninety (90) days
24.	Whistleblower Policy	The date the CFSP shall develop and submit a Whistleblower Policy related to whistleblower protections	Contract Award + ninety (90) days
25.	Opioid Misuse Prevention and Treatment Program Policy	The date the CFSP shall develop and submit an Opioid Misuse Prevention Program Policy	Contract Award + ninety (90) days
26.	Submission of Training Program	The date the CFSP's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
27.	Submission of Transition of Care Policy	The date the CFSP shall submit the Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
28.	Provider Transition of Care Policy	The date the CFSP shall submit the Provider Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
29.	EPSDT Policy	The date the CFSP submits to the Department the EPSDT Policy	Contract Award + ninety (90) days
30.	NEMT Policy	The date the CFSP submits to the Department the NEMT Policy	Contract Award + ninety (90) days
31.	Submission of Local Community Collaboration Strategy	The date the CFSP must submit the Local Community Collaboration Strategy to the Department for review and approval	Contract Award + ninety (90) days

First Revised and Restated Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
32.	Provider Hardship Payment Policy	The date the CFSP shall submit the Provider Hardship Payment Policy to the Department for review and approval	Contract Award + ninety (90) days
33.	Conflict of Interest Policy	The date the CFSP shall submit the Conflict of Interest Policy to the Department	Contract Award + ninety (90) days
34.	Prevention and Population Health Management Plan	The date the CFSP shall submit the Prevention and Population Health Management Plan for review and approval	Contract Award + ninety (90) days
35.	Member Engagement and Marketing Plan for Historically Marginalized Populations	The date the CFSP shall submit Member Engagement and Marketing Plan for Historically Marginalized Populations goals and strategies for engaging with Historically Marginalized Populations, specific initiatives to address disparities, and expected outcomes of the plan.	Contract Award + one hundred twenty (120) days
36.	Key Personnel	The date the CFSP must fill all Key Personnel positions listed in *Section V.A.9. Table 1: CFSP Key Personnel Requirements*	May 9, 2025
37.	Member Grievance Policy	The date the CFSP must submit the Member Grievance Policy.	Contract Award + one hundred twenty (120) days
38.	Provider Grievances and Appeals Policies	The date the CFSP shall submit the CFSP Provider Grievances and Appeals Policies	Contract Award + one hundred twenty (120) days
39.	Submission of key clinical and Care Management materials	The date the CFSP must submit to the Department • Care Management Policies • UM Program Policies, including Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy • System of Care Policy • In-Reach and Transition Policy	Contract Award + one hundred twenty (120) days
40.	AMH Performance Incentive Payments Methodology	The date the CFSP must submit its AMH Performance Incentive Payments Methodology for review and approval	Contract Award + one hundred twenty (120) days

First Revised and Restated Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
41.	Submission of VBP Assessment and VBP Strategy for Medicaid	The date the CFSP's first retrospective VBP Assessment and prospective VBP Strategy must be submitted to the Department	Contract Award + six (6) months
42.	Draft CFSP Marketing Materials	The date the CFSP's Marketing Materials must be submitted to the Department	Ninety (90) days before use of CFSP Marketing Materials
43.	Commencement of Marketing Activities	The date the CFSP is allowed to begin Marketing activities	Eight (8) weeks before Auto-Enrollment
44.	PHP license	Deadline for CFSP to obtain a PHP license issued by the NCDOI, if applicable under Section V.A.2.b.ii	One hundred eighty (180) days before CFSP launch
45.	Contracting with AMHs/PCPs	The date the contracts must be finalized with providers to allow for PCP assignment	Ninety (90) days before CFSP launch
46.	Compliance Program report	The date the CFSP shall submit a Compliance Program report describing the workplans for the upcoming year.	Ninety (90) days before CFSP launch
47.	PCP Auto Assignment	The date that PCP auto assignment must be completed for Members enrolling in the CFSP at launch	Sixty (60) days before CFSP launch
48.	CFSP Care Management Member Enrollment Packets	The date the CFSP will send Members the CFSP Care Management Enrollment packet, with information on their Care Management assignment and options for changing their assignment	Thirty (30) days before CFSP launch
49.	CFSP Launch	The date the CFSP must begin delivering health care services to Members	December 1, 2025
50.	Funding of Risk Reserves	The CFSP must meet the capital requirements as outlined in *Section V.J.3.f. Financial Viability*	December 1, 2025
51.	System Test Plan	The date the CFSP shall submit the System Test Plan to the Department	Contract Award + ninety (90) days
52.	Marketing Plan	The date the CFSP shall submit its marketing plan to the Department for review and approval	Contract Award + sixty (60) days

First Revised and Restated Attachment I: Reporting Requirements

The following tables detail the reports that the CFSP must submit to the Department. The Department will provide additional details on report format, fields and frequency. For select reporting requirements, the CFSP is expected to submit a report with metrics for Medicaid as identified in *First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements* and *First Revised and Restated Attachment I. Table 2: CFSP Data Extracts.*

The Department will provide additional details and on report format, fields and frequency.

1. Although the State has indicated the reports that are required, the CFSP may suggest additional reports.
2. As part of Readiness Review, the CFSP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. The Department reserves the right to require additional reports beyond what is included in this document.
4. The CFSP shall submit complete and accurate data required by the Department for tracking information on Members obtaining Medicaid benefits in the CFSP and with providers contracted to provide those services.
    a. This information shall include information on consumer eligibility for services, shadow claims, demographics, adverse events and service outcomes for consumers served by the CFSP.
5. The CFSP shall submit all data on a schedule provided by the Department.
6. The CFSP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to the Department.
7. The CFSP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to the Department.

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
1. Administration and Management		
a. CFSP Operating Report	Annual report of each entity identified under the CFSP Operating Report, providing evidence of CFSP oversight activities and entity performance (i.e. metrics, CAPs, sanctions).	Annually
2. Members		
a. 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.	Quarterly
b. 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.	Quarterly
c. Member Appeals and Grievances Report	Monthly report on the Appeals and Grievances received and processed by the CFSP including the total number of Appeal and Grievance requests filed with the CFSP, the basis for each Appeal or Grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Monthly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
d. Children with Complex Needs Report	Monthly report containing the names and Member Medicaid ID numbers of Children with Complex Needs statewide.	Monthly
e. Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Quarterly
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
g. CFSP Enrollment Summary Report	Monthly summary report highlighting key Member Enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of Enrollment and disenrollment by Medicaid eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
h. 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).	Weekly
i. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
j. Nursing Facility Admission Disenrollment Report	Ad-hoc report including the process for a Member's disenrollment from the CFSP due to a Nursing Facility stay longer than 90 days.	Ad hoc
3. Care Management		
a. System of Care Report	Quarterly report of System of Care activities, including, but not limited to, coordination with Community Collaboratives, care planning, and implementation of evidence-based practices in communities.	Quarterly
b. CMHRP Corrective Action Plan Report	Quarterly CMHRP report on corrective action plan and the associated decision reasoning.	Quarterly
c. Care Needs Screening Report	Quarterly report of Beneficiary screening results including SDOH and Care Needs Screening	Quarterly
d. Local Health Department (LHD) Contracting Report	Monthly report of LHD Care Management contracting.	Monthly
e. PCP Operational Monitoring Report	Report to gather data related to PCP assignment, provider panel and demographics, and ongoing assignment activities to facilitate the Department's monitoring efforts.	Bi-Weekly
f. Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots. Further guidance will be provided at a later date.	Quarterly
g. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.	Monthly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
h. AMH Contracting Report	Monthly report of paid AMH Medical Home Fees.	Monthly
i. Substance Abuse/Juvenile Justice Initiative Monthly Report	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
j. Nursing Facility Transitions Report	Quarterly report listing CFSP Members discharged from a nursing facility and to where they were discharged.	Quarterly
k. High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
l. Care Management Ineligibility Report	Quarterly report listing Members ineligible for Care Management provided by the CFSP (e.g., Members receiving High-Fidelity Wraparound, Members in ACT)	Quarterly
m. Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a Qualified Professional in Substance Abuse (QPSA).	Quarterly
n. High-Fidelity Wraparound Report	Quarterly report demonstrating • Fidelity to the High-Fidelity Wraparound model using the WFI-EZ • Members' length of stay in High-Fidelity Wraparound • Use of crisis services, including length of service • Residential placements (after initial return home, number of additional placements during High-Fidelity Wraparound, and length of stay in placements during High-Fidelity Wraparound) • Number of informal supports at the end of High-Fidelity Wraparound • Increase in self-efficacy and skills using the Transition Asset Tool	Quarterly
o. Local Department of Social Services (DSS) Office Boarding Report	Daily report of all children under age 18 who are boarding in a DSS office awaiting Medicaid-funded Medically Necessary treatment for twenty-four (24) hours or more, document detailed plans to ensure member receives medically necessary treatment and escalation to CFSP Chief Medical Officer or designee.	Daily
p. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Data entry to document rental subsidy and leasing information and updates for individuals including, but not limited to, members with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) residing in or at risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) platform or other systems determined by the State.	Daily

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
q. 1915(i) Service Care Management Report	Quarterly report providing the number of Members obtaining 1915(i) Services actively engaged in CFSP Care Management. In the event the CFSP delegates CFSP Care Management to care management agencies, report must also include the number of Members obtaining 1915(i) Services at each care management agency that is also a 1915(i) service provider.	Quarterly
4. Providers		
a. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for Provider Contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
b. 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).	Ad hoc
c. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
d. PHP NEMT Provider Contracting Report	Non-emergency provider contracting report at a detailed and summary level from the CFSP's	Twice per month
e. PCP CFSP Panel Capacity Limit Report	PCP CFSP Panel Capacity Limit Report.	Weekly until launch and then monthly
f. 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.	Annually
g. 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. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
h. Provider Grievances and Appeals Report	Monthly report of all Provider Appeals and Grievances and Provider Grievance and Appeal statistics, including number/type of Appeals, Appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
i. 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.	Quarterly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
j. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly
k. 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.	Annually
l. 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. Submit with Timely Access Physical Health Provider Appointment Wait Times Report.	Annually
m. Provider Preventable Conditions Log	Quarterly report of Provider Preventable Conditions.	Quarterly
n. Rate Ceiling Necessity Report	Report to identify provider types for which the CFSP recommends an establishment of a rate ceiling, to include information supporting the recommendation.	Ad hoc
o. Local Health Department Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: local health departments. The CFSPs will leverage the template to use their data to calculate the Directed Payment and submit it as an “invoice” to NC Medicaid for payment. The CFSPs will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the CFSP as an enclosure from NC Medicaid with formal instructions to pay each Local Health Department the amounts in accordance with the invoice summary.	Quarterly
p. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: public ambulance providers. The CFSP will leverage the template to use their data to calculate the Directed Payment and submit it as an “invoice” to NC Medicaid for payment. The CFSP will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the CFSP as an enclosure from NC Medicaid with formal instructions to pay each Public Ambulance Provider the amounts in accordance with the invoice summary.	Quarterly
q. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for OON services, including status of requests of each request, determination, and basis for determination	Monthly
r. Summary UNC_ECU Physician Claims Report	Quarterly report. The CFSP will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
s. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. The CFSP will	Monthly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	include records of Members where no payment was received from the State or payment received differed from the amount expected. The CFSP will only include Member records with discrepancies on this report to the State. The CFSP Capitation Reconciliation Report will be submitted on a monthly cadence. The CFSP will indicate expected values and values observed on ASC x12 834 monthly file for Members.	
t. Emergency Department Boarding for Children in Medicaid	Daily report of all children under age 18 who are boarding in an Emergency Department awaiting Medically Necessary treatment for Behavioral Health, I/DD, or TBI. For any child in the ED for twenty-four (24) hours or more, document escalation to CFSP Chief Medical Officer or designee.	Daily
5. Quality and Value		
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
c. Service Utilization	Quarterly update on underutilization/overutilization and timely utilization of services, including joint reporting by DHB and DSS.	Quarterly
d. VBP Assessment	A report listing the VBP contracts and payments made under VBP arrangements during the relevant reporting period.	Annually
e. VBP Strategy Report	Numerical tables quantifying the CFSP's projected VBP contracts in the coming year, and the amount of payments the CFSP anticipates will fall under these contracts.	Annually
f. VBP Strategy Narrative Report	Annual narrative report accompanying VBP Strategy Report.	Annually
g. Quality Measures Report	Annual CFSP performance on quality measures.	Annually
h. Eligible Mothers for Low Birth Weight Measure	Eligible mothers of all live singleton deliveries within measurement period for low birth weight measure (DHB-0094)	Quarterly
i. Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators since 20061. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.	Quarterly Quality Measures Report

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
6. Stakeholder Engagement		
a. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by the CFSP to collaborate with county organizations to address issues by county.	Monthly
b. Tribal Engagement Report (as indicated)	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
c. Reserved.		
d. Reserved.		
7. Program Administration		
a. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
b. Service Line Issue Summary Report	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
c. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
d. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
8. Compliance		
a. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the CFSP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
b. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
c. 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.	Quarterly
d. 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.	Monthly
e. 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	Monthly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	allegation/complaint, how complaint identified, issues, and resolution.	
f. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
g. Recipient Explanation of Medical Benefits (REOMB) Report	Quarterly summary of potential and actual fraud, waste and abuse by providers including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
h. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
i. Critical Incident Reports	Report of incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance use disorder services.	Ad hoc
9. Benefits		
a. Institution for Mental Disease (IMD) Report	Bi-weekly summary of Members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-weekly
b. Medical Prior Authorization Report	Monthly report that lists each prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
c. Pharmacy Benefit Determination/Prior Authorization Report	Monthly that lists prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
d. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
e. Top GCNs and GC3s	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
f. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
g. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.	Annually
h. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.	Monthly
i. EPSDT Reports	Quarterly reports of provider/Member outreach and education on EPSDT.	Quarterly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
j. Non-Emergency Medical Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
k. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
l. Psychotropic Medications for Youth Report	Monthly report to identify trends/usage of psychotropic medications in children 17 years of age and younger.	Monthly
m. Crossover-Related NEMT Appointments Scheduled	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
n. Ongoing Status Reports on Transitions of Care	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the CFSP on an ongoing basis.	Monthly
o. Quarterly Admission & Readmission Report	Quarterly summary report of admission and readmission.	Quarterly
p. 1915(i) Performance Measures Report	Report is to demonstrate ongoing compliance with annual/semiannual/quarterly 1915(i) state plan performance measures.	Quarterly
q. 1915 (i) Service Authorization Report	The CFSP will report semi-annually on units authorized vs. units billed for certain 1915(c) waiver, 1915(i), and 1915(b)(3) services.	Semi-Annually
10. In-Reach and Transitions		
a. Rate of Institutionalization	Number and percentage of Members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported overall, by setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) and by age.	Quarterly
b. In-Reach Activity Report	Number and percentage of Members eligible for In-Reach activities who are engaged for In-Reach activities; number and percentage of Members who began transition planning following In-Reach. To be reported overall, by setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV) and by age.	Quarterly
c. IDD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that	Quarterly

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	
d. SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly
e. Transition Activity Report for Members age 18 and above	Number and percentage of Members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a Member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall and by setting where Member was discharged (e.g., state psychiatric hospital).	Quarterly
f. Transition Activity for PRTF Residents, Members Under Age 18 in a State Psychiatric Facility, and Members Receiving Residential Treatment Levels II/Program Type, III, and IV	• Average length of stay; • Total number of Members in a PRTF, Members under age 18 in a state psychiatric facility, and Members receiving Residential Treatment Levels II/Program Type, III, and IV; and • Percentage of Members under age 18 in a PRTF, Residential Treatment Levels II/Program Type, III, and IV, or state psychiatric facility.	Quarterly
11. Healthy Opportunities Pilot		
a. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the CFSP may submit if the Department notifies the CFSP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the CFSP's anticipated spending through the remainder of the Healthy Opportunities Pilot service delivery year.	N/A

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
b. Healthy Opportunities Pilot Service Delivery Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.	Monthly
c. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of CFSP administrative fund spending.	Quarterly
d. Healthy Opportunities Pilot Care Management Assignment Report (if applicable)	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Healthy Opportunities Pilot Enrolled Beneficiaries.	Monthly
e. Healthy Opportunities High Priority Population Report	Report that the CFSP will submit outlining the CFSP's plan for enrolling priority populations—including historically marginalized populations & communities in the pilot region—to understand the CFSP's enrollment plans and ensure inclusive representation of priority populations.	Annually
f. Healthy Opportunities High Priority Population Report	Report that the CFSP will submit outlining aggregate enrollment data for priority populations—including historically marginalized populations & communities in the pilot region—to understand the CFSP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a). Please include all members who are part of a high priority population in the report.	Quarterly
12. Financial Requirements		
a. Financial Reporting Template	Monthly financial report providing the Department with details on CFSP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, and expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to Encounter submissions to identify discrepancies.	Monthly
b. Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR expenditures. This report will contain a certification portion attesting that all information included is accurate.	Monthly
c. Financial Status Report	Monthly report containing expenditure categories, allocation letter number, current period expenditures, approved budget, previously reported expenditures, YTD expenditures, and un-expended balance. This report will contain Federal Non-UCR and State Special Categorical expenditures. The Department may request additional submissions of information pertaining to use of these funds on an ad hoc basis.	Monthly
d. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the TP template is	Annually

First Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	
e. Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.	Annually
f. Unaudited Financial Statements	Annual submission of the unaudited financial schedule that includes restated monthly and quarterly financials, as well as a preliminary MLR.	Annually
g. Annual CFSP Medical Loss Ratio (MLR) Report	Annual MLR report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).	Annually
h. Total Cost of Care (TCOC) and Cost Growth Report	As required in Section 5.(6)a. of Session Law 2015-245, annual report to monitor cost growth. Report will also provide a summary of cost drivers and steps the CFSP is taking to address the cost drivers and mitigate future cost growth.	Annually
i. NC PHP Claims Monitoring Report	Monthly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	Monthly

First Revised and Restated Attachment I. Table 2: CFSP Data Extracts		
CFSP Report Name	**CFSP Report Description**	**Frequency**
1. Providers		
a. Network Data Details Extract	Quarterly report containing demographic information on network providers. *Note: Ad-hoc upon request.*	Monthly Until Children and Families Specialty Plan Launch, then Quarterly and Ad Hoc thereafter
2. Members		
a. CFSP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member Enrollment activities, consistent with 42 C.F.R. §	Weekly

First Revised and Restated Attachment I. Table 2: CFSP Data Extracts		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	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. Monthly CFSP 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. *Note* If the date the extract is being submitted is prior to 7/1/2021, the extract would include member eligibility as of 7/1/2021. See the "Appx-Members Included" tab for more details.	Monthly
c. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of ABD issued by the CFSP to a Member and each Grievance received by the CFSP from Members.	Daily
3. Benefits and Care Management		
a. Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual Member, service type, determination date, and approval status.	Weekly
b. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly

First Revised and Restated Attachment L: POLICIES

1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy

a. Background

The Department will ensure that Medicaid Beneficiaries and their families and caregivers are supported in the transition to Medicaid Managed Care and the CFSP throughout the Enrollment process, including enrolling in the CFSP and selecting a Primary Care Provider (PCP). The Department will ensure Beneficiaries and their families experience a smooth transition from NC Medicaid Direct and LME/MCOs or from a Standard Plan, BH I/DD Tailored Plan, or Tribal Option to the CFSP and have the tools and resources to access care throughout CFSP implementation.

b. Scope

The North Carolina Medicaid Managed Care and CFSP Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the CFSP in the Enrollment of Beneficiaries into the CFSP. The intent of this Policy is not to replace any existing Enrollment processes related to NC Medicaid Direct.

c. Identification and Enrollment of Beneficiaries in the Auto-Enrolled Groups Eligible for the CFSP

i. Medicaid Beneficiaries meeting one of the following criteria will be eligible for Enrollment in the CFSP and referred to as the "auto-enrolled groups" unless they are otherwise part of a group excluded from managed care Enrollment:

a) Beneficiaries who are in Foster Care;
b) Beneficiaries receiving adoption assistance;
c) Beneficiaries who are enrolled in the Former Foster Youth eligibility group; and
d) Minor children of populations described in *Section VII. First Revised and Restated Attachment L.1.c.i.a - c* as long as their Parent is enrolled.

ii. The Department will employ the processes described below for the auto-enrolled group:

a) In the period between BH I/DD Tailored Plan and CFSP launch:

1. Beneficiaries eligible for the CFSP receiving services in NC Medicaid Direct will have the option to enroll in a Standard Plan, or BH I/DD Tailored Plan, as eligible, upon BH I/DD Tailored Plan launch.
2. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who become eligible for the CFSP will remain in the Standard Plan or BH I/DD Tailored Plan but will have the option of moving to NC Medicaid Direct.
3. Upon CFSP launch, Beneficiaries eligible for the CFSP in NC Medicaid Direct, enrolled in a Standard Plan or a BH I/DD Tailored Plan will be disenrolled (as applicable) and moved to the CFSP.

A. Prior to CFSP launch, the Department will send Beneficiaries who meet the "auto-enrolled groups" CFSP eligibility criteria, except as outlined below, a notice indicating that they will be auto-enrolled in the CFSP and can elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable) at any point during the coverage year.

I. CFSP excluded populations shall include Beneficiaries eligible for the CFSP:

i. Who are enrolled in the Innovations or TBI waivers;
ii. Residing in or receiving respite services at an ICF-IID;
iii. Ages 18 and older who are receiving State-funded BH, I/DD and TBI services that are not otherwise available through Medicaid,

iv. Beneficiaries receiving State-funded residential services, including group living, family living, supported living, and residential supports; and

v. Recipients enrolled in and being served under Transitions to Community Living.

II. CFSP excluded populations will instead be enrolled into BH I/DD Tailored Plans.

III. Beneficiaries enrolled in the Innovations and TBI waiver who wish to enroll in the CFSP will be required to disenroll from their respective waivers prior to submitting a disenrollment request.

IV. Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a) are exempt from Medicaid Managed Care and are auto-enrolled in the Tribal Option or NC Medicaid Direct depending on their county of residence, but will have the choice to enroll in a Standard Plan, the CFSP (as applicable), or a BH I/DD Tailored Plan (as applicable).

V. The Department will transmit CFSP assignment to the CFSP through a standard eligibility file.

4. For a Beneficiary who is eligible for the CFSP and is either auto-enrolled to the CFSP or selects a Standard Plan or BH I/DD Tailored Plan, coverage by the CFSP, Standard Plan or BH I/DD Tailored Plan begins on the first day of CFSP launch.

b) Period after CFSP Launch (ongoing Enrollment)

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the auto-enrolled groups:

A. The Department will send a notice to Standard Plan and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.

B. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria will be auto-enrolled in the CFSP effective the first of the month when CFSP eligibility was determined, unless the Member calls to request to continue Enrollment in the Standard Plan or BH I/DD Tailored Plan.

C. The following BH I/DD Tailored Plan members will remain in the BH I/DD Tailored Plan:

I. Beneficiaries enrolled in the Innovations or TBI waivers;

II. Recipients enrolled in and being served under Transitions to Community Living;

III. Beneficiaries obtaining state-funded BH, I/DD or TBI services not otherwise available through Medicaid;

IV. Beneficiaries living in state-funded residential treatment;

V. Beneficiaries residing in or receiving respite services at an ICF-IID.[1]

D. Beneficiaries who are auto-enrolled in the CFSP will have the option to re-enroll in a Standard Plan or BH I/DD Tailored Plan at any time during the coverage year.

E. If a Medicaid applicant is determined newly eligible for Medicaid, and is eligible for the CFSP, the Department will auto-enroll the applicant to the CFSP through a standard eligibility file (unless they are in a Managed Care Exempt or a CFSP excepted population).

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined. CFSP Members will have an opportunity to select a

[1] BH I/DD Tailored Plan Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan and transfer to a CFSP.

Standard Plan or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

d. **Identification and Enrollment of Beneficiaries Eligible for the CFSP on an Opt-in Basis**

i. Pending CMS approval, the following populations who are not otherwise excluded from Medicaid Managed Care as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care* shall be eligible for Enrollment in the CFSP on an opt-in basis at a date that may be later than CSFP launch. They shall have the option of enrolling in the CFSP unless they are otherwise exempt or meet an exception outlined above in *Section VII. First Revised and Restated Attachment L.1.c.ii.b.1.C.:*

a) Parents, Caretaker Relatives, Guardians and Custodians of Beneficiaries in Foster Care working toward family reunification;[2,3]
b) Minor siblings of Beneficiaries in Foster Care working toward family reunification;
c) Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home;
d) Adults identified in an open Eastern Band of Cherokee Indians Department of Public Health and Human Services Family Safety program case and any children living in the same home; and
e) Any other Beneficiary that has been involved with the child welfare system who the Department determines would benefit from Enrollment.

ii. The Department will employ the processes described below for the opt-in groups:

a) In the period prior to CFSP launch:

1. Medicaid Beneficiaries in the opt-in groups will enroll in Standard Plans or BH I/DD Tailored Plans, as eligible.

b) In the period after CFSP launch (ongoing Enrollment which may start at a date later than CFSP launch):

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the opt-in groups:

A. The Department will send a notice to Standard Plan, Tribal Option and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.
B. Beneficiaries enrolled in a Standard Plan, Tribal Option, or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria shall have the option of enrolling in the CFSP at any point during the coverage year effective the first of the month following their election.
C. Beneficiaries who elect to enroll in the CFSP will have the option to re-enroll in a Standard Plan, Tribal Option or BH I/DD Tailored Plan, as eligible at any time during the coverage year.
D. A Medicaid applicant determined newly eligible for Medicaid, and eligible for the CFSP on an opt-in basis will have the option of enrolling in a Standard Plan, Tribal Option (if applicable), BH I/DD Tailored Plan (if applicable) or CFSP.

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined for members who select the CFSP. CFSP Members will have an opportunity to select a Standard Plan, Tribal Option or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

[2] Pending CMS approval.
[3] The CFSP will recognize the Tribal definition of "parents, guardians, and custodians" in determining Tribal member eligibility for the Plan.

iii. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Available in the CFSP

a) Beneficiaries enrolled in Standard Plans who have a need for a service only available in the CFSP (i.e., a service-related request) and are eligible for Enrollment in the CFSP on an opt-in basis will be able to transfer to the CFSP in an expedited manner through the standard process that the Department will define.

e. Continuing Enrollment in the CFSP

i. CFSP Plan-eligible and enrolled individuals will continue to be eligible for the CFSP if they meet the eligibility criteria described in *Section V.B.1. Eligibility and Enrollment for CFSP*.

ii. Children in Foster Care whose Foster Care eligibility category status changes and who return to the custody of their Parents, Guardians, or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., the date their eligibility category changes).

iii. Minor children in the auto-enrolled groups shall remain eligible for CFSP Enrollment provided their Parent remains eligible for the CFSP.

iv. Parents, Guardians and Custodians of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their child remains eligible for the CFSP and County DSS is working toward family reunification.

v. Minor siblings of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their sibling remains eligible for the CFSP and County DSS is working toward family reunification.

vi. DSS shall notify the Department and the CFSP in cases where they are no longer working toward family reunification.

vii. Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home shall remain eligible for the CFSP if they continue to receive CPS In-Home Services.

a) County DSS shall notify the Department and the CFSP upon the conclusion of CPS In-Home Services Agreement.

viii. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan or BH I/DD Tailored Plan (if applicable) at Redetermination and noticed as part of their Redetermination process.

f. Medicaid Eligibility Redeterminations

i. At a CFSP Member's Medicaid renewal, if a Member is redetermined eligible for Medicaid and continues to be eligible for the CFSP, the Department will auto-enroll the Member into the CFSP, unless the Member chooses to enroll in a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment).

a) The Member will continue to have the opportunity to elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment at any point during the coverage year.

b) Members who enroll in the Innovations or TBI waiver, residing in or receiving respite services at an ICF-IID, ages 18 and older who require State-funded BH, I/DD and TBI services, including residential services, that are not otherwise available through Medicaid, and recipients enrolled in and being served under Transitions to Community Living will be disenrolled and transferred to the BH I/DD Tailored Plan effective on the first day of the month following the service request.

c) If the Member selects a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment), the Enrollment Broker will transmit the selection to the Department. The Department will in turn transmit the selection to the Standard Plan, BH I/DD Tailored Plan or Tribal Option through a standard eligibility file. Coverage of the Member by the Standard Plan, BH I/DD Tailored Plan, or Tribal Option will begin on the first day of the next month in which the Member selected the Standard Plan, BH I/DD Tailored Plan or Tribal Option.

ii. If a Member is determined to no longer be eligible for Medicaid, the Member will be notified and disenrolled from the CFSP by the Department.

g. **Special Enrollment Cases**

i. Exempt Populations

a) Exempt Population as defined in *Section V.B.1.c.ii.* that are CFSP eligible will be able to enroll in the CFSP on an opt-in basis.
b) The Enrollment Broker will provide Choice Counseling to Exempt Populations and support BH I/DD Tailored Plan (as applicable), Standard Plan, NC Medicaid Direct, CFSP, Tribal Option (as applicable), and PCP selection throughout the Beneficiary's eligibility year.
c) If a Beneficiary in an Exempt Population selects the CFSP, the Enrollment Broker will transmit the CFSP selection to the Department. The Department will transmit CFSP selection to the CFSP through a standard eligibility file.
d) If a Beneficiary in an Exempt Population elects to move from the CFSP to a Standard Plan, BH I/DD Tailored Plan or other delivery system (such as NC Medicaid Direct or Tribal Option) at any point during the Beneficiary's eligibility year, coverage of the Beneficiary by the Standard Plan, BH I/DD Tailored Plan or other delivery system begins on the first day of the next month in which the Beneficiary selected the Standard Plan, BH I/DD Tailored Plan or other delivery system.[4]
e) Beneficiaries who are eligible for the Tribal Option will be permitted to transfer to the Tribal Option from any delivery system at Redetermination and at any point during the year.

ii. Deemed newborns

a) If a Member is known to be pregnant, the CFSP shall validate that the Member selects an AMH/PCP for the child prior to the birth.
b) Upon delivery, a deemed newborn will be assigned to the CFSP unless the newborn is the child of an enrollee who meets the definition of Indian under 42 C.F.R. § 438.14(a), and the CFSP will begin providing coverage to the newborn immediately. The CFSP is responsible for the provision and payment of services for the deemed newborn in the hospital or birthing center, even if the deemed newborn has not appeared on the CFSP's roster.
c) If the CFSP receives notification of birth prior to discharge, the CFSP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.
d) The CFSP shall report the deemed newborn's birth to the Department within five (5) Calendar Days upon learning of the birth and, at a minimum, provide the Department with the mother's name, social security number, NC FAST case number, Member identification number, residing county, and the newborn's name, sex, and date of birth.
e) If the CFSP has not received confirmation of a deemed newborn's Enrollment in the CFSP through a standard eligibility file following the deemed newborn's birth, the CFSP shall notify the Department and the Enrollment Broker and send notification of the birth within sixty (60) Calendar Days from the date of delivery.

[4] There may be instances (e.g., an urgent medical need), as determined by the Department and based on the Beneficiary's needs, in which Enrollment in the new CFSP or the new delivery system may become effective sooner.

f) If the newborn is enrolled in Medicaid, the CFSP shall send a notification of the newborn's Enrollment and issue a Member identification card for the newborn to the mother within fourteen (14) Calendar Days of learning of the birth. This notice must include information on how the mother or caregiver can access care for the newborn.

h. **Disenrollment from the CFSP and Medicaid Managed Care**

i. Member disenrollment from the CFSP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from the CFSP to a Standard Plan, BH I/DD Tailored Plan (as applicable) or Tribal Option (as applicable).

ii. Member requested disenrollment

a) A Member, or an Authorized Representative, may submit a verbal or written request for disenrollment from the CFSP to the Enrollment Broker by phone, mail, in-person, or electronically.
b) A Member may request disenrollment from the CFSP and transfer to a Standard Plan, BH I/DD Tailored Plan (if applicable) or the Tribal Option (if applicable) any time during the coverage year.
c) The Member, or the Authorized Representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
d) At the time of the disenrollment request, Choice Counseling for the Member or the Member's Authorized Representative will be available from the Enrollment Broker.
e) The Enrollment Broker will process disenrollment requests in accordance with the following:

1. The Enrollment Broker will evaluate the request and will approve it.
2. The Enrollment Broker will notify the Department of its decision by the next Business Day following receipt of the request.

f) Notice of disenrollment determination

1. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval of the disenrollment request in accordance with G.S. 108D-5.7 and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
2. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.[5]

g) Expedited review of Member-initiated requests for disenrollment

1. A Member, or an Authorized Representative, may request an expedited review of the Member's disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued Enrollment in the CFSP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2. The Enrollment Broker will process requests for expedited review in accordance with the following:

A. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
B. The Department will evaluate and decide whether to approve or deny the request.

[5] 42 C.F.R. § 438.56(e).

3. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) Calendar Days of receipt of the request by the Enrollment Broker.

iii. Disenrollment required by the Department

a) The Department shall disenroll Beneficiaries from the CFSP who are no longer eligible for the CFSP who remain Medicaid Managed Care eligible at Redetermination as follows:

1. CFSP Members no longer eligible for the CFSP who remain Medicaid Managed Care mandatory will be notified by the Department that they are no longer eligible for the CFSP, that they will be auto-enrolled into a Standard Plan or BH I/DD Tailored Plan (as applicable) and that they can select a different plan. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.
2. Children in Foster Care who return to the custody of their Parents, Guardians or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., when their eligibility category changes).

b) The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:

1. Loss of eligibility

A. If the Department determines that a Member is no longer eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the CFSP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.

B. If a Member is disenrolled from a CFSP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the CFSP upon reenrollment in Medicaid. 42 C.F.R. § 438.56(g).

2. Change in Medicaid eligibility category

A. If the Department determines that a Member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care,* the Member will be notified by the Department and the Department will disenroll the Member from the CFSP. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.

3. Nursing facility long-term stays

A. A Member with a nursing facility stay that exceeds ninety (90) continuous Calendar Days will be disenrolled from the CFSP on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[6]

B. The CFSP shall utilize the Department-developed standardized process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) Calendar Days.

C. To monitor and report a Member's length of stay in a nursing facility the CFSP must use the following process:

[6] Session Law 2015-245, as amended by Session Law 2018-49.

I. Within thirty (30) days of admission to a nursing facility, the CFSP will assess a Member's health care needs and estimate the potential length of stay. If the Member requires a stay for longer than ninety (90) Calendar Days, the CFSP must notify the Department in writing within five (5) Calendar Days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.

II. The CFSP is responsible for tracking the total continuous length of stay for each Member residing in a nursing facility.

III. The Department will send the CFSP and the Member, or Authorized Representative, a written notice of disenrollment at least fourteen (14) Calendar Days before the effective date of the Member's disenrollment from the CFSP.

IV. The CFSP must notify the Department with an attestation of any Member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.

V. Coverage of the Member by the CFSP will end on the effective date provided by the Department.

c) Neuro-Medical Centers and Veterans Homes

1. A Beneficiary, otherwise eligible for Enrollment in the CFSP, residing in a state-owned Neuro-Medical Center[7] or a DMVA-operated Veterans Home[8] when the Department implements the CFSP is excluded and will receive care in these facilities through NC Medicaid Direct.
2. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of the CFSP will be disenrolled from the CFSP by the Department.

A. The Neuro-Medical Center or Veterans Home will submit the Member's information including date of admission to the Department within fourteen (14) Calendar Days of admission.

B. The Department will notify the Member and the CFSP of the disenrollment and the disenrollment effective date.

C. Coverage of the Member by the CFSP will end on the effective date provided by the Department.

3. In accordance with 42 C.F.R. § 438.56(f), Members, or an Authorized Representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department.

i. **CFSP and Managed Care Enrollment Policy Changes**

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the Enrollment processes.

[7] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities.
[8] Department of Military and Veterans Affairs, North Carolina State Veterans Homes: https://www.milvets.nc.gov/services/nc-state-veterans-homes.

2. CFSP Advanced Medical Home Program Policy

a. **Background**

i. The AMH program refers to an initiative under which a Standard Plan, a BH I/DD Tailored Plan, or the CFSP must pay Medical Home Fees to all participating primary care practices that act as PCPs. The CFSP must include the standard terms and conditions below in contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.E.4.p. Payments of Medical Home Fees to Advanced Medical Homes*

ii. An AMH "practice" will be defined by an NPI and service location.

b. **Standard Terms and Conditions for CFSP Contracts with All AMH Providers**

i. General requirements:

a) Accept Members and be listed as a PCP in the CFSP's Member-facing materials for the purpose of providing care to Members and managing their healthcare needs;
b) Provide primary care and patient Care Coordination services to each Member, in accordance with CFSP policies;
c) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for Emergency Medical Conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;
d) Provide direct patient care a minimum of thirty (30) office hours per week;
e) Provide preventive services, in accordance with *First Revised and Restated Attachment L.2. Table 1: Required Preventive Services*;
f) Maintain a unified patient medical record for each Member following the CFSP's medical record documentation guidelines;
g) Promptly arrange referrals for Medically Necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record;
h) Transfer the Member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or CFSP (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge;
i) Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the CFSP's Network Adequacy Standards;
j) Refer for a second opinion as requested by the Member, based on Department guidelines and CFSP standards;
k) Review and use Member utilization and cost reports provided by the CFSP for the purpose of AMH-level UM and advise the CFSP of errors, omissions or discrepancies if they are discovered; and
l) Review and use the monthly Enrollment report provided by the CFSP for the purpose of participating in CFSP or practice-based population health or Care Management activities.

ii. Requirements specific to Members in Foster Care:

a) Review all available clinical documentation prior to each visit.
b) Coordinate with the Member's assigned care manager and/or County Child Welfare Worker, as appropriate, and make best efforts to ensure the following occur:

1. Initial physical examination within seven (7) days of entering County DSS custody; and
2. Comprehensive physical examination within thirty (30) days of entering County DSS custody.

c) Complete DSS Child Health Summary forms during required physical examinations and return forms to the assigned County DSS.

1. For the initial 7-day physical examination, complete and return Form DSS-5206; and
2. For the comprehensive 30-day physical examination, complete and return Form DSS-5208.

d) Make best efforts to schedule and conduct follow-up well visits in accordance with the AAP Health Care Standards for Members in Foster Care:

1. Members from ages zero (0) to six (6) months: every month;
2. Members from ages six (6) to twenty-four (24) months: every three (3) months; and
3. Members from ages two (2) to twenty-one (21) years: every six (6) months.

e) Conduct required health screenings in accordance with required timeframes (as appropriate based on age and the Member's clinical condition):

1. Screening for evidence of ACEs and trauma: within thirty (30) days of entry into Foster Care and as determined necessary after that;
2. General developmental and behavioral screening (e.g., ASQ-3, PEDS, PEDS DM): within thirty (30) days of entry into Foster Care and at six (6), twelve (12), eighteen (18) and twenty-four (24) months, and three (3), four (4), and five (5) years of age;
3. Psychosocial assessment (e.g., ASQ-SE, PSC, PSC-Y, SDQ, PSQ-A, Beck's, CRAFFT, Vanderbilt, Conners, Bright Futures Adolescent Questionnaire, GAPS, HEADSSS): within thirty (30) days of entry into Foster Care and every well visit thereafter as Medically Necessary;
4. Autism Spectrum Disorder screening (e.g., MCHAT R/F, STAT): at eighteen (18) and twenty-four (24) months; and
5. Oral health screening and risk assessment (e.g., NC Priority Oral Risk and Referral Tool, Bright Futures Oral Health Risk Tool): within thirty (30) days of entry into Foster Care all subsequent well visits up to age three-and-a-half (3 ½).

f) As appropriate, coordinate with care manager to refer Member to a dental home.

g) As appropriate, utilize best practices described in "Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System" from the American Academy of Child and Adolescent Psychiatry (AACAP) when treating Members served by the child welfare system.

First Revised and Restated Attachment L.2. Table 1: Required Preventive Services

		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening						Y		Y		Y	Y	Y

First Revised and Restated Attachment L.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
	(applicable to females only)												
4	Diphtheria, Tetanus, Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenza Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

3. CFSP Pregnancy Management Program Policy

a. Background

i. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among Participating Providers. Refer to the Contract for additional detail regarding the Pregnancy Management Program.

b. Scope

i. The scope of this Policy covers the requirements that must be in agreements between the CFSP and providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program outlined below and in *Section V.D.4.c. Pregnancy Management Program in Coordination with Care Management for High-Risk Pregnant Women.*

c. Pregnancy Management Program Requirements

i. The CFSP shall incorporate the following requirements into their contracts with all providers of prenatal, perinatal and postpartum care, including the following requirements for providers of the Pregnancy Management Program:

a) Complete the standardized risk-screening tool at each initial visit.
b) Allow the CFSP or the CFSP's designated Vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
c) Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
d) Commit to decreasing the cesarean section rate among nulliparous women.
e) Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
f) Complete a high-risk screening on each pregnant CFSP Member in the program and integrate the plan of care with CFSP Care Management and/or CMHRP.
g) Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty percent (20%)).
h) Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
i) Require that CFSP network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for Members in CMHRP to the CFSP or LHD that is responsible for the provision Care Management services for high-risk pregnancy.

4. CFSP Care Management for High-Risk Pregnancy Policy

a. **Background**

i. "Care Management for High-Risk Pregnancy" refers to Care Management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs). Refer to the Contract for additional detail regarding CMHRP in *Section V.D.4.b. Local Health Departments*.

ii. For Contract Year 1, LHDs shall have "right of first refusal" as contracted providers of CMHRP Women. Women participating in CMHRP with an LHD are also eligible for CFSP Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.

iii. After Contract Year 1, CMHRP shall be fully subsumed into the CFSP Care Management model.

b. **Scope**

i. The scope of this Policy covers the agreement between the CFSP and LHD providers offering CMHRP, as outlined below and in the Contract.

c. **General Contracting Requirement**

i. LHD shall accept referrals from the CFSP for CMHRP services.

d. **Care Management for High-Risk Pregnancy: Outreach**

i. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in Care Management.

e. **Care Management for High-Risk Pregnancy: Population Identification and Engagement**

i. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated Care Management documentation system within five (5) Calendar Days of receipt of risk screening forms.

ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

iii. LHD shall accept pregnancy Care Management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Division of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

iv. LHD shall review available CFSP data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and CMHRP teams to facilitate cross-county partnerships to ensure coordination of care and appropriate Care Management assessment and services for all patients in the target population.

f. **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**

i. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for Care Management for level of need for Care Management support.

ii. LHD shall utilize assessment findings, including those conducted by the CFSP, to determine level of need for Care Management support.

iii. LHD shall document assessment findings in the Care Management documentation system.

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

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

g. **Care Management for High-Risk Pregnancy: Interventions**

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

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

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

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

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

vi. LHD shall document all Care Management activity in the Care Management documentation system.

h. **Care Management for High-Risk Pregnancy: Integration with the CFSP and Health Care Providers**

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

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

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

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

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

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

i. **Care Management for High-Risk Pregnancy: Collaboration with CFSP**

i. LHD shall work with the CFSP to ensure program goals are met.

ii. LHD shall review and monitor CFSP reports created for the Pregnancy Management Program and CMHRP services to identify individuals at greatest risk.

iii. LHD shall communicate with the CFSP regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

iv. LHD shall participate in pregnancy Care Management and other relevant meetings hosted by the CFSP.

j. **Care Management for High-Risk Pregnancy: Training**

i. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy Care Management training offered by the CFSP and/or the Department, including webinars, new hire orientation or other programmatic training.

ii. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the CFSP and/or the Department.

iii. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based Care Management of pregnancy and postpartum women at risk for poor birth outcomes.

iv. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and Trauma-Informed Care techniques on an ongoing basis.

k. **Care Management for High-Risk Pregnancy: Staffing**

i. LHD shall employ care managers meeting pregnancy Care Management competencies, defined as having at least one of the following qualifications:

a) Registered nurses
b) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
c) Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

ii. LHD shall ensure that Community Health workers for CMHRP services work under the supervision and direction of a trained care manager.

iii. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.

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

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

vi. LHD shall ensure that pregnancy care managers demonstrate:

a) A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
b) Proficiency with the technologies required to perform Care Management functions
c) Motivational interviewing skills and knowledge of adult teaching and learning principles
d) Ability to effectively communicate with families and providers
e) Critical thinking skills, clinical judgment and problem-solving abilities

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

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

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following CFSP/Department guidance about communication with the CFSP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

ix. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the CFSP.

5. CFSP Uniform Credentialing and Re-credentialing Policy

a. **Background**

This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a CFSP in determining whether to allow a provider to be included in the CFSP's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider.

b. **Scope**

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

c. **Policy Statement**

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

i. **Centralized Provider Enrollment and Credentialing**

a) The Department, or Department designated Vendor, will implement a CCRP with the following features:

1. The Department, or Department designated Vendor, shall collect information and verify credentials, through a centralized Credentialing process for all providers currently enrolled or seeking to enroll in the North Carolina's Medicaid program.

A. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.

B. The Department may, at its option, contract with a Vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

2. The Department shall apply the Credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for the Medicaid services, including all providers that must be credentialed under Credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
3. The process and information requirements shall meet the most current data and processing standards for a Credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.

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

4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid enrolled provider, with the application

serving for enrollment as a Medicaid Fee-for-Service provider as well as a Medicaid Managed Care Provider.

A. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

5. Providers will be reverified and recredentialed as permitted by the Department in the Contract.
6. The CFSP shall use its Provider Credentialing and Re-credentialing Policy to decide whether to contract with a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
7. The Department, or its designated Vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled Providers.

A. The CFSP shall use the Provider Enrollment File to identify active Medicaid Enrolled Providers who are eligible for contracting.

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

a) The CFSP shall develop and implement, as part of its Credentialing and Re-credentialing Policy, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:

1. Meet the requirements specified in 42 C.F.R. § 438.214;
2. Meet the requirements specified in this Contract;
3. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;
4. Establish that the CFSP shall accept provider Credentialing and verified information from the Department and shall not request any additional Credentialing information without the Department's approval.
5. Establish a documented process for determining if a provider is an active Medicaid Enrolled Provider and therefore eligible for contracting;
6. Prohibit the CFSP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
8. Prohibit the CFSP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E;
10. If the CFSP requires a provider to submit additional information as part of its contracting process, the CFSP's Policy shall include a description of all such information.

A. The CFSP shall make network contracting decisions based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates.

B. Examples of valid additional information include the provider's office hours, accepting new patients, ages served, and EFT information.

11. CFSP shall re-credential providers as follows:

A. The CFSP shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
B. After the Provider Credentialing Transition Period, no less frequently than every five (5) years.
C. CFSP shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.
D. CFSP shall have discretion to make network contracting decisions consistent with the Policy.

12. Include all previous versions, be published on the CFSP's website and include the Policy effective dates.
13. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of CFSP services. At a minimum, these standards shall assess a provider's ability to deliver care.
14. Describe the information that providers will be requested to submit as part of the contracting process.
15. Describe the process by which the CFSP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.214.

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

6. CFSP Management of Inborn Errors of Metabolism Policy

a. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.

b. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.

c. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that CFSP cover the full cost of evidence-based therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized Care Plan.

d. Once a client is established with a specialized treatment facility a nutrition Care Plan is developed and products prescribed. The current system of product coverage is four pronged:

    i. Clients with Health Insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers.

    ii. Clients with Medicaid coverage are served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product. Medicaid is billed for the cost of the product by IHC. The IHC will no longer serve Medicaid Beneficiaries once they transition into managed care.

    iii. Clients participating in WIC are served through the Nutrition Services Branch (NSB). Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. WIC funds are used to pay the metabolic product invoices.

    iv. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC

agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

e. The CFSP will need to establish working relationships with the NSB, Specialty Treatment Centers, and metabolic formulas suppliers/manufacturers.

DHHS/DPH/Nutrition Services Branch Contacts		
Contact Name	Title	Contact Email Address
Grisel Rivera	Nutrition Program Supervisor	Grisel.rivera@dhhs.nc.gov
Mary Anne Burghardt	State Director, Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	maryanne.burghardt@dhhs.nc.gov

Innovation Health Contact		
Contact Name	Title	Contact Email Address
Cindy Edwards	Finance and Operations Manager	cedwards@innovationhealthcenter.org

Specialty Treatment Center Contacts		
Facility	Contact Name	Contact Email Address
UNC Hospitals	Emily Ramsey, MPH, RD, CSP, LD	Emily.Ramsey@unchealth.unc.edu
UNC Hospitals	Christi Hall, MS, RD	Christine.Hall@unchealth.unc.edu
Duke University Medical Center	Surekha Pendyal, MSc, Med, RD	surekha.pendyal@dm.duke.edu
Atrium Health – Levine Children's Specialty Center	Sara Erickson	Sara.Erickson@carolinashealthcare.org

f. Members with IEM will require tracking while enrolled with the CFSP. If a Member with IEM does not appear on the CFSP monthly Enrollment roster, the CFSP must follow up with the Department, to confirm disenrollment, and specialized treatment facility to assure that the Member has ongoing coverage with another provider. The IEM client requires life-long intervention and treatment and must have the added safety net of the prior CFSP confirming coverage after leaving their plan.

7. CFSP Behavioral Health Service Definition Policy

a. Background

The CFSP Behavioral Health Service Definitions Policy provides the CFSP with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

b. Behavioral Health Services Definitions

i. 1915(i) Services: The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members covered by this Contract.

ii. Opioid Treatment Program (adults only): a location-based service for the purpose of Network Adequacy Standards.

iii. Adult Facility-Based Crisis Services: a crisis service for the purpose of Network Adequacy Standards.

iv. Facility-based Crisis Services for Children and Adolescents: a crisis service for the purpose of Network Adequacy Standards.

v. Professional treatment services in facility-based crisis: a crisis service for the purpose of Network Adequacy Standards.

vi. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of Network Adequacy Standards.

vii. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

viii. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

ix. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

x. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xi. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xii. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiii. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiv. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xv. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvi. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvii. Acute Care Hospitals with Child Inpatient Psychiatric Beds as inpatient BH services for the purpose of Network Adequacy Standards.

xviii. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xix. Partial Hospitalization: partial hospitalization for children and adults for the purposes of the Network Adequacy Standards.

xx. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxi. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxii. Urgent care for SUD:
   a) Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
   b) Services to treat a condition in which a person displays a condition which could without Diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxiii. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxiv. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxv. Urgent Care for Mental Health:
   a) Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without Diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.

b) Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxvi. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.

xxvii. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.