

Amendment Number 1
Prepaid Health Plan Services
#30-190029-DHB – PHP

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

Background:

On February 4, 2019 the Department of Health and Human Services awarded contracts for Prepaid Health Plan Services through Request for Proposal #30-190029-DHB (RFP). During the RFP evaluation process the Contractor accepted changes to the RFP through Addenda and Negotiation Documents issued by the Department. Negotiation Document #2 was incorporated into the Contract pursuant to Section III.D.17. The Entire Agreement and Order of Precedence revised and restated the RFP in its entirety to reflect changes made through Addendum 7 and Negotiation Documents #1 and #2.

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

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

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

a. Section III.A. Definitions 53. Fee-for-Service is revised and restated as follows:

53. Fee-for-Service: A payment model in which providers are paid for each service provided. NC Medicaid's Fee-for-Service program is also known as NC Medicaid Direct.

b. Section III.D. Terms and Conditions 6. BACKGROUND CHECKS is revised and restated as follows:

6. BACKGROUND CHECKS: The Department reserves the right to request a criminal background check on any Contractor's or subcontractor's current or prospective employee. The Contractor is responsible for obtaining from each prospective Contractor employee or subcontractor employee a signed statement permitting a criminal background check. Where requested by the Department, the Contractor must obtain (at their own expense) and provide the appropriate Departmental Contract Administrator with a North Carolina State Bureau of Investigation (SBI) and/or FBI background check on all new employees prior to assignment. Neither the Contractor nor their subcontractor may hire an employee who has a criminal record that consists of a felony unless prior written approval is obtained from the appropriate Departmental Contract Administrator. The Contractor shall keep any records related to these verifications for the life of the contract.

c. Section III.D. Terms and Conditions 11. CONTRACT ADMINISTRATORS.

The Department's Contract Administrator regarding day to day activities is modified as provided for below:

Name & Title	Sarah Gregosky Deputy Director of Standard Plans
Physical Address	820 S. Boylan Ave McBryde Building Raleigh, NC 27603
Mail Service Center	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7027
Fax Number	919-832-0225
Email Address	Sarah.Gregosky@dhhs.nc.gov

d. Section III.D. Terms and Conditions 28. MEDIA CONTACT APPROVAL AND DISCLOSURE is revised and restated as follows:

28. MEDIA CONTACT APPROVAL AND DISCLOSURE: Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract or a recipient of services under the Contractor shall make immediate contact with the Department when the contact occurs. Contractor must submit any information related to such media release or public disclosure to the Department for review and approval at least seven (7) business days in advance of intended disclosure. The Department may, at its sole discretion, object to its publication or require changes to the information intended for public release. The requirements of this Section shall not apply to any information the Contractor is required by law to disclose.

e. Section III.D. Terms and Conditions 32. PAYMENT AND REIMBURSEMENT b. PMPM Capitated Payments i. is revised and restated as follows:

- i. The Contractor must accept capitation rates and risk adjustment methodology developed by the Department and its actuary and approved by CMS as follows:
 - a. The Department will send the Contractor a written Notification of CMS Approved Capitation Rates (Notification of Approved Rates) within ten (10) state business days of receipt of CMS approval of the capitation rates for a Contract Year or other applicable rating period. The Notification of Approved Rates will be incorporated into the Contract as though originally set forth herein.
 - b. Contractor shall acknowledge receipt of CMS approved capitation rates by signing and returning a copy of the Department's Notification of Approved Rates within ten (10) state business days. Failure to timely return signed Notification of Approved Rates may delay PMPM payment to Contractor.

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

Specific subsections are modified as stated herein.

a. Section V.A. Administration and Management 5. Implementation e-g. are revised and restated as follows:

- e. The PHP shall provide to the Department a draft Implementation Plan fourteen (14) calendar days after Contract Award that defines, at a minimum, the following tasks and milestones:
 - i. PHP licensure and other DOI requirements;
 - ii. Provider network development, including provider education, training and contracting;
 - iii. Member engagement program, including educational materials, welcome and enrollment materials, and community outreach;
 - iv. Service Line operations;
 - v. Utilization management development and implementation;
 - vi. Care management program development and implementation, including AMH/PCP assignment;
 - vii. Transition of care data exchange;
 - viii. Quality management infrastructure;
 - ix. Member and provider enrollment systems;
 - x. Claims and encounter systems;
 - xi. Required system interfaces;
 - xii. Design, Development, and Testing Activities; and
 - xiii. Other administrative supports.
- f. To support Medicaid Managed Care implementation and operations, the PHP shall perform the following testing:
 - i. Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable.
 - ii. End to End testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting.
 - iii. Production defect resolution and testing of production incidents
- g. The Department maintains the discretion to require the PHP to establish similar implementation teams, plans and testing requirements, including additional environments to support testing and implementation, on an ongoing basis as new program requirements are implemented or prior to the PHP effectuating, for example, a material program, operational or technical change

b. Section V.A. Administration and Management 9. Staffing and Facilities d. Key PHP Personnel is revised to add the following:

- viii. If the PHP is unable to find a candidate for a key personnel position that meets the full requirements of the Contract, the PHP may submit an exception request for the Department's approval. The exception request shall include the proposed candidate and mitigation and reporting strategy to fulfil the full requirements of the Contract. The Department reserves the right to provide input on the mitigation and reporting strategy, specify conditions for approval, and request documentation and provide feedback on performance of candidate.

- c. Section V.A. Administration and Management 9. Staffing and Facilities i. Conflict of Interest iii. a) is revised and restated as follows:**
- a) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee if such Department employee participated personally and substantially in the procurement of the PHP's contract or the oversight of such contract as a Department employee.
- d. Section V.B. Members 3. Member Engagement e. Member Services Department v. is revised and restated as follows:**
- v. The PHP shall conduct ongoing quality assurance of its Member Services Department via Member surveys and internal audits of departments to ensure Member satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - a) Member surveys shall be made available after each web, call center (with exception of Behavioral Health Crisis Line) or in-person interaction.
 - b) Surveys and internal audits are intended to measure Member's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
 - c) Reports, including the results of member surveys and the PHP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- e. Section V.B. Members 3. Member Engagement k. Member Welcome Packet ii. is revised to add the following:**
- d) The PHP may opt to send the ID card or handbook separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
- f. Section V.B. Members 3. Member Engagement k. Member Welcome Packet is revised to add the following:**
- iv. All materials mailed to potential Members, and when applicable, authorized representatives, shall be sent via first class mail, unless otherwise approved by the Department through the Member Mailing Policy.
- g. Section V.B. Members 5. Member Rights and Responsibilities is revised to add the following:**
- i. The PHP shall not avoid costs for services covered in its Contract by referring NC Health Choice beneficiaries to publicly supported health care resources. 42 CFR 457.1201(p).
- h. Section V.B. Member 6. Member Grievances and Appeals b. Member Grievances and Appeals General Requirements is revised to add the following:**
- x. The PHP shall comply with Chapter 108D of the North Carolina General Statutes for all appeals and grievance proceedings.
- i. Section V.B. Members 6. Member Grievances and Appeals e. Continuation of Benefits is revised and restated as follows:**
- e. Continuation of Benefits
 - i. Timely Request for Continuation of Benefits: The PHP shall continue and pay for the Member's benefits during the pendency of the plan appeal and State Fair Hearing if all of the following occur:

- a) The Member, or the Member's authorized representative, files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(2)(ii);
 - b) The plan appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - c) The services were ordered by an authorized provider;
 - d) The period covered by the original authorization has not expired; and
 - e) The Member files for continuation of benefits within ten (10) calendar days of the PHP sending the notice of the adverse benefit determination (or before), or on the intended effective date of the PHP's proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(b).
- ii. If the PHP continues the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:
 - a) The Member withdraws the appeal or State Fair Hearing request, in writing;
 - b) The Member does not request a State Fair Hearing and continuation of benefits within ten (10) calendar days from when the PHP mails an adverse PHP decision regarding the Member's PHP appeal; or
 - c) A State Fair Hearing decision adverse to the Member is made. 42 C.F.R. § 438.420(c).
 - iii. The PHP shall not allow a provider to request continuation of benefits on behalf of a Member. 42 C.F.R. § 438.402(c)(ii).
 - iv. Following a request for continuation of benefits, the PHP shall notify the Department within twenty-four (24) hours of the decision to approve or deny the request.
 - v. Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
 - a) The PHP shall be permitted to recover the cost of services furnished to the Member during the pendency of the plan appeal and the contested case hearing if:
 - i. The PHP notified the Member of the potential for recovery;
 - ii. The PHP furnished benefits to the Member solely because of the requirement for continuation of benefits; and
 - iii. The final resolution of the plan appeal or the contested case hearing is adverse to the Member (i.e., upholds the PHP's adverse benefit determination). 42 C.F.R. § 438.420(d).
 - b) If the PHP chooses to seek to recover the cost of services provided to Members during the pendency of the plan appeal or the fair hearing, the PHP shall do the following:
 - i. Develop a Member hardship exemption process; and
 - ii. Obtain prior approval from the Department for each instance in which the PHP seeks to recover the costs of benefits provided to Members under this Section which includes an explanation of the services provided to the Member, the amount the PHP is seeking to recover and a detailed explanation for why the PHP is seeking recovery.

- j. Section V.B. Members 6. Member Grievances and Appeals f. State Fair Hearing Process i. is revised and restated as follows:**
 - i. The PHP shall comply with Chapter 108D and Article 3 of Chapter 150B of the North Carolina General Statutes for all State Fair Hearing proceedings.
- k. Section V.B. Members 6. Member Grievances and Appeals f. State Fair Hearing Process vi. Mediation is revised and restated as follows:**
 - vi. Mediation
 - a) The PHP shall notify Members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
 - b) The PHP shall inform Members that mediation is voluntary and that the Member is not required to request a mediation to receive a State Fair Hearing with OAH.
 - c) The PHP shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
- l. Section V.B. Members 6. Member Grievances and Appeals. i. Appeals and Grievances Recordkeeping and Reporting v. Medicaid Appeals and Grievance Clearinghouse is renamed and revised and restated as follows:**
 - v. Appeals and Grievance Reporting
 - a) In accordance with 42 C.F.R. § 438.416, the Department will monitor the PHP to ensure compliance with all applicable laws and rules pertaining to Member appeals and grievances.
 - b) To support the Department’s monitoring efforts, the PHP shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
 - i. Each Notice of Adverse Benefit Determination issued by the PHP;
 - ii. Each Notice of Resolution issued by the PHP; and
 - c) The PHP shall provide a report on all appeals and grievances received by the PHP from Members, or an authorized representative, in a form and frequency as described in Attachment J. Reporting Requirements.
- m. Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package a. is revised and restated as follows:**
 - a. Throughout the term of this Contract, the PHP shall promptly provide, arrange, purchase or otherwise make available all medically necessary services required under this Contract to all its Members enrolled with the PHP. Services shall be delivered within the standard of care and meet Department quality standards and expectations.
 - i. Medical Benefits is inclusive of LTSS services, including Nursing Facility Services, Home Health Services, Private Duty Nursing, Personal Care Services, and Hospice Services.
- n. Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package, Table 1: Summary of Medicaid and NC Health Choice Covered Services is revised and restated as set forth in Attachment 1, First Revised and Restated Section V.C. Table 1 Summary of Medicaid and NC Health Choice Covered Services, to this Amendment.**
- o. Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package, Table 2: Services Carved Out of Medicaid Managed Care is revised and restated as follows:**

First Revised and Restated Section V.C. Table 2: Services Carved Out of Medicaid Managed Care¹⁰
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

- p. **Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package, Table 3: Behavioral Health Services Covered in Standard Plan and BH I/DD Tailored Plans** is revised and restated as follows:

First Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plan and BH I/DD Tailored Plans ^[1]	
BH, TBI and I/DD Services Covered by <u>Both</u> SPs and BH I/DD TPs	BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD TPs (or LME-MCOs Prior To Launch)
Enhanced behavioral health services are italicized	
State Plan BH and I/DD Services <ul style="list-style-type: none"> • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Peer Support Services (upon approval of State Plan Amendment 19-006 by CMS) • <i>Partial Hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment</i> • <i>Ambulatory detoxification</i> • <i>Research-Based Behavioral Health Treatment</i> • <i>Diagnostic assessments</i> • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization</i> EPSDT	State Plan BH and I/DD Services <ul style="list-style-type: none"> • Residential treatment facility services • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • <i>Psychiatric residential treatment facilities (PRTFs)</i> • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • <i>Substance use non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) Waiver Services <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services • 1915(b)(3) services State-Funded BH and I/DD Services State-Funded TBI Services

- q. **Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package c. Covered Services** is revised to add the following requirement:

xiii. For beneficiaries newly enrolled in the PHP with no immediately prior period of Medicaid managed care enrollment or fee-for-services enrollment with inpatient coverage, the PHP shall be responsible for any diagnosis-related group based inpatient facility claims if the beneficiary's first day of PHP enrollment is during the hospital stay.

- r. **Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package e. Utilization Management xiv.e) 1-2** is deleted entirely.

- s. **Section V.C. Benefits and Care Management 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) e. is revised and restated as follows:**
 - e. When adjudicating service authorizations for members under twenty-one (21) years of age, the PHP shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the member.

- t. **Section V.C. Benefits and Care Management 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) I. is revised and restated as follows:**
 - l. The PHP shall comply with the Department’s standards for the timely provision of EPSDT services. For purposes of this Contract, the “timely provision of EPSDT services” shall mean that a Member shall have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks form the date of the request for an appointment.

- u. **Section V.C. Benefits and Care Management 3. Pharmacy Benefits d. Utilization Management iv. is revised to add the following requirement:**
 - j) The PHP shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid or NC Health Choice program or another PHP through the expiration date of the active service authorization.

- v. **Section V.C. Benefits and Care Management 3. Pharmacy Benefits h. Pharmacy Reimbursement is revised and restated as follows:**
 - i. Dispensing Fees
 - a) In accordance with Section 5.(5)a. of Session Law 2015-245, the PHP shall reimburse pharmacies a dispensing fee at a rate established by the Department.
 - b) The pharmacy dispensing fee shall be defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).
 - 1. The PHP may choose to reimburse based on flat dispensing fee of \$10.24 as defined in the Department’s 2015 cost of dispensing (COD) study or the Department’s current composite rate utilized in fee-for-service.
 - c) The Department shall perform a cost of dispensing study every five (5) years to inform the Fee-for-Service dispensing rate and notify the PHP of any changes to the pharmacy dispensing fee.
 - d) The calculation used to determine the quarterly generic dispensing rate (GDR) for tiered reimbursement shall be the same used by the Department.
 - e) A claim level GDR report shall be provided to each pharmacy provider prior to each quarterly dispensing rate adjustment for tiered reimbursement.
 - ii. Ingredient Costs
 - a) The PHP shall reimburse pharmacies ingredient costs at the same rate at the Medicaid and NC Health Choice Fee-for-Service rate.
 - b) The Fee-for-Service rates include, but are not limited to, the Wholesale Acquisition Cost, National Average Drug Acquisition Cost (NADAC), the State Maximum Allowable Cost (SMAC) list, and other financial arrangements established by the Department.
 - c) Based on lesser of logic methodology, such that the pharmacy is reimbursed the U&C if it is less than the allowed amount.

- iii. The PHP shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.
- iv. Subject to Department review and approval, in Contract Year Two (2), the PHP may develop its own pharmacy contracting for ingredient reimbursement if the PHP can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the PHP must also submit a pharmacy network access monitoring plan.
- v. The PHP shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the PHP.
- vi. Reimbursement Inquiries. The PHP shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.

w. Section V.C. Benefits and Care Management 4. Transition of Care. c. vii.-viii. are revised and restated as follows:

- vii. The PHP shall bear the financial responsibility for diagnosis-related group based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the PHP (or prior in the case of a beneficiary who is inpatient on their first day of enrollment in the PHP if there is no prior Medicaid managed care or fee-for-service coverage for inpatient) through the date of discharge from such facility. Post discharge care may be coordinated prior to discharge.
- viii. The PHP shall establish a written PHP Transition of Care Policy.
 - a) The PHP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and processes and procedures for:
 1. Coordination of care for Members who have an ongoing special condition;
 2. Coordination of Members transitioning from Medicaid Fee-for-Service into Medicaid Managed Care;
 3. Coordination of Members transitioning from Local Management Entity/Managed Care Organization (LME/MCOs) into Standard Plans;
 4. Coordination of Members transitioning from Medicaid Managed Care into Medicaid Fee-for-Service;
 5. Coordination of Members transitioning from the PHP to another PHP, including the Tribal Option or other types of PHPs established by the Department;
 6. Coordination for Members in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in Section V.C.7. Prevention and Population Health Management Programs;
 7. Coordination of services delivered under other sources of coverage, including Medicaid Fee-for-Service;
 8. Notification of the Department of members who have had two (2) or more visits to the emergency department for a psychiatric problem or two (2) or more episodes using behavioral health crisis services within the prior eighteen (18) months as defined in Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48; and
 9. Other requirements as defined in this Section.
 - b) The PHP shall submit the PHP Transition of Care Policy to the Department for review and approval ninety (90) calendar days after Contract Award.

- x. **Section V.C. Benefits and Care Management 6. Care Management d.i. is revised to add the following:**
 - o) Proposed methodology for calculating Return on Investment (ROI) of the Care Management Program.

- y. **Section V.C. Benefits and Care Management 7. Prevention and Population Health Management Programs g. Tobacco Cessation Services is revised to add the following:**
 - iv. The PHP shall develop a comprehensive Tobacco Cessation Plan, which includes the Department’s QuitLine benefit, and a tobacco cessation program aimed at reducing tobacco use, including associated marketing strategies.
 - v. The PHP shall submit the Tobacco Cessation Plan to the Department for review and approval annually or upon request by the Department.

- z. **Section V.C. Benefits and Care Management 7. Prevention and Population Health Management Program is revised to add the following:**
 - k. In addition to the Opioid Misuse Prevention Program description and Tobacco Cessation Plan, the PHP shall develop a comprehensive Prevention and Population Health Management Plan that defines the PHP’s methods to promote better health outcomes, including the Department’s selected health priorities, and integration with the Department’s other public health and human services programs. The Prevention and Population Health Management Plan shall be submitted to the Department for review and approval annually or upon request by the Department.

- aa. **Section V.D. Providers 2. Provider Network Management c. Provider Contracting xx. is revised and restated as follows:**
 - xx. The PHP shall contract with the Division of State-Operated Healthcare Facilities using a Department-developed contract template to be delivered after award for the purposes of contracting with the following State-operated facilities for alcohol treatment, drug treatment, and psychiatric care:
 - a. Julian F Keith ADATC,
 - b. R.J. Blackley ADATC,
 - c. Walter B. Jones ADATC,
 - d. Cherry Hospital,
 - e. Broughton Hospital, and
 - f. Central Regional Hospital.

- bb. **Section V.D. Providers 2. Provider Network Management c. Provider Contracting is revised to add the following:**
 - xxi. The Department may at its discretion require the PHP to use a Department-developed contract template for other state-owned providers.

- cc. **Section V.D. Providers 2. Provider Network Management g. Credentialing and Re-credentialing Process is revised to add the following:**
 - ix. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to Section III.D.5. Availability of Funds, DHHS shall indemnify, defend, and hold harmless the PHP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing

information provided to the PHP by the Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the PHP and relied upon by the PHP in credentialing a provider for participation in the PHP's network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The PHP shall have the option to participate at its own expense in the defense of such claims or actions filed and the PHP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the PHP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The PHP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PHP's use of and reliance on such credentialing information.

dd. Section V.D. Providers 2. Provider Network Management I. Provider Directory vi. is revised and restated as follows:

- vi. All provider directories must comply with 42 C.F.R. § 438.10(h)(1). The full provider file, also known as the PHP Network File, delivered to the Enrollment Broker as described in Section V.K. Technical Specifications shall include the following information, at a minimum:
- a. Provider name;
 - b. Provider demographics (first, middle, and last name, gender);
 - c. Providers 3-digit Location Code;
 - d. Provider DBA Name;
 - e. Provider Service Location Name;
 - f. Provider mailing address;
 - g. Provider type (AMH Tier 1, AMH Tier 2, PCP, etc.);
 - h. Provider type effective date;
 - i. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - j. Street address(as) of service location(s);
 - k. County(ies) of service location(s);
 - l. Telephone number(s) at each location;
 - m. After hours telephone number(s) at each location;
 - n. Website URL(s);
 - o. Provider specialty (Taxonomy Codes) by location;
 - p. Whether provider is accepting new beneficiaries;
 - q. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
 - r. Whether provider has completed cultural competency training;
 - s. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
 - t. A telephone number a Member can call to confirm the information in the directory;
 - u. Excluded provider indicator;
 - v. Essential provider indicator;
 - w. IHCP indicator; and
 - x. Contract Start/End Date.

ee. Section V.D. Providers 2. Provider Network Management I. Provider Directory is revised to add the following:

- ix. For purposes of PHP's consumer-facing provider directories referenced in Section V.D.2.I.i.-ii., the directories shall include, at a minimum, all of the fields listed in Section V.D.2.I.vi. except for subsections c., f., h., u., and x of Section V.D.2.I.vi. For purposes of Section V.D.2.I.vi.o., consumer-facing directories shall include the description of the respective provider specialty by location in place of the taxonomy code.

ff. Section V.D. Providers 3. Provider Relations and Engagement c. Provider Education and Training i. is revised and restated as follows:

- i. The PHP shall provide education, specific to the Medicaid Managed Care requirements, policies, including the Department's Managed Care Provider Billing Guide, and procedures, training and technical assistance on all PHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.

gg. Section V.D. Providers 4. Provider Payments d. Physician and Physician Extender Payments i. is revised and restated as follows:

- i. The PHP shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid Fee-for-Service Fee Schedule rate or bundle, as set by the Department, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

hh. Section V.D. Providers 4. Provider Payments g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments i. is revised and restated as follows:

- i. The PHP shall reimburse FQHCs and RHCs for covered services at no less than the following rates:
 - a) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
 - b) All core services shall be based on each FQHC or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.

ii. Section V.D. Providers 4. Provider Payments i. Local Health Department (LDH) Payments i. is revised and restated as follows:

- i. The PHP shall reimburse in-network local health departments no lower than base rates specified in the North Carolina Medicaid Local Health Department Fee Schedule. The PHP shall reimburse the LHDs in accordance with this schedule for EPSDT well child exams, low-risk family planning and obstetrical services or STD exams provided by enhanced role nurses.

jj. Section V.D. Providers 4. Provider Payments m. Nursing Facility Payments i. is revised and restated as follows:

- i. For Contract Years 1 – 3, the PHP shall reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee-for-Service rate in effect the first day of each quarter (e.g., January 1, April 1, July 1 and October 1), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

kk. Section V.F. Stakeholder Engagement is revised to add the following:

4. Local Area Crisis Services Plan

- a. As defined in N.C. General Statute § 122c-202.2(b), the PHP shall participate in the development and implementation of behavioral health community crisis services plans, including:
 - i. Actively participate in the development of all local area crisis services plans in each Region covered by this Contract,
 - ii. Mutually agree in writing to all local area crisis services plans in each Region covered by this Contract,
 - iii. Contract for the relevant behavioral health crisis services with the provider(s) identified in each local area crisis plan, and
 - iv. Coordinate with LME-MCOs and local communities around efforts to increase access to and secure the sustainability of behavioral health crisis options, including through development of innovative approaches to behavioral health crisis management as defined in each local area crisis plan.
- b. The PHP shall develop Comprehensive Local Crisis Management Plan that outlines the following:
 - i. Approach to integrate with each LME/MCO and local communities in the development and implementation of each local area crisis service plan,
 - ii. Planned activities for the upcoming year to support the development, implementation and ongoing operations of all plans in each Region covered by this Contract,
 - iii. Progress on planned activities for the prior year to support the development, implementation and ongoing operations of all plans in each Region covered by this Contract, and
 - iv. Barriers to accomplishing the planned activities for the prior year.
- c. The PHP shall submit the Comprehensive Local Crisis Management Plan annually within sixty (60) days of the end of each Contract Year, when significant changes (including agreement on new Local Area Crisis Service Plan) are made or as requested by the Department.
 - i. The first Comprehensive Local Crisis Management Plan is due within sixty (60) calendar days of the PHP's agreement of any Local Area Crisis Service Plan.
 - ii. If the PHP has not agreed to any Local Area Crisis Plan by November 30, 2019, the PHP shall provide a status update on progress on each required Local Crisis Management Plan, including contracting with behavioral health crisis providers.

II. Section V.G. Program Operations 1. Service Lines b.v. Behavioral Health Crisis Line is revised and restated as follows:

- v. Behavioral Health Crisis Line: To provide Members with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year through a confidential, toll free access, and emergency referral with immediate access to trained, skilled, licensed behavioral health professionals who provide assistance for any type of

behavioral health distress the Member may be experiencing, and offers assistance in linking Members to supportive available community resources. In addition to accessing call recordings in real time, the PHP shall maintain a record of telephonic crisis line encounters, including date of the call, type of call, and disposition and make available to the Department upon request.

mm. Section V.G. Program Operations 1. Services Lines d. is revised and restated as follows:

- d. The PHP service lines shall be accessible via a toll-free telephone line. The PHP shall establish and maintain a direct inward dialing (DID) number for each required service line to allow for warm transfers between the PHP, the Department and other Department vendors.

nn. Section V.G. Program Operations 2. Staff Training c. is revised and stated as follows:

- c. The PHP shall begin training new staff to the North Carolina Medicaid Program within seven (7) calendar days of their start date and complete within sixty (60) calendar days, unless otherwise approved by the Department.

oo. Section V.G. Program Operations 3. Reporting g. is revised and restated as follows:

- g. The PHP shall provide all necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements, including in the administration of North Carolina's Section 1115 Demonstration Waiver and to maximize federal match of state funds.

pp. Section V.H. Claims and Encounter Management 1. Claims a. is revised and restated as follows:

- a. In order to incentivize successful Medicaid Managed Care and increase provider participation, the PHP shall pay all providers on a timely basis upon receipt of any clean medical and pharmacy claims for covered services rendered to covered Members who are enrolled with the PHP in accordance with state and federal statutes. To maximize federal match and ensure accurate reporting, the PHP shall comply with the Department's Managed Care Provider Billing Guide or as otherwise directed by the Department.

qq. Section V.I. Financial Requirements 1. Capitation Payments g. is revised and restated as follows:

- g. The Department has established a separate maternity event payment. This payment will be made to the PHP after the PHP submits required documentation of a successful delivery event, defined as a qualifying birth, to the Department. The required documentation and process for submission will be finalized prior to Contract Year 1 effective date, and annually thereafter, and included in an Amendment.

rr. Section V.I. Financial Requirements 3. Financial Management is revised to add the following:

- g. Financial accounting and audit
 - i. The PHP's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), and this Contract. The Department will not recognize or pay services that cannot be properly substantiated by the PHP and verified by HHSC. The PHP shall:

- a) Maintain accounting records for this Contract separate and apart from other corporate accounting records;
 - b) Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
 - c) Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the PHP. The PHP must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the PHP; and
 - d) Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts.
- ii. The PHP shall reimburse the Department, if reimbursement is sought, for reasonable costs incurred by the Department to perform examinations, investigations, audits, or other types of attestations the Department reasonably determines are necessary to ensure PHP compliance with this Contract. The use of and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are also at Department's sole discretion.
 - iii. If, as a result of an audit or review of payments made to the PHP, the Department discovers a payment error or overcharge, the Department will notify the PHP of such error or overcharge. The Department will be entitled to recover such funds as an offset to future payments to the PHP, or to collect such funds directly from the PHP.
 - a) The PHP must return funds owed to the Department within 30 Days after receiving notice of the error or overcharge, or interest will accrue on the amount due.
 - b) The Department will calculate interest at 12% per annum, compounded daily. In the event that an audit reveals that errors in reporting by the PHP have resulted in errors in payments to the PHP, the PHP will indemnify the Department for any losses resulting from such errors, including the cost of audit.

ss. Section V.K. Technical Specifications 6. Technology Documents is revised to add the following:

- e. System Test Plan. The PHP shall develop and maintain a System Test Plan inclusive of the PHP'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 annually at the end of each Contract Year by July 31 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 technique or tools that will be used for testing;
 - v. Test Environment; and
 - vi. Test Metrics and Reporting of Defects.

tt. Section V.K.7. PHP Data Management and Health Information Systems is revised to add the following:

- b. The PHP shall submit encounters and claims to North Carolina’s Health Information Exchange, known as NC HealthConnex, as defined in Session Law 2019-23.

3. Section VII. Attachments A-N.

Specific attachments and subsections are modified as stated herein.

a. Section VII. Attachment G. Required Standard Provisions for PHP and Provider Contracts is revised and restated in its entirety as set forth in Attachment 2, First Revised and Restated Attachment G. Required Standard Provisions for PHP and Provider Contracts, to this Amendment.

b. Section VII. Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers is revised and restated in its entirety as set forth in Attachment 3, First Revised and Restated Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers, to this Amendment.

c. Section VII. Attachment M. POLICIES 2. Advanced Medicaid Home Program Policy is renamed, Advanced Medical Home Program Policy, and any reference to the policy found in the Contract is revised accordingly.

4. Effective Date. Except as otherwise provided, this Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS. Section 2.a. is effective as of the Contract Award Date.

By signing below, the Parties agree to the amended terms and conditions outlined herein.

PHP Name

PHP Authorized Signature

Date: _____

Department of Health and Human Services

Dave Richard
Deputy Secretary
NC Medicaid

Date: _____

Amendment #1, List of Attachments:

1. Section V.C. First Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services
2. Section VII. First Revised and Restated Attachment G. Required Standard Provisions for PHP and Provider Contracts
3. Section VII. First Revised and Restated Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers

Attachment 1 to Amendment #1

FIRST REVISED AND RESTATED				
Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Inpatient hospital services	<p>Services that –</p> <ul style="list-style-type: none"> Are ordinarily furnished in a hospital for the care and treatment of inpatients; Are furnished under the direction of a physician or dentist; and Are furnished in an institution that - <ul style="list-style-type: none"> (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. <p>Inpatient hospital services include:</p> <p>Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66.</p> <p>Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to Subsection 1.1.1, above) may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a).</p> <p>Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid and NCHC beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary’s need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive</p>	<p>SSA, Title XIX, Section 1905(a)(1)</p> <p>42 C.F.R. § 440.10</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>North Carolina Medicaid State Plan, Att. 3.1-E</p> <p>NC Health Choice State Plan, Section 6.2.1</p> <p>NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services</p> <p>NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services</p> <p>NC Clinical Coverage Policy 2A-3, Out of State Services</p>	Yes	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven (7)-consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58.</p> <p>Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS.</p> <p>Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services.</p> <p>Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval.</p> <p>Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program</p>			
Outpatient hospital services	<p>Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—</p> <p>Are furnished to outpatients;</p> <p>Are furnished by or under the direction of a physician or dentist; and</p> <p>Are furnished by an institution that—</p> <p>(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and</p> <p>(ii) Meets the requirements for participation in Medicare as a hospital; and</p>	<p>SSA, Title XIX, Section 1905(a)(2)</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan, Section 6.2.2</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.</p> <p>Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program</p>			
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	<p>SSA, Title XIX, Section 1905(a)(4)(B)</p> <p>42 U.S.C. 1396(d)(r)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p> <p>NC Clinical Coverage EPSDT Policy Instructions</p> <p><i>Section V.C.2.: Early and periodic screening, diagnostic and treatment services (EPSDT) of the Contract</i></p>	YES	NO
Nursing facility services	<p>A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services.</p> <p>A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility</p>	<p>SSA, Title XIX, Section 1905(a)(4)(A)</p> <p>42 C.F.R. § 440.40</p> <p>42 C.F.R. § 440.140</p> <p>42 C.F.R. § 440.155</p> <p>NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9</p> <p>NC Clinical Coverage Policy 2B-1, Nursing Facility Services</p> <p>NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities</p>	YES	YES
Home health services	Home Health Services include medically necessary skilled nursing services, specialized	SSA, Title XIX, Section 1905(a)(7)	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	<p>42 C.F.R. § 440.70</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 3A</p>		
Physician services	<p>Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician—</p> <p style="padding-left: 40px;">Within the scope of practice of medicine or osteopathy as defined by State law; and</p> <p style="padding-left: 40px;">By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.</p> <p>All medical services performed must be medically necessary and may not be experimental in nature.</p> <p>Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.</p> <p>In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through</p> <ol style="list-style-type: none"> 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. <p>Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.</p>	<p>SSA, Title XIX, Section 1905(a)(5)</p> <p>42 C.F.R. § 440.50</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h</p> <p>NC Health Choice State Plan, Section 6.2.3</p> <p>NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment</p> <p>NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry</p> <p>NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants</p> <p>NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children</p> <p>NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation</p> <p>NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy		
		NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair)		
		NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy		
		NC Clinical Coverage Policy 1A-12, Breast Surgeries		
		NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy		
		NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia		
		NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity		
		NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum		
		NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy		
		NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies		
		NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services		
		NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm		
		NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision		
		NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services		

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education		
		NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation		
		NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation		
		NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies		
		NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP)		
		NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy		
		NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing		
		NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures		
		NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services		
		NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA)		
		NC Clinical Coverage Policy 1A-38, Special Services: After Hours		
		NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions		

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation</p> <p>NC Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone</p> <p>NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation</p> <p>NC Clinical Coverage Policy 1B, Physician's Drug Program</p> <p>NC Clinical Coverage Policy 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc)</p> <p>NC Clinical Coverage Policy 1B-2, Rituximab (Rituxan)</p> <p>NC Clinical Coverage Policy 1B-3, Intravenous Iron Therapy</p>		
Rural health clinic services	<p>Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. Child health assistance in RHCs is authorized for NC Health Choice beneficiaries in 42 U.S.C. 1397jj(a)(5).</p> <p>The specific health care encounters that constitute a core service include the following face to face encounters:</p> <ul style="list-style-type: none"> a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician’s services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; 	<p>SSA, Title XIX, Section 1905(a)(9)</p> <p>42 C.F.R. § 405.2411</p> <p>42 C.F.R. § 405.2463</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p> <p>NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>c. nurse practitioners and incident services supplied;</p> <p>d. nurse midwives and incident services supplied;</p> <p>e. clinical psychologists and incident services supplied; and</p> <p>f. clinical social workers and incident services supplied.</p>	<p>NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>		
Federally qualified health center services	<p>Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program.</p> <p>Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in U.S.C. 1397jj(a)(5).</p> <p>The specific health care encounters that constitute a core service include the following face to face encounters:</p> <p>a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician’s services, including drugs and biologicals that cannot be self-administered;</p> <p>b. services provided by physician assistants and incident services supplied;</p> <p>c. nurse practitioners and incident services supplied;</p> <p>d. nurse midwives and incident services supplied;</p> <p>e. clinical psychologists and incident services supplied; and</p> <p>f. clinical social workers and incident services supplied.</p>	<p>SSA, Title XIX, Section 1905(a)(9)</p> <p>42 C.F.R. § 405.2411</p> <p>42 C.F.R. § 405.2463</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p> <p>NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>	YES	YES
Telemedicine	<p>The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.</p>	<p>42 C.F.R. § 410.78</p> <p>NC Clinical Coverage Policy 1-H, Telemedicine and Telepsychiatry</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	<p>42 C.F.R. § 410.32</p> <p>42 C.F.R. § 440.30</p> <p>NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C</p> <p>NC Health Choice State Plan, Section 6.2.8</p> <p>NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing</p> <p>NC Clinical Coverage Policy 1S-2, HIV Tropism Assay</p> <p>NC Clinical Coverage Policy 1S-3, Laboratory Services</p> <p>NC Clinical Coverage Policy 1S-4, Genetic Testing</p> <p>NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring</p> <p>NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures</p> <p>NC Clinical Coverage Policy 1K-2, Bone Mass Measurement</p> <p>NC Clinical Coverage Policy 1K-6, Radiation Oncology</p> <p>NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services</p>	YES	YES
Family planning services	Regular Medicaid Family Planning (Medicaid FP) and NCHC services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	<p>SSA Title XIX, Section 1905(a)(4)(C)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p> <p>NC Health Choice State Plan Section 6.2.9</p>	YES	YES

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Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 1E-7, Family Planning Services		
Certified pediatric and family nurse practitioner services	<p>(a) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section.</p> <p>If the State specifies qualifications for pediatric nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. <p>If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. <p>(Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section.</p> <p>If the State specifies qualifications for family nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. <p>If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for</p>	<p>SSA, Title XIX, Section 1905(a)(21)</p> <p>42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a</p>	YES	YES

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Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a family nurse practice limited to providing primary health care to individuals and families.			
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11	YES	NO
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 NC NEMT Policy	YES	NO
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program or NC Health Choice beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary. Ambulance services include only emergency transport via ground and air medical ambulance for a NCHC beneficiary.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15	YES	YES
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2	YES	NO
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h	YES	YES

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Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Health Choice State Plan, Sections 6.2.6, 6.2.7 NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters <i>Section V.C.3. Pharmacy Benefits of the Contract</i>		
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist. (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Health Choice State Plan Section 6.2.5	YES	YES

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Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>not reside in a permanent dwelling or does not have a fixed home or mailing address.</p> <p>Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program</p>			
Physical therapy	<p>Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.</p>	<p>SSA, Title XIX, Section 1905(a)(11)</p> <p>42 C.F.R. § 440.110</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 5A, Durable Medical Equipment</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p> <p>NC Clinical Coverage Policy 10B, Independent Practitioners (IP)</p>	YES	YES
Occupational therapy	<p>Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.</p>	<p>42 C.F.R. § 440.110</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p>	YES	YES

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p> <p>NC Clinical Coverage Policy 10B, Independent Practitioners (IP)</p>		
Speech, hearing and language disorder services	<p>Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.</p>	<p>42 C.F.R. § 440.110</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p> <p>NC Clinical Coverage Policy 10B, Independent Practitioners (IP)</p>	YES	YES
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policy	<p>There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Please refer to NC Clinical Coverage Policies and services listed.</p>	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35</p> <p>NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19</p> <p>NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed):</p> <p>Mobile Crisis Management</p> <p>Diagnostic Assessment</p> <p>Partial Hospitalization</p> <p>Professional Treatment Services in Facility-based Crisis</p> <p>Ambulatory Detoxification</p>	YES	YES

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		Non-hospital Medical Detoxification Medically Supervised or ADATC Detox Crisis Stabilization Outpatient Opioid Treatment NC Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers		
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	SSA, Title XIX, Section 1905(a)(28) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services	YES	YES
Other diagnostic, screening, preventive and rehabilitative services	(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and "(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5	YES	NO

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;</p> <p>(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level</p>			
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, “is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less.”	<p>SSA, Title XIX, Section 1905(a)(5)</p> <p>42 C.F.R. § 440.60 G.S. § 90-202.2</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a</p> <p>NC Clinical Coverage Policy 1C-1, Podiatry Services</p> <p>NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care</p>	YES	YES
Optometry services	<p>Medicaid and NCHC shall cover the following optical services when provided by ophthalmologists and optometrists:</p> <ul style="list-style-type: none"> a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids. <p>Opticians may dispense approved visual aids.</p>	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 440.30</p> <p>NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a</p> <p>NC Health Choice State Plan Section 6.2.12</p> <p>G.S. § 108A-70.21(b)(2)</p> <p>NC Clinical Coverage Policy 6A, Routine Eye Exam and</p>	YES	YES

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Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		Visual Aids for Recipients Under Age 21		
Chiropractic services	<p>Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation.</p> <p>Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.</p>	<p>SSA, Title XIX, Section 1905(g)</p> <p>42 C.F.R. § 440.60</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11</p> <p>NC Clinical Coverage Policy 1-F, Chiropractic Services</p>	YES	YES
Private duty nursing services	<p>Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient’s physician in accordance with 42 C.F.R. § 440.80 and prior approval by the Division of Medical Assistance, or its designee.</p> <p>This service is only approvable based on the need for PDN services in the patient’s private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual’s normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.</p> <p>Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.</p> <p>Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North</p>	<p>SSA, Title XIX, Section 1905(a)(8)</p> <p>42 C.F.R. § 440.80</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b</p> <p>NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older</p> <p>NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age</p>	YES	NO

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>Carolina Board of Nursing and employed by a licensed home care agency.</p> <p>A member of the patient’s immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.</p>			
Personal care	<p>Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary’s home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary’s plan of care.</p> <p>PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c.</p> <p>In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary’s approved plan of care.</p>	<p>SSA, Title XIX, Section 1905(a)(24)</p> <p>42 C.F.R. § 440.167</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29</p> <p>NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)</p>	YES	NO
Hospice services	<p>The North Carolina Medicaid (Medicaid) and NC Health Choice (NCHC) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of</p>	<p>SSA, Title XIX, Section 1905(a)(18)</p> <p>42 C.F.R. §418</p> <p>North Carolina Medicaid State Plan 3.1-A, Page 7</p> <p>NC Health Choice State Plan Section 6.2.14</p>	YES	YES

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care.</p> <p>The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions.</p> <p>Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C).</p> <p>A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.</p>	<p>NC Clinical Coverage Policy 3D, Hospice Services</p>		
Durable medical equipment	<p>Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home:</p> <ol style="list-style-type: none"> 1. Inexpensive or routinely purchased items 2. Capped rental/purchased equipment 3. Equipment requiring frequent and substantial servicing 4. Oxygen and oxygen equipment 5. Related medical supplies 6. Service and repair 7. Other individually priced items 8. Enteral nutrition equipment 	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3</p> <p>NC Health Choice State Plan Section 6.2.12, 6.2.13</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5B, Orthotics & Prosthetics</p>	<p>YES</p>	<p>YES</p>

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Prosthetics, orthotics and supplies	<p>Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider.</p> <p>Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.</p>	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 440.120</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b</p> <p>NC Clinical Coverage Policy 5B, Orthotics and Prosthetics</p>	YES	YES
Home infusion therapy	<p>Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) or NC Health Choice (NCHC) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following:</p> <ul style="list-style-type: none"> a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy 	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3</p> <p>NC Health Choice State Plan Section 6.2.14</p> <p>NC Clinical Coverage Policy 3H-1, Home Infusion Therapy</p>	YES	YES
Services for individuals age 65 or older in an institution for mental disease (IMD)	<p>Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.</p>	<p>SSA, Title XIX, Section 1905(a)(14)</p> <p>42 C.F.R. § 440.140</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b</p> <p>NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services</p>	YES	NO
Inpatient psychiatric services for individuals under age 21	<p>Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.</p>	<p>SSA, Title XIX, Section 1905(a)(16)</p> <p>42 C.F.R. § 440.160</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17</p> <p>NC Health Choice State Plan Section 6.2.10</p>	YES	YES

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services		
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.	<p>North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9</p> <p>NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)</p> <p>NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia</p> <p>NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia</p> <p>NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias</p> <p>NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors</p> <p>NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma</p> <p>NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis</p> <p>NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow</p>	YES	YES

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SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms</p> <p>NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma</p> <p>NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin’s Lymphoma</p> <p>NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells</p> <p>NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood</p> <p>NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL)</p> <p>NC Clinical Coverage Policy 11B-1, Lung Transplantation</p> <p>NC Clinical Coverage Policy 11B-2, Heart Transplantation</p> <p>NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation</p> <p>NC Clinical Coverage Policy 11B-4, Kidney Transplantation</p> <p>NC Clinical Coverage Policy 11B-5, Liver Transplantation</p>		

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation</p> <p>NC Clinical Coverage Policy 11B-7, Pancreas Transplant</p> <p>NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multi-visceral Transplants</p>		
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.	<p>North Carolina Medicaid State Plan, Att. 3.1-E, Page 2</p> <p>NC Clinical Coverage Policy 11C, Ventricular Assist Device</p>	YES	YES
Allergies	<p>Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody.</p> <p>Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.</p>	<p>NC Clinical Coverage Policy 1N-1, Allergy Testing</p> <p>NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy</p>	YES	YES
Anesthesia	<p>Refers to practice of medicine dealing with, but not limited to:</p> <p>a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures.</p> <p>b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations.</p> <p>c. The clinical management of the patient unconscious from whatever cause.</p> <p>d. The evaluation and management of acute or chronic pain.</p> <p>e. The management of problems in cardiac and respiratory resuscitation.</p> <p>f. The application of specific methods of respiratory therapy.</p> <p>g. The clinical management of various fluid, electrolyte, and metabolic disturbances</p>	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4;</p> <p>NC Clinical Coverage Policy 1L-1, Anesthesia Services</p> <p>NC Clinical Coverage Policy 1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement	YES	YES
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes	YES	YES
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound	YES	YES
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease-related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES	YES
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES	YES
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for	YES	NO

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>Newborn Care and Assessment</p> <p>NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care</p> <p>NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit</p>		
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)</p> <p>NC Clinical Coverage Policy 1E-1, Hysterectomy</p> <p>NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions</p> <p>NC Clinical Coverage Policy 1E-3, Sterilization Procedures</p> <p>NC Clinical Coverage Policy 1E-4, Fetal Surveillance</p> <p>NC Clinical Coverage Policy 1E-5, Obstetrics</p> <p>NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home</p>	YES	NO
Ophthalmological Services	<p>General ophthalmologic services include</p> <p>a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable.</p> <p>b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session.</p> <p>Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general</p>	<p>NC Clinical Coverage Policy 1T-1, General Ophthalmological Services</p> <p>NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services</p>	YES	YES

FIRST REVISED AND RESTATED

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	ophthalmological services or in which special treatment is given.			
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	<p>North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h</p> <p>NC Clinical Coverage Policy 9, Outpatient Pharmacy Program</p> <p>NC Clinical Coverage Policy 9A, Over-the-Counter-Products</p> <p>NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program</p> <p>NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administration Procedures</p> <p>NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17</p> <p>NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older</p>	YES	YES
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	<p>NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery</p> <p>NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery</p> <p>NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision</p>	YES	YES
Vision Services	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5</p> <p>NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21</p>	YES	YES

Attachment 2 to Amendment #1

Section VII. First Revised and Restated Attachment G. Required Standard Provisions for PHP and Provider Contracts

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

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

- a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
- b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
- c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
- e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the PHP's insolvency the contract must address:
 1. Transition of administrative duties and records; and
 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
 - i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
 - ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
 2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.
- h. Member Billing: The contract must address the following:
 - i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance

- that the PHP may not cover or continue to cover specific services and the Member to receive the service; and
- ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- i. **Provider Accessibility.** The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.
 - j. **Eligibility Verification.** The contract must address the PHP's obligation to provide a mechanism that allows providers to verify Member eligibility, based on current information held by the PHP, before rendering health care services.
 - k. **Medical Records** The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
 - i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;
 - ii. Maintain adequate medical and other health records according to industry and PHP standards; and
 - iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
 - l. **Member Appeals and Grievances:** The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.
 - m. **Provider Payment:** The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).
 - n. **Data to the Provider:** The contract must address the PHP's obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.
 - o. **Utilization Management:** The contract must address the provider's obligations to comply with the PHP's utilization management programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
 - p. **Provider Directory:** The provider's authorization and the PHP's obligation to include the name of the provider or the provider group in the provider directory distributed to Members.
 - q. **Dispute Resolution:** Any process to be followed to resolve contractual differences between the PHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.D.5. Provider Grievances and Appeals*.
 - r. **Assignment:** Provisions on assignment of the contract must include that:
 - i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.
 - ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
 - s. **Government Funds:** The contract must include a statement that the funds used for provider payments are government funds.
 - t. **Interpreting and Translation Services:** The contract must have provisions that indicate:

- i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
- ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
- iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.
- u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
- v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.
- w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.
- x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- y. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in Section V.D.4. of the PHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PHP shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the PHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

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

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

3. All contracts between PHP and providers that are created or amended, must include the following provisions verbatim, except PHP may insert appropriate term(s), including pronouns, to refer to the PHP,

the provider, the PHP/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:

- a. Compliance with State and Federal Laws
The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
- b. Hold Member Harmless
The [Provider] agrees to hold the Member harmless for charges for any covered service. The [Provider] agrees not to bill a Member for medically necessary services covered by the Company so long as the Member is eligible for coverage.
- c. Liability
The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].
- d. Non-discrimination
Equitable Treatment of Members
The [Provider] agrees to render Provider Services to Members with the same degree of care and skills as customarily provided to the [Provider's] patients who are not Members, according to generally accepted standards of medical practice. The [Provider] and [Company] agree that Members and non-Members should be treated equitably. The [Provider] agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender, or disability.
- e. Department authority related to the Medicaid program
The [Provider] agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.
- f. Access to provider records
The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [PHP and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [PHP and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
 - i. *The United States Department of Health and Human Services or its designee;*
 - ii. *The Comptroller General of the United States or its designee;*
 - iii. *The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee*
 - iv. *The Office of Inspector General*
 - v. *North Carolina Department of Justice Medicaid Investigations Division*
 - vi. *Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;*

- vii. *The North Carolina Office of State Auditor, or its designee*
- viii. *A state or federal law enforcement agency.*
- ix. *And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.*

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

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

- g. *Provider ownership disclosure*

The [Provider] agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

The [Provider] agrees to notify, in writing, the [Company] and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

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

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

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

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

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

- ii. *For Pharmacy Claims:*

- 1. The [Company] shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.*
- 2. A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.*

- iii. *If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).*

- 1. The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).*

- iv. *If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and penalty. Late Payments will bear interest at the annual*

rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

- v. *Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.*
- vi. *The [Company] shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require the [Provider] to request the interest or the penalty.*

Attachment 3 to Amendment #1

SECTION VII. First Revised and Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers

The PHP shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. Purpose of Addendum; Supersession.

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

2. Definitions.

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

- (a) "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a Member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:
- i. Is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such Member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
 - iv. Is determined to be an Indian under regulations issued by the Secretary.

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

- (b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- (c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.
- (d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.
- (e) "Indian tribe" has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).
- (f) "Tribal health program" has the meaning given in the IHCA Section 4(25), 25 U.S.C. §

1603(25).

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

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.

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

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

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

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

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

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

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

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.

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

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

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

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

9. Non-Taxable Entity.

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

10. Insurance and Indemnification.

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

(b) *Indian Tribes and Tribal Organizations.* A provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability to the extent that the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such Provider, any employee of such provider, or any personal services contractor to operate outside of the scope of FTCA coverage.

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

11. Licensure and Accreditation.

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

12. Dispute Resolution.

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

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

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

15. Claims Format.

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

16. Payment of Claims.

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

17. Hours and Days of Service.

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

18. Purchase/Referred Care Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan. The Provider shall comply with coordination of care and referral obligations of the Managed Care Plan issuer except only in specific circumstances in which such obligations would conflict with requirements

applicable to Purchased/Referred Care at 42 C.F.R. Part 136. The Provider will notify the Managed Care Plan issuer when such circumstances occur.

19. Sovereign Immunity.

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

20. Endorsement.

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

APPROVALS

For the Managed Care Plan:

For the IHCP:

Date: _____

Date: _____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS as an IHCP:

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

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

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

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

- (1) IHCA, 25 U.S.C. § 1601 et seq.
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;