STATE OF NORTH CAROLINA

Department of Health and Human Services

Division of Health Benefits

Revised and Restated Request for Proposal #: 30-190029-DHB

Prepaid Health Plan Services

Date of Issue:

August 9, 2018

Date Revised and Restated:
January 25, 2019

Proposal Opening Date:

At 2:00 p.m. ET

Direct all inquiries concerning this RFP to:

Kimberley Kilpatrick

Contract and Compliance Specialist

Email: Medicaid.Procurement@dhhs.nc.gov

Phone: 919-527-7015

STATE OF NORTH CAROLINA

Request for Proposal

30-190029-DHB

For internal State agency processing, please provide your company's Federal Employer Identification Number or alternate identification number (e.g. Social Security Number). Pursuant to North Carolina General Statute 132-1.10(b) this identification number shall not be released to the public. **This page will be removed and shredded, or otherwise kept confidential**, before the procurement file is made available for public inspection.

This page is to be filled out and returned with your Proposal.

ID Number:

_____

Federal ID Number or Social Security Number

_____

Offeror Name

STATE OF NORTH CAROLINA
Department of Health and Human Services

Refer *ALL* Inquiries regarding this RFP to:	**Request for Proposal** # 30-190029-DHB
Kimberley Kilpatrick Contract and Compliance Specialist Medicaid.Procurement@dhhs.nc.gov 919-527-7015	**Proposals will be publicly opened:** October 12, 2018 at 2:00 p.m. ET
	Contract Type: Open Market
	Commodity Number:
	Description: Prepaid Health Plan Services
	Using Agency: Department of Health and Human Services, Division of Health Benefits
	Requisition No.:

EXECUTION

In compliance with this Request for Proposal (RFP), and subject to all the conditions herein, the undersigned Offeror offers and agrees to furnish and deliver any or all items at the capitation rates and other payments established by the Department. By executing this proposal, the Offeror confirms it has read, understands, and will comply with all specifications and requirements in the RFP and any addendums in the event of contract award. By executing this proposal, the undersigned Offeror certifies that this proposal is submitted competitively and without collusion (N.C. Gen. Stat. § 143-54), that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934 (N.C. Gen. Stat. § 143-59.2), and that it is not an ineligible Contractor as set forth in N.C. Gen. Stat. § 143-59.1. False certification is a Class I felony. Furthermore, by executing this proposal, the undersigned certifies to the best of Offeror's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal or State department or agency. As required by N.C. Gen. Stat. § 143-48.5, the undersigned Offeror certifies that it, and each of its subcontractors for any Contract awarded as a result of this RFP, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the Federal E-Verify system. N.C. Gen. Stat. § 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By executing this proposal, you attest, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

Failure to execute/sign proposal prior to submittal shall render proposal invalid and it WILL BE REJECTED. Late proposals will not be accepted.

OFFEROR:			
STREET ADDRESS:		P.O. BOX:	ZIP:
CITY & STATE & ZIP:		TELEPHONE NUMBER:	TOLL FREE TEL. NO:
PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE			
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF OFFEROR:		FAX NUMBER:	
OFFEROR'S AUTHORIZED SIGNATURE:	**DATE:**	EMAIL:	

Offer valid for at least **240** calendar days from date of proposal opening unless extended by the State in writing. After this time, any withdrawal of offer shall be made in writing, effective upon receipt by the agency issuing this RFP.

ACCEPTANCE OF RESPONSE

If any or all parts of this proposal are accepted by the State of North Carolina, an authorized representative of the Department of Health and Human Services shall affix his/her signature hereto and this document and all provisions of this Request for Proposal along with the Offeror's proposal, and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Offeror.

FOR STATE USE ONLY: Offer accepted and Contract awarded this ____ day of _____, 20____, as indicated on the attached certification, by _____

(Authorized Representative of NC Department of Health and Human Services)

Table of Contents

I. Introduction

A. Vision for North Carolina's Medicaid Managed Care Program

1. North Carolina is transitioning its Medicaid and NC Health Choice programs' care delivery system for most beneficiaries and services from a predominately Medicaid Fee-for-Service model to a Medicaid Managed Care model, as directed by the North Carolina General Assembly. Through Medicaid Managed Care, the Department seeks to advance integrated and high-value care, improve population health, engage and support providers, and establish a sustainable program with more predictable costs.

2. The Department's goal is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which purchases health while addressing both medical and non-medical drivers of health.

3. Through this Request for Proposal (RFP), the Department seeks experienced Medicaid Managed Care partners in the form of Prepaid Health Plans (PHPs) to support the goals of Medicaid Managed Care, through:
   a. Delivering **whole-person care** through the coordination of health, behavioral health, addressing unmet health-related resource needs and I/DD care models with the goal of improved health outcomes and more efficient and effective use of resources;
   b. Utilizing cost-effective resources and uniting communities and health care systems to **address the full set of factors that impact health;**
   c. Performing **localized care management** at the site of care, in the home or in the community where face-to-face interaction is possible to build on the strengths of North Carolina's care management infrastructure;
   d. Streamlining the Medicaid Managed Care **Member experience** with a simple, timely, and user-friendly eligibility and enrollment process focused on Member service and education;
   e. Maintaining broad **provider participation** by removing or mitigating provider administrative burden from the system; and
   f. Supporting the Department's overall vision of creating a **healthier North Carolina**.

B. Background on North Carolina's Medicaid Transformation

1. In September 2015, the North Carolina General Assembly (General Assembly) enacted North Carolina Session Law 2015-245[1] directing the transition of North Carolina's Medicaid program from a predominantly Fee-for-Service model to a predominantly Medicaid Managed Care model.[2] North Carolina State law requires the North Carolina Department of Health and Human Services (the Department), through the Division of Health Benefits (DHB), to implement a Medicaid Managed Care program.

2. As directed by the General Assembly, the Department will delegate direct management of physical health, behavioral health and pharmacy services, and financial risks to PHPs. PHPs will receive a monthly, actuarially sound, capitated payment and will contract with providers to deliver health services to their Members. The Department will monitor and oversee the administrative, operational,

[1] Session Law 2015-245 has been amended by Session Law 2016-121; Section 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186; Section 11H.10.(c) of Session Law 2018-5; Sections 4-6 of Session Law 2018-49; and Session Law 2018-48.

[2] The Department currently has a managed care delivery system for behavioral health and intellectual and developmental disabilities through local management entities/managed care organizations (LME/MCOs). Fee-for-Service used throughout the RFP refers primarily to physical health services.

clinical, and financial function of the PHPs to ensure adherence to the PHP's contract and the Department's expectations.

3. Beginning with the launch of Medicaid Managed Care, most North Carolina Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs.

4. There will be limited exceptions to mandatory enrollment for certain populations that may be better served outside of Medicaid Managed Care. These populations may be "exempt" from Medicaid Managed Care in that the beneficiary may choose to enroll in either Fee-for-Service or Medicaid Managed Care, or "excluded" in that they are required to remain enrolled in Medicaid Fee-for-Service and do not have the option to enroll in Medicaid Managed Care.
    a. Exempt populations include members of federally recognized tribes, including the Eastern Band of Cherokee Indians (EBCI).[3]
    b. The following populations will be excluded from Medicaid Managed Care:[4]
        i. Beneficiaries who are enrolled in both Medicare and Medicaid for whom North Carolina Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
        ii. Qualified aliens subject to the five-year bar for means tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
        iii. Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
        iv. Medically needy North Carolina Medicaid beneficiaries;
        v. Presumptively eligible beneficiaries, during the period of presumptive eligibility;
        vi. Beneficiaries participating in the NC Health Insurance Premium Payment (HIPP) program;
        vii. Beneficiaries enrolled under the Medicaid Family planning program;
        viii. Beneficiaries who are inmates of prisons;
        ix. Beneficiaries being served through the Community Alternatives Program for Children (CAP/C);
        x. Beneficiaries being served through the Community Alternative Program for Disabled Adults (CAP/DA). (The population exclusion includes beneficiaries receiving services under CAP/Choice, the consumer-directed care option under the CAP/DA program.); and
        xi. Program of All-Inclusive Care for the Elderly (PACE) participants.
    c. For a period not to exceed five (5) years from Contract Year 1, the Department will temporarily exclude the following populations:[5]
        i. Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA.
        ii. Beneficiaries who are enrolled in both Medicare and North Carolina Medicaid and for whom North Carolina Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding individuals served through CAP/DA.
    d. The Department will exempt the following populations from Medicaid Managed Care until such point that Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans) are available:[6] Beneficiaries with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact.

[3] Section 4.(5)e. of Session Law 2015-245, as amended by Session Law 2016-121.
[4] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2016-121 and Session Law 2018-48.
[5] Section 4.(5)m. of Session Law 2015-245, as amended by Session Law 2018-49 and Session Law 2018-48.
[6] Section 4.(5)*l.* of Session Law 2015-245, as amended by Session Law 2018-48.

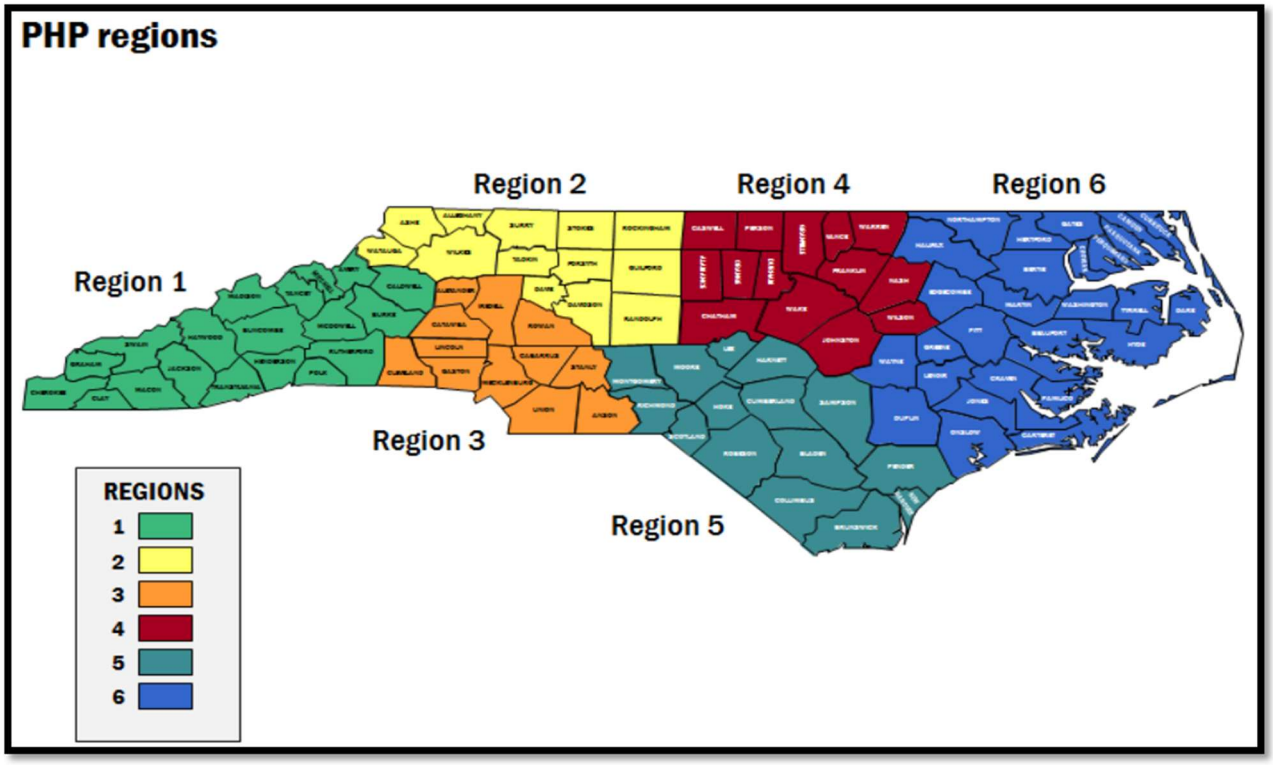
5. Pursuant to Session Law 2015-245, as amended, the Department may enter into capitated contracts with two types of entities: Commercial Plans (CPs) and Provider-Led Entities (PLEs), collectively referred to as Prepaid Health Plans (PHPs). Section 4.(6) of Session Law 2015-245, as amended by Session Law 2016-121 and Session Law 2018-48, requires the Department to award four (4) statewide contracts and up to twelve (12) regional contracts. The Department may contract with CPs or PLEs for statewide contracts, but can only contract with PLEs for regional contracts. If a PLE is awarded one of the four (4) statewide contracts, that PLE will no longer be considered for award of a regional contract.

6. The Department has defined six (6) Medicaid Managed Care Regions, called PHP Regions, within North Carolina. See *Section I. Table 1: List of Counties by PHP Region* for the counties included in each of the six (6) PHP Regions, and *Figure 1: Map of PHP Regions* that illustrates the PHP Regions in map format.

Section I. Table 1: List of Counties by PHP Region

PHP Regions	Counties
Region 1	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region 2	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
Region 3	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Region 4	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
Region 5	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
Region 6	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

Figure 1 – Map of PHP Regions



7. As required by Section 4.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, a PLE must cover any region in its entirety in which the PLE is contracted. Actuarial analysis has indicated that to best ensure the financial and administrative viability of all contracted PHPs, the Department should establish an aggregated minimum of 45,000 to 50,000 lives for a given entity across all regions it is awarded. Given the number of required statewide contracts and the projected distribution of Medicaid Managed Care enrollment across the six regions, a PLE that submits an offer on only one region may find reaching the minimum enrollment challenging and would be at an increased risk for financial instability. Therefore, the Department strongly encourages PLEs to submit an offer on more than one region. The Department will cap the number of regional contracts awarded at one (1) for each of Regions 1 and 6, and two (2) for each of Regions 2, 3, 4 and 5. The Department will award contracts in the best interest of the State, which includes consideration for ensuring each PHP has a viable risk pool.

8. The Department shall execute contracts with PHPs to offer Standard Benefit Plans which are Medicaid Managed Care plans that will serve most North Carolina Medicaid and NC Health Choice beneficiaries, including adults and children. These Standard Plans will provide integrated physical health, behavioral health, and pharmacy services at the launch of North Carolina's Medicaid Managed Care.

9. The Department is planning for a regional phase-in approach for the Fee-for-Service to Medicaid Managed Care cross-over population in Contract Year 1 to ensure successful implementation of Medicaid Managed Care. North Carolina Medicaid and NC Health Choice beneficiaries who are not members of designated special populations will be transitioned from Medicaid Fee-for-Service into Medicaid Managed Care on a regional basis. The Department is planning for a two (2) phase approach – with two (2) corresponding and distinct open enrollment periods for each subset of the initial cross-over population. Phase 1 of Medicaid Managed Care is scheduled to begin on November 1, 2019 with open enrollment period beginning at least one hundred five (105) calendar days prior to the beginning

of Phase 1; Phase 2 of Medicaid Managed Care is scheduled to begin on February 1, 2020 with the open enrollment period beginning at least one hundred one (105) calendar days prior to the beginning of Phase 2. At or soon after PHP Contract Award, the Department will determine which Regions will be selected for Phase 1 and Phase 2 Medicaid Managed Care roll out depending on several factors including, but not limited to, the number of Members in the Regions, a goal of including a mix of "urban" and "rural" regions in Phase 1, as well as a mix of commercial plans and PLEs, in Phase 1. If possible, the Department will select contiguous regions to minimize Member or provider confusion.

10. To ease the transition to Medicaid Managed Care and develop Medicaid Managed Care plans that best meet the needs of the North Carolina Medicaid and NC Health Choice populations, the Department anticipates offering additional types of prepaid health plans and phasing in high need populations at a later date. Those future Medicaid Managed Care changes are beyond the scope of this RFP, but include:
    a. Tailored Plans: Plans that will be specifically designed to serve designated special populations with potentially unique health care needs. The Department intends for BH I/DD TPs to be operational at the start of the first State fiscal year that is one (1) year after the implementation of the first contracts for Standard Benefit Plans. BH I/DD TPs will provide integrated physical health, behavioral health (BH), intellectual and developmental disabilities (I/DD), and pharmacy services to beneficiaries with significant BH disorders, I/DD, and traumatic brain injury as specified in Section 4.(5). of Session Law 2015-245, as amended by Session Law 2018-48.
    b. Tribal Option: The Department consulted with the State's only federally recognized tribe, the Eastern Band of Cherokee Indians (EBCI), and jointly concluded that Tribal members will benefit from having the choice between Medicaid Fee-for-Service, enrollment in a tribal plan, or a PHP. The Department and EBCI will continue to collaborate on the development of a "Tribal Option" that operates in five southwestern NC counties, may be full or partial risk health plan; supports the Tribe's autonomy in managing the care needs of tribal enrollees and considers and addresses the unique cultural, behavioral health and medical needs of the EBCI, Current estimates indicate there are approximately four-thousand (4,000) EBCI members enrolled in North Carolina Medicaid and NC Health Choice.
    c. Temporarily excluded populations: The transition of high-need populations to Medicaid Managed Care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. The Department believes that certain targeted populations with complex health care needs should be allowed more time to make the transition to Medicaid Managed Care. This means phasing in the mandatory enrollment of some vulnerable populations after Medicaid Managed Care is fully established. To avoid care disruption during the transition period, designated special populations, as described above will continue to have access through the Medicaid Fee-for-Service program.

II. General Procurement Information and Notice to Offerors

A. Important Notices

Offerors are Cautioned to Read Carefully

1. **Read, Review, and Comply**: It is the Offeror's responsibility to read this entire document, review all attachments and appendices, and comply with all instructions specified herein.

2. **Execution of Proposal**: Failure to sign the Execution Page (Page 1 of 63) in the indicated space or return all attachments, completed and signed where required, may render the proposal non-responsive and it may be rejected.

3. **Resulting Contract**: Under the State's procurement process, **any contract resulting from this RFP will consist of the RFP and the Offeror's response**, along with any addenda to the RFP, written clarifications, best and final offers (BAFO), and negotiation documents. The Contractor will be obligated to perform services as proposed in its offer, unless otherwise modified by clarification, BAFO, negotiation, or Contract Amendment, or superseded by a document with higher order of precedence. See *Section III.D.17. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE* for more information and the order of precedence of the contract documents and *Section II.C.2. Request for Proposal Functionality and Related Notices* for more information on the RFP, changes in specifications, and instructions regarding modifications to the terms and conditions.

4. **Potential Negotiations**: The Department reserves the right to enter into negotiations with any Offeror to establish a contract that is in the best interest of the Department. Such negotiations are at the Department's sole discretion and may result in modifications to the Offeror's Proposal and Response.

5. **Events and Deadlines**:
   a. **Preproposal Offerors Conference** will be hosted by the Department on August 21, 2018. See *Section II.D.2. Preproposal Offerors Conference* for details and instructions.
   b. **Questions** concerning this RFP must be submitted in writing by August 24, 2018. See *Section II.D.3. Offeror Questions Concerning this Request for Proposal* for details and instructions.
   c. **Submission of Proposals** will be accepted until October 12, 2018 at 2:00 p.m. ET. See *Section II.E. Submission of Proposal and Offeror's Response* for details and instructions.

6. **Offeror Eligibility for PHP Proposals:**
   a. CPs are eligible to submit offers for Statewide Contracts.
   b. PLEs are eligible to submit offers for Statewide and/or Regional Contracts.

7. **Statewide Contracts**:
   a. The Department will determine the award of Statewide Contracts prior to determining the award of Regional Contracts.
   b. If a PLE is awarded one of the four Statewide Contracts, that PLE will no longer be considered for award of a Regional Contract.

8. **Regional Offers and Contracts**:
   a. Pursuant to Section 4.(6)b of SL 2015-245, as amended, only Offerors meeting the definition of Provider-led Entity are eligible for award of a regional contract.
   b. PLEs are strongly encouraged to submit proposals for more than one Region.
   c. The Department will award no more than one regional contract each for Regions 1 and 6.
   d. The Department will award no more than two regional contracts each for Regions 2, 3, 4 and 5.

B. General Procurement Information & Instructions

1. *INFORMATION AND DESCRIPTIVE LITERATURE*: The Offeror shall furnish all information requested as part of this RFP. Each Offeror shall submit with their proposal detailed narratives, diagrams, exhibits, examples, sketches, descriptive literature, complete specifications, etc. to support the services and products offered.

2. *RECYCLING AND SOURCE REDUCTION*: It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable, and less toxic to the extent that the purchase or use is practicable and cost-effective. The State also encourages and promotes using minimal packaging and the use of recycled/recyclable products in the packaging of commodities purchased. However, no sacrifice in quality of packaging will be acceptable. The Offeror remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Offerors are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.

3. *SUSTAINABILITY*: To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all proposals meet the following:
   a. All copies of the proposal are printed double-sided;
   b. All submittals and copies are printed on recycled paper with a minimum post-consumer content of thirty percent (30%);
   c. Unless necessary, all proposals and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable; and
   d. Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.

4. *HISTORICALLY UNDERUTILIZED BUSINESSES*: Pursuant to G.S. § 143-48 and Executive Order 150 (1999), the Department invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises, and nonprofit work centers for the blind and severely disabled.

5. *MISCELLANEOUS*: Pronouns, whether masculine, feminine, or gender-non-specific, shall be read to be inclusive of all genders and shall be read to include the plural and vice versa.

6. *INFORMAL COMMENTS*: The Department shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the Department prior to or during the competitive process or after award. The Department is bound only by information provided in this RFP and in formal Addenda issued.

7. *COST FOR PROPOSAL PREPARATION*: Any costs incurred by an Offeror in preparing or submitting proposals are the Offeror's sole responsibility. The Department will not reimburse any Offeror for any costs incurred prior to award.

8. *OFFEROR'S REPRESENTATIVE*: Each Offeror shall submit with its proposal the name, title, email address, physical address, and telephone number of the person(s) with authority to bind the Offeror and answer questions or provide clarification concerning the firm's proposal. This information must be included in the Offeror's Proposal and Response.

9. *INSPECTION AT OFFEROR'S SITE*: The Department reserves the right to inspect, at a reasonable time, the equipment/item, plant, or other facilities of a prospective Offeror prior to Contract Award, and during the Contract Term as necessary for the Department determination that such equipment/item, plant or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.

C. Request for Proposal Functionality and Related Notices

1. RFP Functionality
   a. This RFP serves two functions:
      i. Define the specifications of the services, which are sought by the Department and to be provided by the PHPs; and
      ii. Provide the requirements and terms of any contract resulting from this procurement.
   b. All Terms and Conditions in this RFP shall be enforceable. The use of phrases such as "shall", "will", "must", "required" and "requirements" are intended to create enforceable Contract conditions. In determining whether proposals should be evaluated or rejected, the Department will take into consideration the degree to which the Offeror has proposed or failed to propose solutions that are responsive to the Department's needs as describe in this RFP.

2. Notices Regarding RFP & Terms and Conditions
   a. It is the Offeror's responsibility to read the instructions, terms and conditions, specifications, requirements, attachments and appendices, and any other components made a part of this RFP, and comply with all instructions and directives. The Offeror is responsible for obtaining and complying with all Addenda and other changes that may be issued relating to this RFP.
   b. All questions and issues regarding any term, condition, instruction or other component within this RFP must be submitted in accordance with *Section III.D. Terms and Conditions*. If the Department determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an RFP Addendum posted on the State's Interactive Purchasing System (IPS). The Department may also elect to leave open the possibility for later negotiation and amendment of specific provisions of the Contract that have been raised during the question and answer period. Other than through this process, and except as provided in *Section II.C. Request for Proposal Functionality and Related Notices*, the Department rejects and will not be required to evaluate or consider any additional or modified terms and conditions submitted with Vendor's proposal. This applies to any language appearing in or attached to the RFP document as part of the Offeror's proposal that purports to vary any terms and conditions, or Offeror's Instructions therein to render the proposal non-binding or subject to further negotiation.
   c. The Offeror's proposal to this RFP shall constitute a firm offer. **By execution and delivery of a proposal to this RFP, the Offeror agrees that any additional or modified terms and conditions, including Instructions to the Offeror, whether submitted purposely or inadvertently, or any purported condition to the offer, shall have no force or effect, and will be disregarded. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject the Offeror's proposal.**

3. Proposed Modifications to Terms and Conditions
   a. Offerors are urged and cautioned to inquire during the question period, in accordance with the instructions in this RFP, about whether specific language proposed as a modification is acceptable to or will be considered by the Department.
   b. Identification of objections or exceptions to the terms and conditions in the proposal itself shall not be allowed and shall be disregarded or the proposal rejected.

c. If the Offeror wishes to suggest changes to any of the terms and conditions included in *Sections III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D-F* of this RFP, those *must be submitted* in *Attachment O.17. Request for Proposed Modifications to the Terms and Conditions.* The Department, in its sole discretion, may consider any proposed modifications identified by the Offeror. Where necessary, any modification(s) to the terms and conditions agreed upon by the Department may be incorporated as part of an Addendum to the RFP, BAFO, negotiation document, Execution of Contract, or Contract Amendment after award. Other than through this process, the Department rejects and shall not be required to evaluate or consider any additional or modified terms, conditions, or instructions included in the Offeror's proposal.

4. Changes in Requirements and Specifications
   a. The Offeror is cautioned that the requirements of this RFP can only be altered by written Addendum issued by the Department, and that oral or emailed communications from whatever source(s) are of no effect.
   b. The Department reserves the right to modify any specification contained herein without modifying the timelines in this RFP. Any modification to specifications will be specified in an Addendum posted to IPS.

5. Right Reserved

   The Offeror is cautioned that this is a Request for Proposal, not a request to contract, and the Department reserves the unqualified right to reject all offers deemed failing to meet minimum qualifications, not responsive, incomplete, or non-compliant with the requirements described herein; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina.

   The Department may also:
   a. Modify provisions of this RFP in response to changes in law or as required by CMS;
   b. Waive any formality;
   c. Waive any undesirable, inconsequential, or inconsistent provisions of this RFP;
   d. Negotiate directly with one or more Offerors, if the responses to this solicitation demonstrate a lack of competition, or offers are found non-responsive; and/or
   e. Cancel this RFP at any time. Notice of Cancellation will be posted on the IPS website.

D. Schedule and Important Events

a. The Department will make every effort to adhere to the following schedule. The Department reserves the right to adjust the schedule and will post an Addendum on the IPS website.

Section II. Table 1: RFP Schedule

Activity	Responsible Party	Due Date
Issue Request for Proposal	Department	August 9, 2018
Preproposal Offerors Conference	Department	August 21, 2018, 8:00 a.m.
Deadline to Submit Written Questions to the Department	Offeror	August 24, 2018, 2:00 p.m.
Issue Addendum with Responses to Offerors' Questions	Department	September 10, 2018
Deadline to Submit Proposals	Offeror	October 19, 2018 2:00 pm
Conduct Evaluation of Proposals	Department	October 19, 2018 – February 1, 2019
Contract Award	Department	February 4, 2019

2. Preproposal Offerors Conference
    a. The Department will hold a Preproposal Offerors Conference on August 21, 2018, 8:00 a.m. ET at the North Carolina State University, McKimmon Conference and Training Center, 1101 Gorman St, Raleigh, NC 27606.
    b. The purpose of the conference is to allow the Department to review key priorities of Medicaid Managed Care and to provide Offerors with a clear understanding of the Scope of Services within this RFP.
    c. While Offerors may ask questions at the Preproposal Conference, the Department is not required to respond during the conference. The Department will respond to written questions from potential Offerors per the process described in this RFP.
    d. Potential Offerors are not required to attend the Preproposal Conference in order to submit responses to this RFP.
    e. To ensure adequate accommodations, Offerors are required to pre-register for the conference by sending an email to Medicaid.Procurement@dhhs.nc.gov stating the name of the Offeror, the Offeror representatives to attend, the current role of each representative, and requests for a sign language interpreter or other accommodations. Offerors must pre-register at this email address no later than 3:00 p.m. ET on August 17, 2018. There is no limit to the number of representatives Offerors may bring.
    f. The preproposal conference is in person attendance only and will not be available by dial in or conference call.
    g. Audio and video recording will not be permitted. Statements and materials discussed at conference are informational only, are not binding upon the Department and do not replace reading, reviewing and complying with this RFP.
    h. Offerors will be required to check in upon arrival to the conference by signing the attendance roster. Offerors should bring a copy of the RFP to the conference, if needed. The Department will not provide paper or digital copies of the RFP during the conference.

3. Offeror Questions Concerning this Request for Proposal
    a. Written questions concerning this RFP will be received until August 24, 2018, 2:00 p.m. ET.
    b. They must be sent via email to Medicaid.Procurement@dhhs.nc.gov. Insert "***Questions RFP 30-190029-DHB***" as the subject of the email. The questions should be submitted in the format below.

RFP Section	RFP Page Number	Offeror Question
Example: V.A.1.a)		

    c. The Department will prepare responses to all written questions submitted by the stated deadline and post an Addendum to IPS. The Offeror is cautioned that contacting anyone other than the Contract Specialist noted on the Execution Page (Page 1 of 63) of this RFP may be grounds for rejection of said Offeror's response.

E. Submission of Proposal and Offeror's Response

1. Consideration
    a. The Offeror must meet all the minimum qualifications of this RFP, as defined in *Section IV. Minimum Qualifications*, for its proposal to be evaluated.
    b. Offeror's proposal must clearly demonstrate compliance with all the requirements stated within this RFP. The Department reserves the right to reject proposals deemed incomplete, non-

responsive, or non-compliant with the RFP requirements; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina.

c. The Offeror must demonstrate it will comply with the Scope of Services requirements within this RFP and must provide a detailed description to demonstrate its ability to completely fulfill each requirement.

2. Responses to RFP Requirements and Scope of Services
   a. The Offeror must complete and return all documents and attachments as required in the RFP. Failure to complete and return all documents and attachments as indicated may result in disqualification.
   b. The proposal must clearly articulate and address all requirements of this RFP. The Offeror must provide a detailed narrative description with supporting information that may include diagrams, exhibits, examples, samples, sketches, descriptive literature, etc.
   c. For some requirements, the Offeror may need to provide an affirmative statement to the question or requirement by, at a minimum, inserting the word CONFIRM in its proposal.
   d. The Offeror must describe any limitations, qualifications or contingences impacting the ability to perform as required by the RFP.
   e. The Offeror must not include any assumptions in its proposal. The Offeror should seek clarity on any questions or concerns during the defined question period.

3. Qualifications, Use Cases, Disclosures, References, and Contract Administrators
   To demonstrate the Offeror is qualified to meet the on-going demands of the Department and comply with federal and state requirements, the Offeror must include in its proposal information regarding:
   a. Qualifications, including Offeror prior experience (*Attachment O. Offeror's Proposal and Response*);
   b. Use Cases, demonstrating ability to link RFP requirements to day-to-day PHP operations (*Attachment O.4. Use Case Scenarios*);
   c. Disclosure of location of workers (*Attachment O.14. Location of Workers Utilized by the Contactor)*;
   d. State and Federal Certifications (*Attachment O.15. State Certifications – Required by North Carolina Law* and *Attachment O.16. Federal Certifications*);
   e. Documents of financial stability necessary to perform the services of this RFP. The Offeror must submit the required documents and information as part of *Attachment O.8. Certification of Financial Condition*;
   f. Client references. These clients will be contacted and asked to respond to questions developed by the Department regarding Offeror's performance of services similar to those outlined in this RFP. The Offeror must provide a reference to meet each of the specific requirements stated in *Attachment O.5. Offeror's Client References*; and
   g. Administrators for the Contract. The Offeror must complete *Attachment O.7. Contractor's Contract Administrators*.

5. Required Proposal Documents
   a. The Offeror is required to return the following documents, completed and signed where indicated, with their RFP response, the entirety of which shall be called the ***Offeror's PHP Proposal***.
      i. Completed Offeror Name and Tax ID Number page;
      ii. Completed and signed Execution Page (Page 1 of 60);
      iii. The entire body of this RFP, and signed receipt pages of any addenda released in conjunction with the RFP;
      iv. Attachments A through N; and

v. Completed *Attachment O: Offeror's Proposal and Response* to address all requirements and specifications identified within this RFP. The Offeror should include detailed narratives, diagrams, exhibits, examples, samples, descriptive literature, complete specifications, etc. to demonstrate their ability to fulfill each requirement and specification. This must be marked as *Attachment O: Offeror's Proposal and Response.*

b. The Offeror **should not** submit the Draft Rate Book with its response.

6. Proposal Submission and Number of Copies

Sealed responses of the Offeror's proposal, subject to the conditions made a part hereof and the receipt requirements described herein, must be received at the address indicated below.

Section II. Table 2: Proposal Submission Address

MAILING ADDRESS FOR DELIVERY OF PROPOSAL VIA U.S. POSTAL SERVICE	OFFICE ADDRESS FOR DELIVERY BY ANY OTHER MEANS, SPECIAL DELIVERY, OVERNIGHT DELIVERY, OR BY ANY OTHER CARRIER
PROPOSAL NUMBER: 30-190029-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 1950 Mail Service Center Raleigh, NC 27699-1950	PROPOSAL NUMBER: 30-190029-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 820 S. Boylan Ave. McBryde Building, Office 462 Raleigh, NC 27603

The Offeror **must** deliver the following simultaneously to the address identified above by the deadline to submit proposals in *Section II. Table 1: RFP Schedule*:

a. Hard Copies:
   i. One (1) signed, original executed response of **Offeror's PHP Proposal**; and
   ii. Twenty (20) copies of *Attachment O: Offeror's Proposal and Response*.

b. Soft Copies:
   i. One (1) copy of the signed, original executed **Offeror's PHP Proposal** submitted separately on a CD, DVD, or flash drive marked ***RFP 30-190029-DHB***; and
   ii. One (1) copy of the signed, original executed **Offeror's PHP Proposal** *redacted* in accordance with G.S. § 132, the Public Records Act, on a separate CD, DVD, or flash drive marked ***RFP 30-190029-DHB-Redacted.*** For the purposes of this RFP, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Offeror and meets the definition of Confidential Information set forth in G.S. § 132-1.2**.** Any information removed by the Offeror should be replaced with the word, "Redacted." If the response does not contain Confidential Information, Offeror should submit a signed statement to that effect.

The electronic copies of the response must not be password protected.

IMPORTANT NOTE: It is the responsibility of the Offeror to have the above documents and electronic copies physically in the Office provided above by the specified time and date of opening, regardless of the method of delivery. **This is an absolute requirement.** The time of delivery will be marked on each proposal when received, and any proposal received after the submission deadline **will not be accepted or evaluated**.

All risk of late arrival due to unanticipated delay, whether delivered by hand, U.S. Postal Service, courier or other delivery service or method, is entirely on the Offeror. Note that the U.S. Postal Service generally does not deliver mail to the street address above, but to the State's Mail Service Center stated above. The Offeror is cautioned that proposals sent via U.S. Mail, including Express Mail, may not be delivered by the Mail Service Center to the Contract and Compliance Specialist named on Page 1 of this RFP by the Due Date and time to meet the proposal submission deadline. The Offeror is urged to take the possibility of delay into account when submitting a proposal.

7. Falsified Information
   The Department may initiate proceedings to debar an Offeror from participation in the offer process and from Contract Award as authorized by North Carolina law if it is determined that the Offeror has withheld relevant or provided false information.

F. Confidentiality and Prohibited Communications During Evaluation

1. As provided for in the North Carolina Administrative Code (NCAC), including but not limited to 01 NCAC 05B.0210, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature. In accordance with these and other applicable rules and statutes, such materials shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by G.S. § 132, **must be clearly marked as such and reflected in the redacted copy submitted on *RFP 30-190029-DHB-Redacted* as applicable.** By submitting a redacted copy, the Offeror warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked ***Confidential*** and/or ***Redacted*** meet the requirements of G.S. § 132. The Offeror must identify the legal grounds for asserting that the information is confidential, including the citation to state law. ***However, under no circumstances shall price information be designated as confidential.***

2. Except as otherwise provided above, pursuant to G.S. § 132-1, et seq., information or documents provided to the Department in response to this RFP are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, G.S. § 132-1.2. Redacted copies provided by the Offeror to the Department may be released in response to public record requests without notification to the Offeror.

3. During the period spanning the issuance of the RFP and Contract Award, possession of proposals, accompanying information, and subsequent negotiations are limited to personnel of the Department and any third parties involved in this procurement process.

4. Each Offeror submitting a proposal (including its representatives, sub-contractors and/or suppliers) is prohibited from having any communications with any person inside or outside the using agency, issuing agency, other government agency office, or body (including the purchaser named above, department secretary, agency head, members of the general assembly and/or governor's office), or private entity, if the communication refers to the content of Offeror's proposal or qualifications, the content of another Offerors proposal, another Offeror's qualifications or ability to perform the contract, and/or the transmittal of any other communication of information that could be reasonably considered to have the effect of directly or indirectly influencing the evaluation of proposal and/or the award of the contract. An Offeror not in compliance with this provision shall be disqualified from Contract Award, unless it is determined in the Department's s discretion that the communication was harmless, that it was made without intent to influence and that the best interest of the Department would not be served by the disqualification. An Offeror's proposal may be disqualified if its sub-contractor and supplier engage in any of the foregoing communications during the time that the

procurement is active (i.e., the issuance date of the procurement to the date of Contract Award). Only those discussions, communications or transmittals of information authorized or initiated by the issuing agency for this RFP or general inquiries directed to the purchaser regarding requirements of the RFP (prior to proposal submission) or the status of the Contract Award (after submission) are excepted from this provision.

5. The Department may serve as custodian of Offeror's confidential information and not as an arbiter of claims against Offeror's assertion of confidentiality. If an action is brought pursuant to G.S. § 132-9 to compel the Department to disclose information marked confidential, the Offeror agrees that it will intervene in the action through its counsel and participate in defending the Department, including any public official(s) or public employee(s). The Offeror agrees that it shall hold the Department, State of North Carolina, and any official(s) and individual(s) harmless from all damages, costs, and attorneys' fees awarded against the Department in the action. The Department agrees to promptly notify the Offeror in writing of any action seeking to compel the disclosure of Offeror's confidential information. The Department shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The Department shall have no liability to Offeror with respect to the disclosure of Offeror's confidential information ordered by a court of competent authority pursuant to G.S. § 132-9 or other applicable law.

G. Evaluation Process and Contract Award

The Evaluation process will commence on the date and time responses are unsealed as defined in this RFP. The Department will utilize the phases, evaluation method and scoring/weighting criteria stated herein for the evaluation of each Offeror's proposal.

1. Evaluation Committee and Method
   a. An Evaluation Committee (Committee) will be established to review each Offerors' PHP Proposal and make award recommendations. The Department may designate other individuals or subject matter experts to assist in the evaluation process. The Department reserves the right to alter the composition of the Committee or designate other staff or vendors to assist in the process.
   b. The Committee will review and evaluate all qualified responses submitted by the deadlines specified in this RFP. The Committee will be responsible for the entire evaluation process, including any BAFOs and/or negotiations, and scoring will be determined by consensus.

2. Investigation and Inspection

   The Department may make such reasonable investigations or readiness reviews to determine the ability of the Offeror to perform the services, and the Offeror must furnish to the Department all such information and data within requested timeframes. The Department reserves the right to inspect Offeror's physical facilities, including any located outside of North Carolina prior to award and at any time during the Contract period to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, the Offeror fails to satisfy the Department that the Offeror is properly qualified to carry out the obligations of the Contract and to provide the required services.

   The Department may request to review any policy, procedure, process, script, manual or other material used to fulfill a Scope of Work Requirement and require changes as a condition of participation under the Contract.

3. Evaluation Phases
   a. *Phase 1* – The Department will review each Offeror's PHP Proposal to validate that all required proposal documents are included and completed, and all Instructions to Offerors have been

followed. Failure to adhere to these requirements may render the Offeror's response incomplete and may be grounds for rejection during Phase 1.

b. *Phase 2* – The Committee will determine if Minimum Qualifications are met as required in *Section IV. Minimum Qualifications*. If the Offeror does not provide the required information, or the Department determines that the Offeror does not meet the Minimum Qualifications, that Offeror's response shall be excluded from further consideration and evaluation after Phase 2 or at any time during the evaluation process if not identified during Phase 2.

c. *Phase 3* – The Committee will review the Offeror's Proposal and Response and make an Award Recommendations. Each Offeror should exercise due diligence to ensure their response is consistent with the instructions, clearly written and addresses all requirements and questions of this RFP. The Department reserves the right to evaluate the Offeror's Proposal and Response in step and narrow the pool of Offerors for further evaluation to those within a competitive range.

d. *Phase 4* – The Department reserves the right to request in-person presentations from any Offeror which shall be conducted in Raleigh, NC at a site chosen by the Department to address specific topics that will be provided in advance to the Offeror by the Department. However, the Department *is not required* to request in-person presentations from any or all Offerors and may limit any presentations only to those Offerors which are deemed competitive after Phase 3. Additional details regarding the scheduling of the in-person presentations will be provided to selected Offerors by the Department upon completion of Phase 3 and if needed. The Offeror is solely responsible for any costs associated with making in-person presentations, including but not limited to travel and the preparation of additional materials.

e. *Phase 5* – The Department reserves the right to enter into negotiations with any Offeror to establish a contract that is in the best interest of the Department. Such negotiations may result in modifications to the Offeror's Proposal and Response.

f. *Phase 6* - The Evaluation Committee will make an Award Recommendation. Upon approval of the recommendation by the Department, the Notice of Award will be issued with the Department executing a Contract with the successful Offerors, subject to approval by CMS.

g. *Clarifications* - The Department reserves the right to request clarifications at any time from any Offeror, and such clarifications must be submitted in writing to the Offeror to respond. However, the Department *is not required* to request clarifications from any Offeror.

4. Scoring, Criteria, and Overall Weights

   a. The Department will evaluate the Offeror's Proposal and Response for completeness and reasonableness and to determine if it complies with the instructions described in the RFP.

   b. The Offeror's response will be evaluated and scored on several factors. The Offeror's Proposal and Response will be scored based on an overall weighted point scale developed by the Department.

   c. Scoring of proposals will reflect the following weights:

Section II. Table 3: Proposal Scoring, Criteria and Overall Weights		
Proposal Evaluation Criteria	**Sub Weight**	**Weights**
1. OFFEROR QUALIFICATIONS / EXPERIENCE		20%
2. SCOPE OF SERVICES		70%

Section II. Table 3: Proposal Scoring, Criteria and Overall Weights		
Proposal Evaluation Criteria	**Sub Weight**	**Weights**
The following requirements as demonstrated in the written proposal of the Offeror's experience and strategies or innovations as a Medicaid Managed Care contracted PHP to:	**Sub Weight of 100**	
a) Develop, implement and sustain the organizational, operational, technical and administrative functions and capabilities to reliably serve as an effective partner in delivering Medicaid Managed Care to North Carolinians.	7.5%	
b) Improve the likelihood of better health outcomes by enhancing the Member experience through promoting Member rights, engaging Members through health education, providing optimal customer service and support, and delivering services in a culturally competent manner.	15%	
c) Develop coordinated programs and services that deliver health through whole-person care, comprehensive care management, improve population health, and provide programs and services addressing healthy opportunities.	25%	
d) Develop and maintain a robust provider network that maintains strong provider and community participation and demonstrates an understanding of the health needs of the North Carolina population to ensure available, accessible, high quality care and services are delivered to all Members.	15%	
e) Develop a comprehensive quality improvement and value-based purchasing approach to drive the Department's overall vision for advancing and measuring high-value care.	15%	
f) Engage and integrate key Department partners and stakeholders including tribal populations, county agencies, community-based organizations, other managed care program entities, and Department partners to support North Carolina's Medicaid Managed Care goals.	7.5%	
g) Promote and monitor North Carolina's Medicaid Managed Care sustainability by developing the processes, standards, and data protocols needed to demonstrate good financial stewardship of limited resources and adherence to financial management objectives.	10%	
h) Promote a culture of compliance through comprehensive oversight and program integrity strategies aligned with industry best practices and compliant with federal and state law and regulation.	5%	

Section II. Table 3: Proposal Scoring, Criteria and Overall Weights		
Proposal Evaluation Criteria	**Sub Weight**	**Weights**
3. USE CASES		5%
4. CLIENT REFERENCES		5%
5. BONUS POINTS: Marketplace Participation		2.5%

5. Contract Award
   Upon conducting a comprehensive, fair, and impartial evaluation of the proposals received in response to this RFP, the Department reserves the right to award multiple contracts resulting from this RFP. Upon award, the Department will sign the "Acceptance of Proposal" found at the bottom of the Execution of Proposal Section or require the signing of an Execution of Contract, thus resulting in the formation of the Contract(s). Within two (2) business days after notification of award, the Offeror must register in NC E-Procurement @ Your Service. See http://vendor.ncgov.com.

6. Protest Procedures: If an Offeror wishes to protest a Contract resulting from this solicitation that is awarded by the Department, the Offeror shall submit a written request addressed to contact identified in *Section II.E.6 Proposal Submission and Number of Copies*. The protest request must be received in the proper office within thirty (30) calendar days from the Contract Award. Protest letters shall contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party's claims. **Note:** Contract Award notices are sent only to the Offeror awarded the Contract, and not to every person or firm responding to a solicitation. Proposal status and Award notices are posted on the Internet at https://www.ips.state.nc.us/ips/. All protests will be handled following the process defined in the North Carolina Administrative Code, 01 NCAC 05B.1519, but will be administered by Department of Health and Humans Services personnel.

7. Administrators for the Contract
   The Offeror must complete *Attachment O.7. Contractor's Contract Administrators*.

III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections

A. Definitions

1. **1115 Demonstration Waiver:** As defined by Section 1115 of the Social Security Act, state demonstrations that give states additional flexibility to design and improve their programs by demonstrating and evaluating state-specific policy approaches to better serving Medicaid populations. Specifically, North Carolina's amended 1115 demonstration waiver application to the federal Centers for Medicare & Medicaid Services (CMS) focuses on the specific items of the Medicaid Managed Care transformation that require CMS waiver approval.

2. **Advanced Medical Home (AMH):** Refers to an initiative under which PHPs delegate care management responsibilities and functions to State-designated AMH practices to provide local care management services.

3. **Adverse Benefit Determination:** Has the same meaning as Adverse Benefit Determination as defined in 42 C.F.R. § 438.400.

4. **Appeal:** Has the same meaning as Appeal defined in 42 C.F.R. § 438.400(b).

5. **Authorized Representative:** An individual, provider or organization designated by a beneficiary, or authorized by law or court order, to act on their behalf in assisting with the individual's participation in the Medicaid Managed Care program. With written consent of the Member, or as otherwise legally authorized, an authorized representative may, for example, request an appeal, file a grievance, or request a State Fair Hearing on behalf of the beneficiary with the exception that a provider cannot request continuation of PHP benefits.

6. **Auto-Assignment:** Automated process by which the Department enrolls a beneficiary who has not actively selected a PHP during open enrollment or at application.

7. **Automated Call Distribution System (ACD):** An automated call center system that disperses incoming calls of all Members and potential Members to appropriate service line staff.

8. **Automated Voice Response System (AVRS):** An automated system that allows Members to perform self-service activities and resolve simple inquiries without the need to interact with an agent. The AVRS interacts with the Member through voice prompts and recognition or numeric prompts.

9. **Behavioral Health:** For the purposes of the Contract is inclusive of mental health and substance use disorders.

10. **Behavioral Health Intellectual / Developmental Disability Tailored Plan (Behavioral Health I/DD Tailored Plan):** A plan specifically designed to provide targeted care for individuals with severe mental health disorders, substance use disorders, and intellectual and/or developmental disabilities as described in Section 4.(10) of Session Law 2015-245, as amended by Session Law 2018-48.

11. **Beneficiary:** An individual that is eligible to receive North Carolina Medicaid or NC Health Choice benefits but who may or may not be enrolled in the Medicaid Managed Care program.

12. **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals: with HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving 1915(b)(3), Innovations or TBI Waiver services.

13. **Business Associate Agreement (BAA):** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the contract between a HIPAA-covered entity and HIPAA Business Associate. The BAA protects personal health information (PHI) according to HIPAA guidelines

14. **Business Day:** Business days are defined as traditional workdays, Monday – Friday and includes traditional work hours 8:00 AM – 5:00 PM EST. State holidays are excluded. A list of North Carolina State Holidays is located at https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays.

15. **Calendar Day:** A calendar day includes the time from midnight to midnight each day. It includes all days in a month, including weekends and holidays. Unless otherwise specified within the Contract, days are tracked as Calendar Days.

16. **Care Coordination:** Defined as organizing patient care activities and sharing information among all the participants concerned with a Member's care to achieve safer and more effective care. Through organized care coordination, Members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

17. **Care Management:** Defined as a team-based, person centered approach to effectively managing patients' medical, social and behavioral conditions. Care Management shall include, at a minimum, the following:
    a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
    b. Care Needs Screening;
    c. Identification of Members in need of care management;
    d. Development of Care Plans (across priority populations);
    e. Development of comprehensive assessments (across priority populations);
    f. Transitional Care Management: Management of Member needs during transitions of care and care transitions (e.g. from hospital to home);
    g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
    h. Chronic care management (e.g., management of multiple chronic conditions);
    i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
    j. Management of unmet health-related resource needs and high-risk social environments;
    k. Management of high-cost procedures (e.g., transplant, specialty drugs);
    l. Management of rare diseases (e.g., transplant, specialty drugs);
    m. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
    n. Development and deployment of population health programs.

18. **Care Management Fees:** Non-visit based payments to AMH Tier 3 (and 4) practices made in addition to Fee-for-Service and Medical Home Payments, providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.

19. **Care Management for High Risk Pregnant Women:** Care management services provided to a subset of the Medicaid population who is pregnant and identified as "high-risk" by providers, LHDs, social service agencies and/or PHPs.

20. **Care Transitions:** The process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions).

21. **Children with Special Health Care Needs:** Those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.

22. **Choice Counseling:** Has the same meaning as Choice Counseling as defined in 42. C.F.R. § 438.2.

23. **Claim Adjudication:** The process of paying claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.

24. **Claim Adjudication Date:** The date the PHP or its Subcontractor processed for determination of claim payment, acceptance, denial, or rejection.

25. **Clarification:** A written response from an Offeror that provides an answer or explanation to a question posted by the Department about that Offeror's response for their proposal. Clarifications are incorporated into the Offeror's response.

26. **Clean Claim:** A claim for services submitted to a PHP by a Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

27. **Closed Loop Referral:** The capacity to know whether a Member accessed social services to which they were referred.

28. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.

29. **Community Alternatives Program for Disabled Adults (CAP/DA)**: A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement.

30. **Contract Award Date**: The date the Department publishes the Notice of Award to the Interactive Purchasing System.

31. **Contract Effective Date:** The date Contract is fully executed by the Parties and approved by CMS.

32. **Contractor:** The Offeror awarded the Contract to perform the services and requirements defined therein. The Contractor is a PHP.

33. **Commercial Plan (CP):** A type of Prepaid Health Plan defined in Section 4.(2)a. of Session Law 2015-245, as any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to Members on a prepaid basis except for Member responsibility for copayments and deductibles and holds a PHP license issued by the North Carolina Department of Insurance. A Commercial Plan is a PHP and is a Managed Care Organization (MCO).

34. **Comprehensive Assessment:** A person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive Care Management and will inform the Member's ongoing care plan and treatment.

35. **Credentialing:** The approach to collecting and verifying provider qualifications (e.g., the provider's training and education, licensure, liability record); and determining, for Medicaid Managed Care,

whether to allow the provider to be included in a PHP's network, subject to certain Department requirements.

36. **Crossover:** The timeframe immediately before and after implementation of the North Carolina Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.

37. **Cross-over Population:** Refers to North Carolina Medicaid and NC Health Choice beneficiaries that are enrolled in the Medicaid Fee-for-Service program and will transition to Medicaid Managed Care at a specific date determined by the Department.

38. **Cultural Competency:** The ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of the individuals are met. The ability to interact effectively with people of different cultures, helps to ensure the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competency means to be respectful and responsive to the health beliefs and practices and cultural and linguistic needs of diverse populations groups.

39. **Date of Payment:** The point in time following the Claim Adjudication Date when reimbursement is generated for services, either initiated by date of Electronic Funds Transfer (EFT) or processes to generate a paper check.

40. **Denied Claim:** When a PHP or its Subcontractor refuses to reimburse a medical or pharmacy service provider for all or a portion of the services submitted on the claim

41. **Designated Care Management Entity:** An entity with which the PHP contracts, that assumes responsibility for performing specific care management and/or care coordination functions with appropriate documentation and oversight. For the purposes of the Contract, Designated Care Management Entities shall include, but shall not be limited to:
    a. Advanced Medical Home (AMH) practices;
    b. Local Health Departments (LHDs) carrying out Care Management for High Risk Pregnant Women and At-Risk Children; and
    c. Other contracted entities capable of performing care management for a designated cohort of Members.

42. **Duplicate Records:** Any claim submitted by a service provider for the same service provided to an individual on a specified date of service that was included in a previously submitted claim.

43. **Durable Medical Equipment (DME):** Has the same meaning as Durable Medical Equipment as defined in 42 C.F.R. § 414.202.

44. **Eastern Band of Cherokee Indian (EBCI:):** A federally recognized Indian Tribe located in southwestern North Carolina whose members are exempt with managed care.

45. **Eligibility:** A series of requirements that determine whether an individual is eligible for North Carolina Medicaid or NC Health Choice benefits.

46. **Emergency Medical Condition:** Has the same meaning as Emergency Medical Condition as defined in 42 C.F.R. § 438.114(a).

47. **Emergency Services:** Has the same meaning as Emergency Services as defined in 42 C.F.R. § 438.114(a).

48. **Enrollment:** The process through which a beneficiary selects or is auto-assigned to a PHP to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program.

49. **Enrollment Broker (EB):** Has the same meaning as Enrollment Broker as defined in 42 C.F.R. § 438.810(a).

50. **Excluded Populations:** Beneficiaries in Excluded Populations may not enroll in PHPs and will continue to receive Medicaid services through Fee-for-Service and LME/MCOs (as applicable).

51. **Exempt Population:** Beneficiaries in Exempt Populations may voluntarily enroll in PHPs on an opt-in basis. Members of Exempt Populations are allowed to opt into Medicaid Managed Care or into Medicaid Fee-for-Service at any time, upon request to the Enrollment Broker.

52. **Family Member:** Any household member who is eligible for North Carolina Medicaid or NC Health Choice and included in Medicaid Manage Care.

53. **Fee-for-Service:** A payment model in which providers are paid for each service provided.

54. **Foster Care:** Has the same meaning as Foster Care as defined in N.C. Gen. Stat. § 131D-10.2(9).

55. **Grievance:** As it relates to a Member has the same meaning as Grievance, as defined in 42 C.F.R. § 438.400(b).

56. **Health Insurance:** A contract that requires a health insurer to pay some or all of one's health care costs, sometimes in exchange for a premium.

57. **Implementation Plan:** Comprehensive schedule of events, tasks, Deliverables, and milestones developed and executed by the Offeror to ensure successful implementation and launch of PHP services

58. **In Lieu of Services (ILOS):** Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

59. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a).

60. **Institute for Mental Disease (IMD):** Has the same meaning as IMD as defined in 42 C.F.R. § 435.1010.

61. **Interactive Purchasing System (IPS)**: The State of North Carolina's on-line system for advertising solicitations and publishing award notifications. Vendors can view and search for procurement opportunities. www.ips.state.nc.us.

62. **Interest:** For the purposes of claim payment or encounter submission, an amount from a PHP that is due to a service provider for holding the provider's money inappropriately as result of the late reimbursement or underpayment of a clean claim.

63. **Into the Mouth of Babes (IMB):** A clinical program that trains medical providers to deliver preventive oral health services to young children insured by North Carolina Medicaid. Services are provided from the time of tooth eruption until age 3½ (42 months), including oral evaluation and risk assessment, parent/caregiver counseling, fluoride varnish application, and referral to a dental home.

64. **Licensed Health Organizations (LHO):** Has the same meaning as LHO as defined in N.C. Gen. Stat. § 58-93-5(7).

65. **Limited English Proficient (LEP):** Has the same meaning as LEP as defined in 42 C.F.R. § 438.10(a).

66. **Local Care Management**: Care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible.

67. **Local Management Entity/Managed Care Organization (LME/MCO):** Defined in N.C. Gen. Stat. § 122C-3(20c) as a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act. An LME/MCO is paid a capitated rate by the Department to provide mental health, developmental disability, and substance use services to Medicaid beneficiaries pursuant to a combination of a Section 1915(b) and a Section 1915(c) waiver and manage federal block grant, State, local and county funds for other behavioral health services. For the Medicaid population, these entities are recognized under CMS Medicaid Managed Care rules and are known as a Prepaid Inpatient Health Plans (PIHP).

68. **Long Term Service and Supports (LTSS):** LTSS shall include:
    a. Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
    b. Care for older adults and people with disabilities who need support because of age, physical cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; and
    c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as:
        i. Eating;
        ii. Taking baths;
        iii. Managing Medications;
        iv. Grooming;
        v. Walking;
        vi. Getting up and down from a seated position;
        vii. Using the toilet;
        viii. Cooking;
        ix. Driving;
        x. Getting dressed; or
        xi. Managing money; and/or
    d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.

69. **Managed Care Organization (MCO):** Has the same meaning as MCO as defined in 42 C.F.R. § 438.2.

70. **Mandatory Populations:** Mandatory Populations are those Medicaid beneficiaries who are required to enroll in a PHP when first offered as a benefit option

71. **Marketing:** Has the same meaning as Marketing as defined in 42 C.F.R. § 438.104(a).

72. **Marketing Materials:** Has the same meaning as Marketing Materials as defined in 42 C.F.R. § 438.104(a).

73. **Medicaid Enterprise System (MES):** The aggregation of technologies and applications required to operate a State Medicaid Agency (SMA) - the core is typically the MMIS.

74. **Medicaid Managed Care:** The name of the North Carolina managed care program for North Carolina Medicaid and NC Health Choice benefits; does not include LME/MCOs.

75. **Medicaid Management Information System (MMIS):** The Department multi-payer system is a centralized repository for recipient and provider information. MMIS also adjudicates claims for DHB, DMH/DD/SA, Division of Public Health, and Office of Rural Health.

76. **Medical Claim:** Inpatient hospital, outpatient hospital (institutional claims), and physician-administered services.

77. **Medical Home Fees:** Non-visit based payments to AMH practices made in addition to fee for service payments, providing stable funding for care coordination support, and quality improvement at the practice level.

78. **Medically Necessary:** Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

79. **Members:** Beneficiaries specifically enrolled in and receiving benefits through the North Carolina Managed Care program.

80. **National Provider Identifier** (NPI): Standard unique health identifier for health care providers adopted by the Secretary of US Department of Health and Human Services in accordance with HIPAA.

81. **Network:** A group of doctors, hospitals, pharmacies, and other health care experts contracted by the PHP to provide health care services to its Members.

82. **Non-Participating Provider:** Non-participating or "non-par" providers are physicians or other health care providers that have not entered into a contractual agreement with the PHP and are not part of the PHP's Provider Network, unlike participating providers. They may also be called out-of-network providers

83. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.

84. **North Carolina Health Choice (NC Health Choice)**: The Health Insurance Program for Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children

85. **North Carolina Identity Service (NCID)**. This is the State's centralized Identity and access management platform provided by the Department of Information Technology. NCID is a web-based application that provides a secure environment for state agency, local government, business and individual users to log in and gain access to real-time resources, such as customer-based applications and information retrieval. https://www.ncid.nc.gov

86. **North Carolina Session Law 2015-245:** The Medicaid Transformation and Reorganization Act enacted on September 23, 2015, authorizing the transition of the North Carolina Medicaid and NC Health Choice Fee-for-Service programs to a Medicaid Managed Care delivery system.

87. **Objective Quality Standard:** Means, as defined in Section 5.(6) d. of Session Law 2015-245, the objective standard that PHP can apply when determining if to refuse a contract to a provider during the credentialing process.

88. **Offeror:** Supplier, bidder, proposer, firm, company, corporation, partnership, individual or other entity submitting an offer in response to this RFP.

89. **Ombudsman Program**: A new Department program to be established to provide education, advocacy, and issue resolution for Medicaid beneficiaries whether they are in the Medicaid Managed Care program or the Medicaid Fee-for-Service program. This program is separate and distinct from the Long-Term Care Ombudsman Program.

90. **Ongoing Course of Treatment:** When a Member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. 42 C.F.R. § 438.62(b).

91. **Ongoing Special Condition:** Has the same meaning as ongoing special condition defined in N.C. Gen. Stat. § 58-67-88(a)(1).

92. **Open Enrollment Period**: Period prior to implementation of North Carolina's Medicaid Managed Care program during which the existing Fee-for-Service, cross-over population will be able to actively select a PHP with the support of the Enrollment Broker.

93. **Participating Provider:** Participating provider or "par" providers are physicians or other health care providers that have a contractual agreement with the PHP and are included in the PHP's Provider Network. These agreements outline the terms and conditions of participation for both the payer and the provider.

94. **Performance Incentive Payments:** Payments additional to fee for service, care management fees and medical home fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics.

95. **Pharmacy Claim:** Includes outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims.

96. **Post-stabilization Care Services:** Has the same meaning as post-stabilization care services as defined in 42 C.F.R. § 438.114(a).

97. **Protected Health Information (PHI):** Has the same meaning as PHI as defined by 45 C.F.R. § 160.103.

98. **Potential Member**: A beneficiary enrolled in Medicaid and eligible for enrollment in a PHP or a Member of another PHP.

99. **Pregnancy Management Program:** A care program that encourages adoption of best prenatal, pregnancy, and perinatal care for Medicaid Managed Care Members.

100. **Prepaid Health Plan (PHP):** Has the same meaning as Prepaid Health Plan, as defined in Section 4. (2) of Session Law 2015-245, as amended by Session Law 2018-48. A PHP is a Managed Care Organization (MCO).

101. **Primary Care Provider (PCP):** The participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the Member to provide and coordinate all the Member's health care needs and to initiate and monitor referrals for specialized services, when required.

102. **Program Integrity (PI):** Has the same meaning as described in 42 C.F.R. Part 455.

103. **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age fifty-five (55) and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

104. **Provider:** Except as it relates to credentialing, has the same meaning as Provider as defined in 42 C.F.R. § 438.2.

105. **Provider (For the purposes of credentialing):** Individual practitioners and facilities, entities, organizations, atypical organizations/providers, and institutions, unless otherwise noted.

106. **Provider Contracting:** The process by which the PHP negotiates and secures a contractual agreement with providers that have undergone a quality credentialing determination and are to be included in the PHP's Provider Network.

107. **Provider Enrollment:** The process by which a provider is enrolled in the North Carolina's Medicaid or NC Health Choice programs, with credentialing as a component of enrollment.

108. **Provider Grievance:** Any oral or written complaint or dispute by a Provider over any aspects of the operations, activities, or behavior of the PHP except for any dispute over for which the provider has appeal rights.

109. **Provider-Led Entity (PLE):** Means, as defined in Section 4.(2)b. of Session Law 2015-245, as amended by Session Law 2016-121. A PLE is a PHP and is a Managed Care Organization (MCO).

110. **Qualified Health Plan** (QHP): Means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of Article 45 of the Code of Federal Regulations issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 of Article 45 of the Code of Federal Regulations. 45 C.F.R. § 155.20.

111. **Qualified Interpreter:** Has the same meaning a described in 45 C.F.R. § 92.4.

112. **Quality Determination:** A PHP's decision, made by its quality Provider Network Participation Committee in accordance with its Provider Retention and Selection Policies, as to whether a provider has met objective credentialing quality standards. Making a Quality Determination is one step in the contracting process between the provider and the PHP.

113. **Readily Accessible:** Has the same meaning as Readily Accessible as defined in 42 C.F.R. § 438.10(a).

114. **Readiness Review**: Has the same meaning as described in 42 C.F.R. § 438.66(d).

115. **Redeterminations:** The annual review of beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and NC Health Choice.

116. **Reprocess:** For the purposes of claims and encounters, the activities completed by a payer to reconsider the outcome of a previously adjudicated claim.

117. **Rising Risk:** Population group that has not yet become high-risk but who may become high-risk if certain risk factors and behaviors are not addressed.

118. **Security Assertion Markup Language (SAML):** This is the State's preferred standard for the implementation of identity and access management.

119. **Significant Change:** Means any change in the services offered by PHPs, the benefits covered under the contract, the geographic service area, and the composition of or payments to the PHP's provider network, and the enrollment of a new population in the PHP.

120. **Standard Plan:** A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most North Carolina Medicaid and NC Health Choice beneficiaries and that are not BH IDD Tailored Plans as described in in Section 4.(10) of SL 2015-245, as amended by SL 2018-48.

121. **State:** The State of North Carolina, the NC Department of Health and Human Services as an agency or in its capacity as the Using Agency.

122. **State Business Day:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, except for North Carolina State holidays as defined by the Office of State Human Resources. https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays .

123. **State Fair Hearing:** The hearing or hearings conducted at the Office of Administrative Hearings (OAH) under N.C. Gen. Stat. § 108D-15 to resolve a dispute between an Member and a PHP about an Adverse Determination.

124. **Subcontractor:** An entity having an arrangement with the PHP, where the PHP uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the subcontractor and the Department, only the Contractor. Network providers are not considered Subcontractors for the Contract.

125. **Transitions of Care:** The Process of assisting a Member to transition between PHPs; between payment delivery systems; including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between providers upon a provider's termination from the PHP network.

126. **Value-Added Services:** Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the PHP's discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

127. **Value-Based Payment (VBP):** Payment arrangements between PHPs and providers that fall within Levels 2 and 4 of the multi-payer Health Care Payment (HCP) and Action Network (LAN) Alternative Payment Model (APM) framework.

128. **Vendor:** A companies, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.

129. **Video Remote Interpreting:** Has the same meaning as described in 28 C.F.R. § 35.104.

130. **Warm transfer:** Defined as a beneficiary or provider call is transferred directly from the original call center to the appropriate party without requiring the caller to make an additional call and without the PHP abandoning the call until the other party answers.

131. **X12 Transactions** – Any EDI transaction included in the x12.org standard. This includes but is not limited to the 834 Benefit Enrollment and Maintenance, the 837 Health Care Claim, and the 277 Health Care Information Status Notification. The entire transaction set can be found at http://www.x12.org.

B. Acronyms

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

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

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

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

156. PMPM: Per Member Per Month
157. PRC: Purchased/Referred Care
158. PSO: North Carolina Department of Health and Human Services Privacy and Security Office
159. PTA: Privacy Threshold Analysis
160. QAPI: Quality Assurance and Performance Improvement
161. QHP: Qualified Health Plan
162. REOMB: Recipient Explanation of Medical Benefit
163. RFP: Request for Proposal
164. RHC: Rural Health Clinic
165. RN: Registered Nurse
166. ROI: Return on Investment
167. SAM: System of Award Management
168. SAML: Security Assertion Markup Language
169. SBI: North Carolina State Bureau of Investigation
170. SBIRT: Screening, Brief Intervention, and Referral to Treatment
171. SED: Serious Emotional Disturbance
172. SFTP: Secure File Transfer Protocol
173. SID: System Integration Design
174. SIP: System Integration Plan
175. SIS: Supports Intensity Scale
176. SIU: Special Investigations Unit
177. SLA: Service Level Agreements
178. SLPA: Speech/Language Pathology Assistant
179. SMA: State Medicaid Agency
180. SMAC: State Maximum Allowable Cost
181. SMI: Serious Mental Illness
182. SNF: Skilled Nursing Facility
183. SOC: Service Organization Control
184. SP: Standard Plan
185. SSA: Social Security Act
186. SSADMF: Social Security Administration Death Master File
187. SUD: Substance Use Disorder
188. TBI: Traumatic Brain Injury
189. TCLI: Transition to Community Living Initiative
190. TCM: Targeted Case Management
191. TDD: Telecommunications Device for the Deaf
192. TP: Tailored Plan
193. TPA: Third Part Administrator
194. TPL: Third party liability
195. TPN: Total Parenteral Nutrition
196. TTY: Text Telephone
197. UM: Utilization Management
198. VBP: Value-based payments
199. VEO: Visual Evoked Potential
200. VFC: Vaccines for Children
201. WCA: Web Content Accessibility Guidelines
202. WHCRA: Women's Health and Cancer Rights Act of 1998
203. WIC: Women, Infants and Children

C. Contract Term

1. The initial Contract Term will be from the Contract Effective Date through June 30, 2022 and shall include an implementation period and Contract Years 1 through 3 as follows:

Section III. C. Table 1: Contract Term	
Contract Period	**Effective Dates**
Implementation Period	Contract Award through October 31, 2019
Contract Year 1 for Phase 1 of Medicaid Managed Care	November 1, 2019 through June 30, 2020
Contract Year 1 for Phase 2 of Medicaid Managed Care	February 1, 2020 through June 30, 2020
Contract Year 2	July 1, 2020 through June 30, 2021
Contract Year 3	July 1, 2021 through June 30, 2022

2. The Department reserves the option, at its sole discretion, to extend the Contract for up to two (2) successive Contract Years in one (1) year increments, or a shorter period as required by the Department. The Department shall notify a PHP in writing if it is exercising its option to renew at least ninety (90) days prior to the expected renewal date.

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

D. Terms and Conditions

1. ACCESS TO PERSONS AND RECORDS: Pursuant to N.C. Gen. Stat. §§ 147-64.7 and 143-49(9), the Department, the State Auditor, appropriate state or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with Paragraph 36. RECORDS RETENTION. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such changes or additions.

The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C. Gen. Stat. § 147-64.7. Nothing in this Section is intended to limit or restrict the State Auditor's rights.

This term shall survive termination or expiration of the Contract.

2. ADVERTISING: Contractor agrees not to use the existence of this Contract or the name of the Department or State of North Carolina as part of any commercial advertising or marketing of its products or services, excepted as permitted under this Contract. A Contractor may inquire whether the Department is willing to act as a reference by providing information directly to other prospective customers. The Department is under no obligation to serve as a reference.

3. **AMENDMENTS:** This Contract may not be amended orally or by performance. This Contract may be amended only by written amendments executed by the Department and the Contractor.

4. **ASSIGNMENT:** No assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted.

   However, upon written request approved by the Department and solely as a convenience to the Contractor, the Department may:

   a. Forward the Contractor's payment check directly to any person or entity designated by the Contractor; and
   b. Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check.

   In no event shall such approval and action obligate the Department to anyone other than the Contractor, and the Contractor shall remain responsible for fulfillment of all Contract obligations. Upon advance written request, the Department may, at its discretion, approve an assignment to the surviving entity of a merger, acquisition or corporate reorganization, if made as part of the transfer of all or substantially all the Contractor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of this Contract.

5. **AVAILABILITY OF FUNDS:** All payments to Contractor are expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the Department for the purposes set forth in the Contract. If the Contract or any Purchase Order issued hereunder is funded in whole or in part by federal funds, the Department's performance and payment shall be subject to and contingent upon the continuing availability of said federal funds for the purposes of the Contract or Purchase Order. If the term of the Contract extends into fiscal years after that in which it is approved, such continuation of the Contract is expressly contingent upon the appropriation, allocation, and availability of funds by the N.C. General Assembly for the purposes set forth in this RFP and any resulting Contract. If funds to effect payment are not available, the Department will provide written notification to the Contractor and may terminate the Contract in accordance with Paragraph 46. TERMINATION. If the Contract is terminated, the Contractor agrees to take back any affected Deliverables and software not yet delivered under the Contract, terminate any Services supplied to the Department under the Contract, and relieve the Department of any further obligation thereof. The Department shall remit payment for Deliverables and Services accepted prior to the date of the previously mentioned notice in conformance with the payment terms.

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 or misdemeanor 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.

7. **BENEFICIARIES:** The Contract shall inure to the benefit and be binding upon the Parties and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of the Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Department and Contractor. Nothing contained in this Contract shall give or allow

any claim or right of action whatsoever by any third person. It is the express intention of the Department and Contractor that any such other person or entity receiving services or benefits under the Contract shall be deemed an incidental beneficiary only and not a contractual third-party beneficiary.

8. **CHANGE IN CORPORATE STRUCTURE:** In cases where Contractor(s) are involved in corporate consolidations, acquisition or mergers, the Parties may negotiate agreements for the transfer of contractual obligations and the continuance of contracts within the framework of the new corporate structure, subject to Department approval and the terms of this Contract.

9. **CMS APPROVAL**: This RFP and subsequent contracts and amendments are subject to approval by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. § 438.806(a).

10. **COMPLIANCE WITH LAWS:** Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business and performance in accordance with this contract, including those of federal, state, and local departments and agencies having jurisdiction and/or authority.

11. **CONTRACT ADMINISTRATORS:** The Contract Administrators are the persons to whom notices provided for in this Contract shall be given, and to whom matters relating to the administration of this contract shall be addressed. Either party may change its administrator or his/her address and telephone number by written notice to the other party.

For the Department

Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick, Contract and Compliance Specialist, Division of Health Benefits
Address 1 Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7015
Fax Number	919-832-0225
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov

Contract Administrator regarding day to day activities herein:

Name & Title	Jay Ludlam, Assistant Secretary for Medicaid Transformation, Division of Health Benefits
Address 1 Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address 2 Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7033
Fax Number	919-832-0225
Email Address	Jay.Ludlam@dhhs.nc.gov

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

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

12. **COOPERATION WITH OTHER STATE VENDORS:** Contractor shall cooperate with Department Vendors that are providing goods or services to or on behalf of the Department in relation to Medicaid Managed Care including those Vendors providing services with respect to system integration, encounter processing, enrollment and eligibility, Ombudsman, data analytics, and those engaged by the Department to monitor, validate, or verify Contractor's performance. Contractor will enter into trade agreements or other agreements as necessary to allow Vendor access to Contractor's confidential information needed in performance of Vendor's service for the Department.

13. **COPYRIGHT:** North Carolina Public Records Laws identifies all documents created for public transactions/business as public records, therefore, no Deliverable items produced in whole or in part under this Contract shall be the subject of an application for copyright by or on behalf of the Contractor, except as otherwise provided herein. The State shall own all Deliverables that the Contractor is required to deliver to the Department pursuant to the Contract, except as provided herein. Contractor shall not acquire any right, title, and interest in and to the copyrights for goods, all software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products provided by the State to Contractor. The State shall, upon payment for the Deliverables in full in accordance with the payment terms of the Contract, own copyrighted works first originated and prepared by the Contractor for delivery to the State. The State hereby grants Contractor a royalty-free, fully paid worldwide, perpetual, nonexclusive, irrevocable license for the Contractor's business use, to non-confidential Deliverables first originated and prepared by the Contractor for delivery to the State. Contractor shall maintain ownership of all pre-existing intellectual property that it provides to the State as part of the Deliverable(s), and the State shall have a royalty-free, fully paid, worldwide, perpetual, non-exclusive, irrevocable license to use such intellectual property solely for its operations. The intellectual property terms of this Contract do not: (i) affect Contractor's ownership of all other intangible intellectual property (e.g., processes, ideas, know how) that Contractor has developed in the course of performance hereunder, (ii) prevent Contractor from selling similar services elsewhere, or (iii) prevent Contractor from marketing, licensing or selling any and all intellectual property it develops hereunder to other customers, provided no State confidential information is used or disclosed in the process.

14. **DISCLOSURE CONFLICTS OF INTEREST:** The Contractor shall disclose any known conflicts of interest, or perceived conflicts of interest, at the time they arise, as follows:
    a. Disclose any relationship to any business or associate to whom the Contractor is currently doing business that creates or may give the appearance of a conflict of interest related to this Contract.
    b. By signing the RFP, the Contractor certifies that it shall not knowingly take any action or acquire any interest, either directly or indirectly, that will conflict in any manner or degree with the performance of its services during the term of the Contract.
    c. Disclose prior to employment or engagement by the Contractor, any firm principal, staff member or subcontractor, known by the Contractor to have a conflict of interest or potential conflict of interest related to this Contract.
    d. All notices required by this subsection must be provided to the Department within thirty (30) calendar days Contractor becoming aware of the conflict.

15. **DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION:** The Contractor's failure to fully and timely comply with the terms of this Section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of the Contract and result in Termination for Cause.
    a. The Contractor shall notify the State in its offer, if it, or any of its subcontractors, or their officers, directors, or key personnel who may provide Services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception. The Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding involving the Contractor or any subcontractor, or any of the forgoing entities' then current officers or directors during the term of the Contract or any Scope Statement awarded to the Contractor.
    b. The Contractor shall notify the State in its offer, and promptly thereafter as otherwise applicable, of any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its subcontractors during the three (3) years preceding its offer, or which may occur during the term of any awarded to the Contractor pursuant to this solicitation, that involve (1) Services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or subcontractor.
    c. In the event the Contractor, an officer of the Contractor, or an owner of a twenty-five percent (25%) or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a state, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Contractor's business integrity, and such contractor shall be prohibited from entering into a contract for goods or Services with any department, institution, or agency of the State.
    d. The Contractor shall notify the State of any legal action that could adversely affect the PHP's financial conditions or ability to meet the requirements of the Contract.
    e. All notices under subsection a, b, c, and d herein shall be provided in writing to the State within thirty (30) calendar days after the Contractor learns about any such criminal, regulatory, or civil matters or financial circumstances or material change to prior disclosures, unless such matters are governed by the other stated terms and conditions annexed to the solicitation. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Contractor may rely on good faith certifications of its subcontractors addressing the foregoing, which certifications shall be available for inspection at the option of the State.

16. **DISCLOSURE OF OWNERSHIP INTEREST**: The Contractor must provide the following information regarding ownership and control as described in 42 C.F.R. § 455.104:
    a. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other

obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. C.F.R. § 455.100-104);

b. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. §§ 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
c. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any sub-contractor of the Contractor in which the Offeror has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;
d. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity as defined in 42 C.F.R. § 455.101 in which an owner of the Contractor has an ownership or control interest; and
e. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section V.A.9. Staffing and Facilities of the Contractor as defined in 42 C.F.R. § 455.101.
f. Contractor and subcontractors must disclose the information on individuals or corporations with an ownership or control interest as described above to the Department as follows:
    i. With the PHP's response to the RFP (Attachment O.11. Disclosure of Ownership Interest);
    ii. Upon effective date of the Contract;
    iii. Upon renewal or extension of the Contractor's contract; and
    iv. Within thirty-five (35) days after any change in the Contractor's ownership.

17. <u>ENTIRE AGREEMENT AND ORDER OF PRECEDENCE</u>: This Contract consists of the following documents incorporated herein by reference:

a. Any amendments, business requirements, or implementation plans, executed by the Parties, in reverse chronological order and any Contractor policies, plans, processes, procedures, strategy documents, work plans or work flows that require Department approval and have been approved, in reverse chronological order;
b. Execution of Contract, if any;
c. Best and Final Offers or negotiation documents, in reverse chronological order, if any;
d. Written clarifications, in reverse chronological order, if any;
e. Addenda to the RFP, in reverse chronological order, if any; and
f. This RFP in its entirety; and
g. Offeror's proposal.

In the event of a conflict between the Contract Documents, the term in the Contract with the highest precedence shall prevail. These documents constitute the entire agreement between the parties and supersede all prior oral or written statements or agreements.

18. **EQUAL EMPLOYMENT OPPORTUNITY:** Contractor shall comply with all federal and state requirements and North Carolina Executive Order 24 dated October 18, 2017, concerning fair employment and employment of the disabled, and concerning the treatment of all employees without regard to discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or veteran status, sexual orientation, gender identity or expression.

19. **FORCE MAJEURE:** Neither Party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations because of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

20. **GENERAL INDEMNITY & LIMITATION OF LIABILITY:** Subject to any limitations of liability specified in the Contract, the Contractor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or intentionally tortious acts of the Contractor. The Contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Contractor goods and/or services to the State. The representations and warranties in the preceding sentences shall survive the termination or expiration of this Contract. The State, Department, and/or Office of the Attorney General shall have the option to participate at their own expense in the defense of such claim(s) or action(s) filed and the State shall be responsible for its own litigation expenses if it exercises this option.

21. **GOVERNING LAWS:** This Contract is made under and shall be governed, construed, and enforced in accordance with the laws of the State of North Carolina, without regard to its conflict of laws or rules. This term shall survive the termination or expiration of this Contract.

22. **GOVERNMENTAL RESTRICTIONS:** In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.

23. **INDEPENDENT CONTRACTORS:** Contractor and its employees, officers and executives, and subcontractors, if any, shall be independent Contractors and not employees or agents of the Department. The Contract shall not operate as a joint venture, partnership, trust, agency, or any other similar business relationship.

24. **INSURANCE:** During the term of the Contract, the Contractor, at its sole cost and expense, shall provide commercial insurance coverage of such type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:
    a. Worker's Compensation - The Contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of $500,000.00, covering all of Contractor's employees who are engaged in any

work under the Contract. If any work is sublet, the Contractor shall require the subcontractor to provide the same coverage for any of his employees engaged in any work under the Contract.

b. Commercial General Liability - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of $2,000,000.00 Combined Single Limit.

c. Automobile - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used relating to the Contract. The minimum combined single limit shall be $500,000.00 for bodily injury and property damage; $500,000.00 for uninsured/under insured motorist; and $50,00.00 for medical payment.

d. Requirements - Providing and maintaining adequate insurance coverage is a material obligation of the Contractor and is of the essence of this Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Contractor shall always comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this Contract. The limits of coverage under each insurance policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract.

25. INHERENT SERVICES: If any services, Deliverables, functions or responsibilities not specifically described in the Contract are required for the proper performance, provision, and delivery of the services and Deliverables to be delivered by Contractor pursuant to the Contract, or are an inherent part of or necessary sub-task included within the Contract, they will be deemed to be implied by and included within the scope of the Contract to the same extent and in the same manner as if specifically described in the Contract. Unless otherwise expressly provided in the Contract, Contractor will furnish all necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies and materials necessary to provide the services to be delivered by Contractor under the Contract.

26. INTELLECTUAL PROPERTY INDEMNITY: Contractor shall hold and save the Department, State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or unpatented invention, articles, device, or appliance delivered relating to this contract. This term shall survive the termination or expiration of this Contract.

27. LITIGATION: If a demand is asserted, or litigation or administrative proceedings, other than those administrative proceedings related to adverse benefit determinations addressed by other provisions of the Contract, are begun against the Contractor or against the Department and Contractor jointly relating to the services being provided under this Contract, the Contractor shall notify the Department within five (5) State Business Days of becoming aware of such action. To the extent no conflict of interest exists or arises, Parties may agree to joint defense and agree to cooperate fully in defense of such litigation.

In the event of litigation against the Department related to the Contract, Contractor's performance, or services provided under the Contract, Contractor will cooperate with Department fully in the defense of such litigation.

Any civil or administrative settlements between the PHP, as a delegee of the Department, and any member, provider, or other person, related to Medicaid Managed Care are public record. All settlements must be reported to the Department within thirty (30) days of an executed settlement agreement and a copy of the settlement agreement must be provided to the Department upon request.

This provision shall survive expiration or termination of the Contract.

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. Contractor 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.

29. **MONITORING OF SUBCONTRACTORS:** Contractor shall perform on-going monitoring of all subcontractors and shall confirm compliance with subcontract requirements. As part of on-going monitoring, the Contractor shall identify to the subcontractor(s) deficiencies or areas for improvement and shall require the subcontractor(s) to take appropriate corrective action. Contractor shall perform a formal performance review of all subcontractors at least annually. Contractor shall review encounter data of its subcontractor for quality and accuracy before the data is submitted to the Department.

30. **NOTICES:** Any notices required under the Contract must be delivered to the appropriate Contract Administrator for each Party. Unless otherwise specified in the Contract, any notices shall be in writing and delivered by both email and U.S. Mail, Commercial Courier, or by hand.

31. **OWNERSHIP OF DELIVERABLES:** All project materials, including software, data, and documentation created during the performance or provision of services hereunder that are not licensed to the Department or other State entity, or are not proprietary to the Contractor are the property of the Department and must be kept confidential or returned to the Department, or destroyed. Proprietary Contractor materials shall be identified to the Department by the Contractor prior to use or provision of services hereunder and shall remain the property of the Contractor. Derivative works of any Contractor proprietary materials prepared or created during the performance of provision of services hereunder shall be subject to a perpetual, royalty free, nonexclusive license to the Department and the State. This term shall survive termination or expiration of the Contract.

32. **PAYMENT AND REIMBURSEMENT:**
    a. **Managed Care Payments**: The Department will make the following Managed Care payments to the Contractor, as applicable:
        i. Risk-adjusted Monthly Per Member Per Month (PMPM) capitated payments;
        ii. Maternity event payments;
        iii. Additional directed payments to certain providers, and
        iv. Enhanced case management pilot payments.
    b. **PMPM Capitated Payments**
        i. The Contractor must accept capitation rates and risk adjustment methodology developed by the Department and its actuary and approved by CMS.
        ii. Capitated payments shall be made on a PMPM, prospective basis at the first check-write of each month, unless another schedule is set by the Department.

iii. The Department will make PMPM capitation payments to the Contractor based on the number of Members in each rate cell (as defined in the Rate Book applicable to the rating period and as determined by the monthly cutoff date in Medicaid Eligibility data system) multiplied by the applicable risk adjustment factor. The payment amount will be pro-rated for partial-month PHP enrollment.

iv. PMPM capitation payments will be reconciled on a regular schedule to account for enrollment and eligibility changes not reflected in the initial monthly payment to the Contractor and may result in changes to a subsequent monthly capitation payment. Additional details on reconciliation can be found in *Section V.K. Technical Specifications*.

v. The PMPM capitated rates are specified in the Rate Book. However, capitated payments shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements at 42 C.F.R. § 438.730.

c. **Maternity Event Payments**: As provided in *Section V.I.1. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required documentation of an eligible delivery event to the Department. The required documentation and process for submission will be finalized prior to Contract Year 1 effective date and included in an Amendment. The Contractor must accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.

d. **Additional Directed Payments for Certain Providers**: The Department will make payments to the Contractor to support additional, utilization-based, directed payments to certain providers as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) and in accordance with *Section V.D.4. Provider Payments*. The required documentation and process for payment will be included in an Amendment.

e. **Enhanced Case Management Pilots to Address Unmet Health-Related Needs**: If the Contractor covers a region that includes an Enhanced Case Management Pilot, the Contractor is eligible to receive payments from the Department, up to a PHP-specific capped allotment, to fund pilot services based on the cost and volume of specified services authorized for and delivered to the Contractor's Members as provided in *Section V.C.8. Opportunities for Health*. The Contractor shall make payments and manage pilot funding as required in *Section V.C 8. Opportunities for Health* and as otherwise provided by Amendment.

f. **Payment in Full**:

i. The PHP shall accept managed care payments under this Section as payment in full for the services provided under Contract, unless otherwise specified by the Contract.

ii. Members shall be entitled to receive all covered services as provided in *Section V.C.1. Medical and Behavioral Health Benefits Package* for the entire period for which payment has been made by the Department.

g. **Payment Adjustments**: Payment adjustments may be initiated by the Department based on the eligibility and enrollment reconciliation or when keying errors or system errors affecting correct managed care payments to the Contractor occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying information and the payment adjustment amount.

h. **Recoupment**:

i. If the Contractor erroneously reports (intentionally or unintentionally), fraudulently reports, or knowingly fails to report any information affecting managed care payments to the Contractor, and is consequently overpaid, the Department may request a refund of the overpayment or recoup the overpayment by adjusting payments due in any one or more subsequent months.

ii. The Department may also recoup erroneous overpayments made to the Contractor as a consequence of keying errors or system errors. Each recoupment transaction shall be

included on the remittance advice in the month following the correction. Each transaction shall include identifying Member information and the recoupment amount.

iii. The Department shall provide at least ten (10) days' notice to Contractor of its intent to recoup overpayments and shall offer Contractor the opportunity to contest any such alleged overpayments. The Department shall not take any collection action under this Contract, including recoupment while the dispute is pending and unresolved, unless otherwise allowed by law.

i. **Other Managed Care Payment Terms and Conditions**:

i. Payment will only be made for services provided and is contingent upon satisfactory performance by the Contractor of its responsibilities and obligations under the Contract.

i. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other or adjustments as described in *Section V.E. Quality Management and Quality Improvement* and *Section VI. Contract Performance* to any payment due to Contractor.

ii. The Contractor is responsible for all payments to subcontractors under the Contract. The Department shall not be liable for any purchases or subcontracts entered into by the Contractor or any subcontracted Provider in anticipation of funding.

iii. All payments shall be made by electronic funds transfers. Contractor shall set up the necessary bank accounts and provide written authorization to Medicaid's Fiscal Agent to generate and process monthly payments.

iv. Contractor shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members**.** 42 C.F.R. § 438.3(c)(2).

v. Contractor shall maintain separate accounting for revenue and expenses for payments under this Contract in accordance with CMS requirements.

j. **Third-Party Resources**:

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties for some of the services rendered to Members. As required in *Section V.J.4. Third Party Liability (TPL)*, the Contractor shall be responsible for actively seeking and identifying the liability of third parties and engaging in third party resource recovery and cost avoidance to pay for services rendered to Members pursuant to this Contract. All funds recovered by the Contractor from third party resources shall be treated as income to Contractor.

33. <u>PERFORMANCE BOND:</u>

a. The PHP shall furnish a performance bond to the Department within thirty (30) calendar days after award of the contract. This security will be in the form a surety bond licensed in North Carolina with an A.M. Best's rating of no less than A-.

b. The amount of the performance bond shall be thirty million dollars ($30,000,000) for Statewide PHPs. The amount of the performance bond shall be five million dollars ($5,000,000) for each Region in which the PHP is awarded a Contract. If a PHP is awarded to Contract in multiple Regions, then PHP shall furnish a single bond for the total amount.

c. The PHP shall bear the cost of the performance bond.

d. The performance bond must be made payable to the North Carolina Department of Health and Human Services.

e. The contract number and contract period must be specified on the performance bond.

f. For as long as the PHP has liabilities of $50,000 or more outstanding under this Contract, or 15 months following the termination date of this Contract, whichever is later, the performance bond must be maintained to guarantee payment of the PHP's obligations.

g. In the event of a default by the PHP, the Department shall obtain payment under the performance bond for the purposes of the following:
    i. Paying any damages sustained by providers, non-contracting providers, non-providers, and other subcontractors by reason of a breach of the PHP's obligations under this Contract;
    ii. Reimbursing the Department for any payments made by the Department on behalf of the PHP, including payment of the PHP's obligations to providers;
    iii. Reimbursing the Department for any administrative expenses incurred by reason of a breach of the PHP's obligations under this Contract, including expenses incurred after termination of this Contract; and
    iv. In the event the PHP terminates the Contract prior to the end of the Contract period, a claim against the bond may be made by the Department to cover cost of issuing a new solicitation and selecting a new PHP or transitioning Members to another PHP.

34. **PLE 1099s:** PLE shall submit 1099s for all voting members that are physicians who have received reimbursement for the treatment of at least one beneficiary as proof of participation.

35. **PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES:** Contractor warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for obtaining any Contract or award issued by the State and its Departments and other agencies or entities. The Contractor further warrants that no commission or other payment has been or will be received from or paid to any third-party contingent on the award of any Contract by the State, except as shall have been expressly communicated to the Department's Office of Procurement, Contracts and Grants in writing prior to acceptance of the Contract or award in question. The Contractor and their authorized signatory further warrant that no officer or employee of the State has any direct or indirect financial or personal beneficial interest, in the subject matter of the Contract; obligation or Contract for future award of compensation as an inducement or consideration for making the Contract. Subsequent discovery by the State of non-compliance with these provisions shall constitute sufficient cause for termination of all outstanding contracts. Violations of this provision may result in debarment of the Contractor(s) as permitted by 09 NCAC 06B.1206, 01 NCAC 05B.1520, or other provision of law.

36. **RECORDS RETENTION:** All records and data held by the Contractor as it relates to this Contract shall be retained and maintained as required by North Carolina law, federal law, State and Department Record Retention requirements and policies.
a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer period is required by federal or state law or policy. Federal record retention standards are located in 45 C.F.R. § 74.53. The State policy is mandated by the State Archives of North Carolina and is located here: https://archives.ncdcr.gov/government/retention-schedules.
b. Records shall not be destroyed, purged, or disposed of without the express written consent of the Department.
c. If any litigation, claim, negotiation, audit, disallowance action or other action involving this Contract start before the expiration of the legally required retention period, the records must be retained until completion of the action and resolution of all issues which arise from it.
d. In the event there are changes in record retention requirements or policies due to North Carolina law, federal law, State or Department record retention Policies, the Contractor shall make the necessary changes to be in compliance with all Records Retention requirements.
e. Record Retention requirements included within the body of this RFP, subsequent contract and amendments, are intended to supplement this term. In the event of conflict, the provisions of this term are the controlling requirements.

f. At the point the Contract terminates/expires, all data must be transitioned to the State in a format prescribed by the Department unless that data has exceeded its archive requirements. The Department may request verification from the Contractor that archive requirements are being met.

g. The PHP shall develop policies and procedures of record retention. The PHP's Policy for Record Retention shall include specific standards for the following:
   i. Reports submitted to the Department;
   ii. Data submitted to the Department;
   iii. Financial records;
   iv. Transfer of medical records;
   v. Quality data; and
   vi. Prescription files.
      a) PHPs shall comply with all standards for record retention standards in 45 C.F.R. § 74.53 and the standards determined by NC DHHS.
      b) PHPs shall submit its PHP Policy for Record Retention to the Department for review. The PHP shall submit its PHP Policy for Record Retention to the Department if there are significant changes.

h. The Contractor shall maintain indirect cost rate proposals and cost allocation plans shall be retained for ten (10) years, unless otherwise required by federal or state law.

i. This term survives termination or expiration of the Contract.

37. **RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION**: The Contractor shall prioritize requests from the Department to respond to inquiries from any Departments under the State of North Carolina, the North Carolina Legislature or other government agencies or bodies. Contractor shall respond to urgent requests from the Department within twenty-four (24) hours and according to the guidance and timelines provided by the Department. Contractor may be required to participate with and respond to inquiries from a consultant contracted with the Department regarding policies and procedures requiring review to determine compliance.

38. **RIGHT TO PUBLISH:** The Department agrees to allow the Contractor to publish material associated with the terms of this Contract provided the Contractor receives prior written approval from the Department. The Contractor shall submit for review any presentation or publication that will be given to outside parties that contains data and information relating to the terms of this Contract at least thirty (30) calendar days in advance. The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

39. **SEVERABILITY:** If a court of competent authority holds that a provision or requirement of the Contract violates any applicable law, each such provision or requirement shall be enforced only to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of the Contract shall remain in full force and effect.

40. **SITUS:** The place of this Contract, its situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in Contract or tort, relating to its validity, construction, interpretation, and enforcement shall be determined.

41. **SOVEREIGN IMMUNITY:** Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the Department and State under applicable law.

42. **STATE CONTRACT REVIEW**: This RFP and subsequent contracts are exempt from the State contract

review and approval requirements pursuant to G.S § 143B-216.80(b)(4).

43. SUBCONTRACTORS:

a. Acceptance of Contractor's proposal will include any subcontractor(s) specified therein. Work performed under this contract by the Contractor or its employees will not be subcontracted without prior written approval of the Department. Contractor must submit a written request for approval at least sixty (60) calendar days prior to the start of services by the subcontractor. (*Attachment O. 12. Subcontractor Identification*.)

b. Upon request, the Contractor shall provide the Department with complete copies of any contracts made by and between the Contractor and all subcontractors. The selected Contractor remains solely responsible for the performance of its subcontractors. Subcontractors, if any, shall adhere to the same standards required of the selected Contractor and this Contract. Any contracts made by the Contractor with a subcontractor shall include an affirmative statement that the Department is an intended third-party beneficiary of the Contract; that the contract with the subcontractor does not create a contract between the Department and subcontractor; and that the Department shall be indemnified by the Contractor for any claim presented by the subcontractor. Notwithstanding any other term herein, Contractor shall timely exercise its contractual remedies against any non-performing subcontractor and, when deemed appropriate by the Department, substitute another subcontractor.

c. The Contractor shall neither participate with nor enter into any agreement with any individual or entity that has been excluded from participation in federal health care programs. The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Act. [42 C.F.R. 438.808(a); 42 C.F.R. 438.808(b)(2); 42 C.F.R. 431.55(h); section 1903(i)(2) of the Act; 42 C.F.R. 1001.1901(c); 42 C.F.R. 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09]

d. Any contract(s) between the Contractor and subcontractor(s) require:

   i. The subcontractor to agree that the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect its premises, any books, records, contracts, computer or other electronic systems of the subcontractor relating to its Medicaid Members, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State;

   ii. The subcontractor to agree that the right to audit by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

   iii. That if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

e. Any contract(s) between the Contractor and subcontractor(s) shall include:

   i. The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Contractor and the subcontractor.

   ii. Provision for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determines that the subcontractor has not performed satisfactorily. 42 C.F.R. § 438.230(c)(1)(i) - (iii)

   iii. Requirement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 C.F.R. § 438.230(c)(2)

44. SURVIVAL: The expiration, termination, or cancellation of this Contract will not extinguish the rights

of either party that accrue prior to expiration, termination, or cancellation or any obligations that extend beyond termination, expiration or cancellation, either by their inherent nature or by their express terms.

45. TAXES: Any applicable taxes shall be invoiced as a separate item and in accordance with this paragraph and applicable laws.

a. N.C. Gen. Stat. § 143-59.1 bars the Department from entering into Contracts with Contractors if the Contractor or its affiliates meet one of the conditions of N.C. Gen. Stat. § 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under N.C. Gen. Stat. § 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the Contractor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the proposal document the Contractor certifies that it and all its affiliates, (if it has affiliates), collect(s) the appropriate taxes.

b. All agencies participating in this Contract are exempt from federal taxes, such as excise and transportation. Exemption forms submitted by the Contractor will be executed and returned by the using agency.

c. Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.

46. TERMINATION: Any notice or termination made under the Contract shall be provided to Contractor's and Department's respective Contract Administrators.

a. The Contractor obligations set forth in this Section shall survive the expiration or termination of this Contract and shall remain fully enforceable by Department against Contractor. In the event that Contractor fails to fulfill each obligation set forth in this Section, Department shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of Contractor, and Contractor shall refund to Department all sums expended by Department in so doing.

b. Termination without Cause:

This Contract may be terminated, in whole or in part, without cause by the Department by giving at least sixty (60) calendar days' prior written notice to the other party. The termination shall be effective at 11:59:59 p.m. on the last day of the calendar month in which the sixty (60) day notice period expires. In the event of termination without cause:

i. Department and Contractor shall work together on a daily basis in good faith to minimize any disruption of services to NC Medicaid beneficiaries;

ii. Contractor shall perform all of the Contractor transition and other obligations specified in the Contract;

iii. Department and Contractor shall resolve any outstanding obligations under this Contract; and

iv. Contractor shall pay Department in full any refunds or other sums due to Department under this Contract.

c. Termination for Cause:

i. In accordance with 42 C.F.R. § 438.708, Department shall have the right to terminate this Contract with Contractor and to enroll Contractor's Members in other managed care plans if Department determines that Contractor has failed to carry out the substantive terms of this Contract or has failed to meet applicable requirements in Sections 1905(t), 1903(m), and/or 1932 of the Social Security Act.

ii. Upon written notification to Contractor of Department's intent to terminate this Contract, Department may give Members written notice of such intent and allow the Members to disenroll immediately without cause in accordance with 42 C.F.R. § 438.722.

iii. If Department seeks to terminate this Contract pursuant to 42 C.F.R. § 438.708, Department shall provide Contractor with a pre-termination hearing as required by 42 C.F.R. § 438.710(b) and as described in this Contract.

iv. Department shall have the right to terminate this Contract for cause when the performance of Contractor or one of its subcontractors has threatened to place the health or safety of any Beneficiary in jeopardy, and Contractor knew or should have known of the issue and failed to take appropriate action immediately to correct the problem;

v. Department shall have the right to terminate this Contract for cause when Contractor becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);

vi. Department shall have the right to terminate this Contract for cause when Contractor has fraudulently misled any Beneficiary or has fraudulently misrepresented the facts or law to any Beneficiary, and Contractor failed to take appropriate action immediately to correct the problem;

vii. Department shall have the right to terminate this Contract for cause when gratuities of any kind with the intent to influence have been offered or received by a public official, employee or agent of the State by or from Contractor, its agents or employees;

viii. Department shall have the right to terminate this Contract for cause if Contractor loses accreditation with NCQA.

ix. Department shall have the right to terminate this Contract for cause if Contractor declares bankruptcy.

x. Department shall have the right to terminate this Contract as otherwise set forth in this Contract.

d. Automatic Termination:

This Contract shall immediately and automatically terminate without further Contractor obligation to Department, except as provided below in Subsection e., if:

i. Either of the two (2) sources of reimbursement for Medical Assistance (appropriations from the North Carolina General Assembly and appropriations from the United States Congress) no longer exists; or

ii. The sum of all contractual obligations of Department exceeds the balance of funds available to Department for a Contract year in which this Contract is effective.

Written certification from the Department that one or the other or both of the conditions described above has been met shall be conclusive and binding upon the parties. Department shall attempt to provide Contractor with ten (10) business days' prior notice of the possible occurrence of events described above.

In the event of immediate and automatic Contract termination, Contractor shall cooperate fully with the Department in transferring any data and information or providing such other assistance as described in this Section in an expedient manner.

e. Contract Expiration, Termination, and Transition Obligations of Contractor:

At least sixty (60) calendar days before Contract expiration, and within thirty (30) calendar days of receipt of notice by Contractor of any Contract termination, Contractor shall provide notice of termination to Members. In all cases, Contractor's notification letter must be approved by Department before Contractor mails the notice to Members.

No less than ninety (90) days prior to the date of planned expiration or forty-five (45) days of planned termination of this Contract, Contractor shall:

i. Provide Department with Contractor's plan for the transfer of all Members to other appropriate managed care entities, and make all Department required changes to said plan;

ii. Assist Department in the implementation of the Department-approved plan for Member transition in such a manner as to ensure the continuity of services for Members;
iii. Promptly provide Department with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;
iv. Arrange for the secure maintenance of all Contractor records for audit and inspection by Department, CMS, and other authorized government officials;
v. Provide for the transfer of all data, including encounter data and records, to Department or its agents as may be requested by Department;
vi. Provide for the preparation and delivery of all reports, forms and other documents to Department as may be required pursuant to this Contract or any applicable policies and procedures of Department; and
vii. Notify all Members in writing of the pending expiration or termination of this Contract. Such notice shall also include all information required by Department.

47. TIME IS OF THE ESSENCE: Time is of the essence in the performance of this contract and all provisions that specify a time for performance.

48. TITLES AND HEADINGS: Titles and headings in this RFP, and in any subsequent contract, are for convenience only and shall have no binding force of effect.

49. USE OF THIRD PARTY ADMINISTRATOR: If a PHP uses the services of a Third Party Administrator (TPA) to adjust or settle claims for Members, then the PHP shall do all of the following:
a. Ensure the TPA has a current license issued by, and is in good standing with DOI, as required by N.C. Gen. Stat. §§ 58-56-2(5) and 58-56-51;
b. Have a written agreement with the TPA that is compliant with Article 56 of Chapter 58 of the General Statutes, as applicable, and includes a statement of the duties the TPA is expected to perform on behalf of the PHP, as specified in N.C. Gen. Stat. § 58-56-6;
c. Establish the rules, in accordance with this Contract, pertaining to claims payment and shall provide the TPA with the rules in accordance with N.C. Gen. Stat. § 58-56-26; and
d. Submit to the Department with the Technical Response an attestation that the PHP understands it is solely responsible to provide for competent administration of its claims under the Contract, as provided in N.C. Gen. Stat. § 58-56-26.

50. WAIVER: The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.

E. Confidentiality, Privacy and Security Protections

1. The requirements of this Section shall survive expiration or termination of the Contract except subsections 5, 6, 7, and 8.

2. Confidential Information
   a. The Contractor, its agents, and its subcontractors shall maintain the privacy, security and confidentiality of all data, information, working papers, and other documents related to the Contract. The Contractor shall treat all information obtained through its performance under the Contract as confidential information and shall not use such information except as provided under this Contract. Any use, sale, or offer of confidential information except as contemplated under the Contract or approved in writing by the Department shall be a violation of the Contract. Any such violation will be considered a material breach of the Contract. Contractor specifically warrants that it, its officers, directors, principals, employees, any subcontractors, and approved

third-party contractors shall hold all information received during performance of the Contract in the strictest confidence and shall not disclose the same to any third party except as contemplated under the Contract or approved in writing by the Department.

b. Contractor warrants that all its employees, subcontractors, and any approved third-party Contractors are subject to a non-disclosure and confidentiality agreement that is enforceable in North Carolina and sufficient in breadth to include and protect confidential information related to the Contract. The Contractor shall, upon request by the Department, verify and produce true copies of any such agreements. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C. Gen. Stat. § 132-1 et. Seq. The Department may, in its sole discretion, provide a non-disclosure and confidentiality agreement satisfactory to the Department for the Contractor's execution. The Department may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including but not limited to 26 U.S.C. 6103, SSA, and IRS Publication 1075 (Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities), HIPAA, and implementing regulation in the Code of Federal Regulations and any future regulations imposed upon the Department of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.

c. The Department, State auditors, State Attorney General, federal officials as authorized by federal law or regulations, and State officials as authorized by state law or regulations, as well as the authorized representatives of the foregoing, shall have access to confidential information in accordance with the requirements of state and federal laws and regulations. No other person or entity shall be granted access to confidential information unless state and federal laws and regulations allow such access. The Department has the sole authority to determine if and when any other person or entity has properly obtained the right to have access to any confidential information and whether such access may be grated. Use or disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.

d. The Contractor warrants that without prior written approval of the Department, the Contractor shall not incorporate confidential or proprietary information of any person or entity not a Party to the Contract into any materials furnished to the Department, nor without such approval shall the Contractor disclose to the Department or induce the Department to use any confidential or proprietary information of any person or entity not a Party to the Contract.

e. The foregoing confidentiality provisions do not prevent the Contractor from disclosing information that (i) at the time of disclosure by the Department is already known by the Contractor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Contractor other than an act that is authorized by the Department, (iii) is rightfully received by Contractor from a third party and Contractor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the Department, (iv) is independently developed by the Contractor without use of the Department's confidential information, (v) is disclosed without similar restrictions to a third party by the Department, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Contractor, to the extent possible provides the Department with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

3. HIPAA and HITECH

a. The Department has declared itself to be a hybrid entity under HIPAA with the Division of Health Benefits being a covered health care component. As such, this Contract and related activities are subject to HIPAA and HITECH. Contractor shall comply with HIPAA and HITECH requirements and regulations, as amended, including:
   i. Compliance with the Privacy Rule, Security Rule, and Notification Rule, Security Rule, and Notification Rule including the confidentiality requirements in 45 C.F.R. parts 160 and 164;
   ii. The development of and adherence to applicable Privacy and Security Safeguards and Policies;
   iii. Timely reporting of violations regarding the access, use, and disclosure of PHI; and
   iv. Timely reporting of privacy and/or security incidents at: https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security
b. Contractor will be performing functions on behalf of the Department that make Contractor a business associate for purposes of HIPAA regulations. Accordingly, Contractor and this Contract are subject to the terms and conditions of *Attachment O. 13. Business Associate Agreement.*
c. Contractor shall cooperate and coordinate with the Department and its Privacy and Security Office (PSO) as mandated by HIPAA and HITECH and accompanying regulations, or as requested by the Department, during performance of the Contract so that both Parties are in compliance with HIPAA and HITECH.
d. In addition to federal law and regulation, Contractor shall comply with state rules and regulation regarding protected information and Department and State policies including State IT Security Policy Manual. These polices may be revised from time to time and the Contractor shall comply with all such revisions.

4. North Carolina Identity Theft Protection Act and Other Protections

   Certain data and information received, generated, maintained or used by Contractor may be classified as "identifying information" within the meaning of N.C. Gen. Stat. § 14-113.20(b) or "personal information" within the meaning of N.C. Gen. Stat. § 75-61(10). Contractor is subject to the North Carolina Identity Theft Protection Act requirements, N.C. Gen. Stat. §§ 132-1.10 and 75-65 and must protect such identifying information and personal information as required by law, Department and State policy, and the terms of this Contract. Contractor shall report security incidents and breaches of all protected information, whether PHI, identifying information, or personal information as required in Subsection 11. below.

5. Information Technology
   a. The PHP shall comply with and adhere to all applicable federal and North Carolina laws, regulations, policies, and guidelines, including but not limited to HIPAA, CMS and State IT Security Policy and Standards, and Department Privacy and Security Policies. These policies may be revised periodically, and the PHP shall comply with any revisions. The State Security Manual is available at https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf and the Department security manual is available at https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/.
   b. The PHP's information technology systems shall meet all state and federal statutes, rules and regulations governing information technology (including but not limited to 26 U.S.C. 6103, SSA, IRS Publication 1075, and HIPAA) and the policies of the NC Department of Information Technology. *See e.g.,* https://it.nc.gov/statewide-resources/policies; https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf and https://it.nc.gov/document/statewide-data-classification-and-handling-policy.
   c. Enterprise Architecture Standards: The North Carolina Statewide Technical Architecture standards are located at https://it.nc.gov/services/it-architecture/statewide-architecture-

framework. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems.

d. Modifications, Updates or Fixes to the PHP's Information Technology Systems: The Contractor will adhere to the Department's Change Management and control policies and procedures for all system modifications. The PHP shall not modify, update, or fix any IT system that shares information with (or interfaces with) the Department's Information Technology systems without the Department's prior written approval. The PHP's request for approval must be communicated to the Department one hundred twenty (120) days prior to the change and contain a detailed description of the changes proposed by the PHP. The PHP must supplement its request with all clarifications and additional information requested by the Department. The PHP shall not place any modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's IT systems. The Department reserves the right to delay implementations if it perceives a risk to its operations.

e. Modifications, Updates, and Fixes Requested by the Department: The PHP shall promptly modify, upgrade, or fix any part of its Information Technology System that shares information with (or interfaces with) the Department's Information Technology Systems as requested by the Department. The PHP shall not place any such modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's Information Technology Systems. The PHP may not unilaterally refuse to make a modification, update or fix requested by the Department. In the event the PHP disagrees with the Department on modification, update or fix requests, the PHP must follow the Change Management and control policies and procedures for resolution. If the Parties cannot come to agreement, the PHP may utilize the Dispute Resolution process **described in this Contract**.

f. Patch Management: The PHP will apply patches based on State requirements on or to any Information Technology Systems or platforms that share information with (or interfaces with) the Department's Information Technology Systems or which may impact the delivery of services to the Department's Members. The State requirements are located at the following URL: https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf
The PHP will coordinate patching activity with the Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with PHP patching. The requirement to apply the patch may come from the PHP, the Department, or an external organization such as https://www.us-cert.gov/.

g. Changes to Department Information Technology Systems: The Department anticipates changes to its Information Technology Systems. The Contractor will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file or overall file size in bytes). The Department will provide test environments to allow adequate testing time.

h. The Department's Rejection of the PHP's Modifications, Updates or Fixes to the PHP's IT Systems: The Department reserves the right to reject any modification, update or fix that does not meet the Department's Information Technology standards or could impair the operation of the Department's Information Technology Systems.

i. Cost of Modifications, Updates, Fixes, and Patches to the PHP's IT Systems: The cost of all modifications, updates, fixes, and patches to the PHP's Information Technology Systems (whether proposed by the PHP or required by the Department) shall be borne solely by the PHP.

j. The PHP shall not connect any of its own equipment to a State LAN/WAN without prior written approval by the State. The PHP shall complete all necessary paperwork as directed and coordinated by the Department's appropriate Contract Administrator to obtain the required written approval by the Department to connect PHP-owned equipment to a State LAN/WAN.

k. The PHP shall be responsible for providing connectivity to the Department's network and systems as required by the Department. This includes any network, connectivity, licensing, or hardware associated with complying with the State's and the Department's policy for securing data. This applies to all communication between the PHP and the Department, and also includes the Department's current and future contractors' networks.

l. Web / Internet Presence - Where necessary, any web presence that is required to complete the terms of this agreement will comply with the Department's the State's, and federal standards including but not limited to those required for accessibility (Web Content Accessibility Guidelines (WCAG) 2.0 and the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Sec. 508 of the Rehabilitation Act of 1973 as amended January 2017). The Department will make these standards available as needed.

m. The PHP shall follow the North Carolina Statewide Information Architecture Framework (located at https://it.nc.gov/services/it-architecture/statewide-architecture-framework), and any Department derivatives of these documents. The PHP shall provide documentation as requested by the Department to assess the security of the PHP's facilities and systems. The security review is part of the overall readiness and noncompliance may be subject to Contract Termination for Cause.

6. Continuous Monitoring

a. The Contractor shall adhere to the mandate for a Continuous Monitoring Process and work with the Department to implement a risk management program that continuously monitors risk through assessments, risk analysis and data inventory. The requirements are based on NIST 800-37, Continuous Monitoring Process and originates from N.C. Gen. Stat. § 143B-1376, located online at: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_143B.html, which requires the North Carolina State CIO to annually assess each agency and each agency's contractors' compliance with enterprise security standards.

b. The Contractor shall assist the Department with risk assessment and security assessment of the Contractor's critical systems and infrastructure.

   i. The Contractor shall perform the required assessments, either through a third-party or a self-assessment, on a three-year cycle (with a third-party assessment mandated every third year).

   ii. All findings identified in the assessment shall be provided, through DHB to the North Carolina Department of Information Technology within thirty (30) calendar days of assessment completion and a plan to remediate each finding.

c. Assessment of agency cloud-hosted providers or off-site hosting services.

   i. Contractors providing Infrastructure as a Service, Platform as a Service and/or Software as a Service are required to obtain approval from the Department and ensure Contractor compliance with Statewide security policies.

   ii. The contractor will provide attestation to their compliance and an industry recognized, third party assessment report performed annually. Types of these reports include: Federal Risk and Authorization Management Program (FedRAMP) certification, SOC 2 Type II, SSA 16/18 or ISO 27001.

   iii. Departments and their divisions/offices are required to review these reports, assess the risk of each PHP, and provide annual certification of their compliance to the State CIO.

iv. PHP shall cooperate with the Department in completing a data inventory of all cloud hosted services as required and performed through completion of a Privacy Threshold Analysis (PTA) documenting the data classification and data fields hosted within the cloud, offsite or vendor hosted environment. The PTA shall be reviewed and updated annually by the Parties and when changes have been made to the data being collected. The Department's PTA form is available at: https://it.nc.gov/documents/privacy-threshold-analysis-pta-form.

7. Secure Integration Services
   a. The PHP's systems shall be able to transmit, receive and process data in HIPAA-compliant or Department-specific formats and methods, including but not limited to Secure File Transfer Protocol (SFTP) over encrypted connections such as a SSL (Secure Sockets Layer) or SSH (Secure Shell).
   b. The Contractor shall work with the Department and Department Vendors to implement data exchanges that comply with the Department, State's security policies, as defined by the North Carolina Department of Information Technology. The State's preferred method of exchanging data with other applications in the Medicaid Enterprise System (MES) is through synchronous real-time web services and/or asynchronous queue-based messaging. High level data exchange information as provided in *Section V.K. Technical Specifications* with detailed specifications being provided upon Contract Award
   c. The Contractor shall have the ability to exchange files through secure protocols with other systems.

8. Service Organization Control (SOC) reports
   All SOC 1 and SOC 2 Type II reports, and associated SOC 2 corrective action plans, must be submitted annually to the DHHS Privacy and Security Office in a format to be specified by the State. The Department will accept ISO 27001 certification for security controls in lieu of a SOC 2 Type II report.

9. North Carolina Identity (NCID) Service
   Any PHP systems that are utilized by the State or by beneficiaries must externalize identity management and may be required to utilize the North Carolina Identity Service for the identity management and authentication related functions performed by PHP's applications. NCID is the State's enterprise identity management (IDM) service. The North Carolina Department of Information Technology operates it. Additional information regarding this service can be found in the DIT Service Catalog at: http://it.nc.gov/it-services (see Identity Management - NC Identity Management under the main menu item Application Services) and the NCID Web site at: https://www.ncid.its.state.nc.us/.

   The use of any other IDM service will require Department and State approval. The protocol (web services, LDAP, SAML, etc.) shall be determined by the Department and the PHP based on the implementation. In addition, the PHP may be required to implement multi factor authentication per the State specifications.

10. Security
    a. State of NC Security Standards and DHHS Privacy and Security Standards
       i. PHP shall comply with all security standards including those published in the State of North Carolina Statewide Information Security Manual, the North Carolina Department of Health and Human Services Privacy and Security Office (PSO) Standards, and any federal regulations and requirements (found at https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/). The State of North Carolina Statewide Information Security Manual is available at the following URL:

https://it.nc.gov/statewide-information-security-policies. The Department will work with the PHP to validate compliance with the PSO standards.

ii. The PHP's systems and processes shall comply with all current and future federal, State, and Department requirements for privacy and security and data exchange within one hundred twenty (120) calendar days of the implementation of that standard.

b. Physical Security

i. Each person who is an employee or agent of PHP or sub-contractor must always display an appropriate State badge and his or her company ID badge while on State premises. Upon request of Department personnel, each such employee or agent must also provide additional photo identification.

ii. At all times at any State facility, PHP's personnel shall cooperate with State site requirements, including being prepared to be escorted, providing information for badging, and wearing the badge in a visible location.

c. State of NC Data Classification and Handling

The State of North Carolina Data Classifications as published in the North Carolina Department of Information Technology Data Classification and Handling Policy guide and the related handling procedures will apply to all data held in PHP's IT systems on behalf of the Department, and in the execution of this contract. The guide is available at the following URL: https://files.nc.gov/ncdit/documents/files/Statewide-Data-Class-Handling.pdf

11. Privacy and Security Incidents and Breaches

a. Contractor shall cooperate with the Department regarding any privacy and security incident or breach.

b. Contractor shall report all privacy and security incidents (whether confirmed or suspected) and any breaches to the Department's Privacy and Security Office Incident Website at https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security within twenty-four (24) hours after the incident is first discovered. If a Social Security number has been compromised, the incident must be reported to the Department's privacy and Security Office within sixty (60) minutes.

c. Contractor in coordination with the Department PSO shall also report any breaches of personal information to the North Carolina Department of Justice Consumer Protection Division as well as to the three major consumer reporting agencies. NCDOJ information is available here: http://ncdoj.gov/Protect-Yourself/2-4-3-Protect-Your-Identity/Protect-Your-Business/Security-Breach-Information.aspx

d. If any applicable federal, state, or local law, regulation or rule requires the Department or the Contractor to give persons written notice of a privacy and/ or security breach arising out of the Contractor's performance under this Contract, the Contractor shall bear the cost of the notice and any other costs related to or resulting from the breach.

e. Contractor shall notify the Department's PSO and the appropriate Contract Administrator of any contact by the federal Office for Civil Rights (OCR) received by the Contractor. This term survives termination or expiration of the Contract, as it relates to contact by OCR related to this Contract.

F. Public Records and Trade Secrets Protections

1. Pursuant to N.C. Gen. Stat. § 132-1, et seq., this Contract and information or documents provided to the Department under the Contract are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute. Any proprietary or confidential information which conforms to exclusions from public records as provided by Chapter 132 of the General Statutes must be clearly marked as such with each page containing the trade secret or confidential information identified with bold face as "**CONFIDENTIAL**." Any material labeled as confidential constitutes a

representation by the Contractor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C. Gen. Stat. § 66-152(2). Under no circumstances shall price information be designated as confidential. Contractor is urged and cautioned to limit the marking of information as trade secret or confidential so far as is possible.

2. Regardless of what Contractor may label as a trade secret, the determination of whether it is or is not entitled to protection will be made in accordance with N.C. Gen. Stat. § 132-1.2 and N.C. Gen. Stat. § 66-152(2). If any challenge, legal or otherwise, is made related to the confidential nature of information redacted by the Contractor, the Department will provide reasonable notice of such action to Contractor, and Contractor shall be responsible for the cost and defense of, or objection to, release of any material. The Department is not obligated to defend any challenges as to the confidential nature of information identified by the Contractor as being trade secret, proprietary, and otherwise confidential. The Department shall have no liability to Contractor with the respect to disclosure of Contractor's confidential information ordered by a court of competent authority pursuant to N.C. Gen. Stat. § 132-9 or other applicable law.

3. A redacted copy of this Contract and any subsequent amendments, documents, or materials relating to or provided as part of this Contract, shall be provided to the Department within thirty (30) days of execution. Redacted copies must clearly indicate where information has been redacted. For the purposes of this Contract, redaction means to edit the document by obscuring information that is considered confidential and proprietary **and** meets the definition of Confidential Information set forth in N.C. Gen. Stat. § 132-1.2. In lieu of redacting information by obscuring, Contractor may replace the information, paragraphs or pages with the word "Redacted." By submitting a redacted copy, the Contractor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked Confidential and/or Redacted meet the requirements of Chapter 132 of the General Statutes. Redacted copies provided by Contractor to the Department may be released in response to public record requests without notification to the Offeror. Information submitted by Contractor that is not marked "Confidential" or "Trade Secret" will become a public record.

IV. Minimum Qualifications

The Department has defined Minimum Qualifications that the PHP must meet to be considered and have its response evaluated as defined in *Section II.G. Evaluation Process and Contract Award*. *Section IV. Table 1: Minimum Qualifications* below defines the Department's Minimum Qualifications. The PHP must complete *Attachment O. 2. Minimum Qualifications Table* and provide the appropriate details to support each requirement as part of the Offeror's Proposal and Response.

Section IV. Table 1: Minimum Qualifications		
Qualification		**Requirement for Regional Contracts only or Both Regional and Statewide Contracts**
1.	The Offeror, by responding to this RFP, agrees to all of the terms and conditions, including confidentiality, privacy and security protections and	Both Regional and Statewide Contracts

Section IV. Table 1: Minimum Qualifications		
Qualification		**Requirement for Regional Contracts only or Both Regional and Statewide Contracts**
	public records and trade secrets protections, specified herein.	
2.	The Offeror confirms compliance with the Conflict of Interest requirements within this RFP.	Both Regional and Statewide Contracts
3.	The Offeror confirms compliance with the Performance Bond requirements within this RFP.	Both Regional and Statewide Contracts
4.	The Offeror shall submit proof, in the form of a copy of the acknowledgement from DOI, that the Offeror submitted an Application for PHP Licensure or a LHO Request for PHP Authority to DOI.	Both Regional and Statewide Contracts
5.	The Offeror certifies the Offeror is not located outside of the United States in accordance with 42 C.F.R. § 438.602(i).	Both Regional and Statewide Contracts
6.	The Offeror confirms that for any proposals to participate in more than one Region, those Regions are contiguous. For the purposes of this Contract, contiguous is interpreted to mean each Region shares a boarder with at least one other Region in the Offeror's response.	Regional Contracts only
7.	The Offeror confirms that any proposals to operate in one or more Regions is for the purpose of operating across the entirety of the Regions proposed.	Regional Contracts only
8.	The Offeror shall have and maintain the majority of voting members on the governing body licensed in North Carolina as physicians, physician assistants, nurse practitioners, or psychologists and have treated beneficiaries of Medicaid Managed Care.	Both Regional and Statewide Contracts (if Offeror is PLE)
9.	The Offeror shall have at least twenty-five percent (25%) of voting members on their governing body that are physicians who have received reimbursement for the treatment of at least one Medicaid Managed Care beneficiary in the previous twenty-four (24) months.	Both Regional and Statewide Contracts (if Offeror is PLE)

V. Scope of Services

The *Scope of Services* is located in a separate document titled ***RFP 30-190029-DHB Section V. Scope of Services.***

VI. Contract Performance

The *Contract Performance* requirements are located in a separate document titled ***RFP 30-190029-DHB Section VI. Contract Performance and Section VII. Attachments A – N.***

VII. Attachments A – N

The following Attachments are located in a separate document titled ***RFP 30-190029-DHB Section VI. Contract Performance and Section VII. Attachments A – N***.

Attachment A. PHP Organization Roles and Positions

Attachment B. Clinical Coverage Policy List

Attachment C. Approved Behavioral Health In Lieu of Services

Attachment D. Anticipated Contract Implementation Schedule

Attachment E. Required PHP Quality Metrics

Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards

Attachment G. Required Standard Provisions for PHP and Provider Contracts

Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers

Attachment I. Provider Appeals

Attachment J. Reporting Requirements

Attachment K. Risk Level Matrix

Attachment L. Managed Care Terminology Provided to the PHP for Use with Members Pursuant to 42 C.F.R. § 438.10

Attachment M. 1. North Carolina Medicaid Managed Care Enrollment Policy

Attachment M. 2. Advanced Medicaid Home Program Policy

Attachment M. 3. Pregnancy Management Program Policy

Attachment M. 4. Care Management for High-Risk Pregnancy Policy

Attachment M. 5. Care Management for At-Risk Children Policy

Attachment M. 6. Uniform Credentialing and Re-credentialing Policy

Attachment M. 7. Management of Inborn Errors of Metabolism Policy

Attachment M. 8. Behavioral Health Service Definition Policy

Attachment N. Business Continuity Management Plan

VIII. Attachment O. Offeror's Proposal and Response

The following Attachments are located in a separate document titled ***RFP 30-190029-DHB Section VIII. Attachment O. Offeror's Proposal and Response***. This includes the following sub attachments that are part of the Offeror's Proposal and Response.

Attachment O. 1. Offeror's Proposal and Response: Instructions

Attachment O. 2. Offeror's Proposal and Response: Minimum Qualifications Table

Attachment O.3. Offeror's Proposal and Response: Offeror Response

Attachment O. 4. Offeror's Proposal and Response: Use Care Scenarios

Attachment O. 5. Offeror's Proposal and Response: Offeror's Client References

Attachment O. 6. Offeror's Proposal and Response: PHP Key Personnel

Attachment O. 7. Offeror's Proposal and Response: Contractor's Contract Administrators

Attachment O. 8. Offeror's Proposal and Response: Certification of Financial Condition

Attachment O. 9. Offeror's Proposal and Response: Disclosure of Litigation and Criminal Conviction

Attachment O. 10. Offeror's Proposal and Response: Disclosure of Conflicts of Interest

Attachment O.11. Offeror's Proposal and Response: Disclosure of Ownership Interest

Attachment O. 12. Offeror's Proposal and Response: Subcontractor Identification

Attachment O. 13. Offeror's Proposal and Response: Business Associate Agreement

Attachment O. 14. Offeror's Proposal and Response: Location of Workers Utilized by the Contractor

Attachment O. 15. Offeror's Proposal and Response: State Certifications – Required by North Carolina Law

Attachment O. 16. Offeror's Proposal and Response: Federal Certifications

Attachment O. 17. Offeror's Proposal and Response: Request for Proposed Modifications to the Terms and Conditions

IX. Draft Rate Book

The Draft Rate Book is located in a separate document titled ***RFP 30-190029-DHB Section IX. Draft Rate Book***.

Revised and Restated RFP 30-190029-DHB

V. Scope of Services

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V. Scope of Services

A. Administration and Management

1. Program Administration

a. 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. In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.

b. During the term of the Contract, and in future years, the Department will modify its Medicaid and NC Health Choice Programs, including Medicaid Managed Care and the supporting technical and operational infrastructure, to conform with Federal and State requirements or Department policies and goals. Modifications may be communicated through administrative memos and bulletins issued by the Department. The PHP is obligated to review such memos and bulletins to assist in staying informed of program changes.

c. The Department will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs, and will delegate the direct management of certain health services, including physical health, behavioral health and pharmacy services, and financial risks to the PHP as defined in the Contract. The PHP will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the PHP has an adequate provider network, delivers high quality care, and operates a successful Medicaid Managed Care program.

d. The PHP shall work cooperatively with the Department to be good stewards of Department funds and Department personnel time and to ensure effective administration of Medicaid Managed Care.

e. In partnership with the Department, the PHP shall develop processes and procedures to ensure the PHP is soliciting stakeholder input, including input from Members and providers, to drive continual improvement in the overall program.

f. The PHP shall provide certification concurrently with the submission of all data, documentation, or information required under federal and state law and under this Contract to the Department in accordance with 42 C.F.R. § 438.606.

g. The PHP shall cooperate with the Department in the administration of North Carolina's Section 1115 Demonstration Waiver, including providing reporting and data, engaging with the Department's External Evaluators, and supporting waiver-required stakeholder engagement.

h. The PHP shall comply with Department policies as identified and required by the Department, including the following, as may be amended from time to time:

   i. Medicaid Managed Care Enrollment Policy;

   ii. Department Clinical Coverage Policies;

   iii. Transition of Care Policy;

   iv. Care Management Policy;

   v. Advanced Medical Home Program Policy;

   vi. Care Management for High-Risk Pregnancy Policy;

   vii. Care Management for At-Risk Children Policy;

   viii. Management of Inborn Errors of Metabolism Policy;

   ix. Uniform Credentialing and Recredentialing Policy.

2. Entity Requirements

a. A PHP operating a contract through the Department for the provision of Medicaid Managed Care services shall hold a valid and current PHP license issued by the Department of Insurance for the duration of the contract.
   i. A PHP license is not required as a condition of award.
   ii. The PHP shall have a PHP license no later than ninety (90) calendar days prior to open enrollment for Phase 1 of Medicaid Managed Care, regardless of the Region the PHP serves. At the discretion of the Department, failure to obtain a license may result in termination of the Contract between the PHP and the Department.
   iii. Upon request by the Department, the PHP shall share with the Department any information related to its Medicaid business that was provided to DOI.

b. PLE Governance and Operations
   i. The majority of voting members on the governing body of each PLE shall be licensed in North Carolina as physicians, physician assistants, nurse practitioners or psychologists, and have treated beneficiaries of North Carolina Medicaid or NC Health Choice.
   ii. A minimum of twenty-five percent (25%) of voting members on each PLE governing body shall be providers who have received reimbursement for the treatment of at least one (1) Medicaid Managed Care eligible beneficiary in the previous twenty-four (24) months (e.g., a provider joining a PLE's governing body on June 1, 2018, must have received reimbursement in the twenty-four (24) months leading up to June 1, 2018, which would be May 31, 2016 through May 31, 2018).
   iii. Voting providers shall play a meaningful role in strategic decisions and day-to-day operations of PLEs to ensure the PLE advances high-value care, improving population health, and engaging and supporting providers.
   iv. The PLE shall make available and submit for review to the Department, upon request,
      a) The bylaws of their governing body;

b) Information to explain the operations and authority of the governing body, (e.g., the types of decisions that will and will not be subject to a board vote);
c) PLE Governance Plan outlining the role of physicians and other health team members in the day-to-day operations of the PLE including, but not limited to:
1. List of clinical staff positions and roles;
2. List of individuals in executive or other leadership positions with clinical experience, and a description of roles and responsibilities.
3. List and description of all provider advisory and consultative committees (e.g., quality committee, advanced medical home advisory committee);
4. List and description of provider relations or provider partnership initiatives;
5. Descriptions of how providers will be held accountable for clinical and financial program outcomes; and
6. Description of any other ways that physicians and other health team members will be involved in the day-to-day business operations of the PLE.

v. The PHP shall submit the PLE Governance Plan to the Department for review and approval:
a) Within thirty (30) days after award;
b) Annually, on June 30 of the calendar year; and
c) Within three (3) business days after request from the Department.

vi. The PHP must provide written notice to the Department within ten (10) business days of any material changes to the PLE Governance Plan.

vii. The PLE shall provide a signed attestation affirming that a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts or North Carolina Medicaid and NC Health Choice providers as described under the Contract. A nonprofit entity bidding as a PLE shall provide a signed attestation affirming that the primary business purpose of the entity is the operation of one or more capitated contracts or North Carolina Medicaid and NC Health Choice providers. The attestation must be signed by a Corporate Officer with authority to bind the PLE.

c. Ownership and Control and PHP Operating Plan

i. The Department seeks the most qualified health plans to serve North Carolina Medicaid Managed Care whom the Department may entrust the care of its Medicaid and NC Health Choice beneficiaries.

ii. As defined in 42 C.F.R. § 455.101, the PHP shall provide information, including corporate or other legal entity name, address, telephone number, and nature of relationship, regarding all entities, including parent entities, subsidiaries and business partners who:
a) Meet the definition of an ownership or controlling interest in the PHP; and
b) Do not meet the definition of ownership or controlling interest.

iii. The PHP shall develop and maintain an up-to-date PHP Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care services.
a) Core Medicaid operations shall include but are not limited to:
1. Managing Medicaid Managed Care beneficiary lives (including Member services and the administration of clinical benefits and services);
2. Provider network management;
3. Performing care management functions;
4. Processing and paying claims; and
5. Assuming risk through capitated contract.

b) Entities included in the plan shall include subcontractors, partners, subsidiaries, and any other entities involved in core Medicaid operations.
c) The PHP Operating Plan shall:
    1. Identify each entity by corporate or other legal entity name, address, and telephone number;
    2. Describe generally roles, responsibilities and functions that the entity performs;
    3. Describe the PHP's legal or contractual relationship with each entity;
    4. Describe how the PHP manages each entity; and
d) After the first year and annually thereafter provide a report for each entity providing evidence of the PHP's oversight activities, and describing entity performance including key metrics, corrective actions taken, and sanctions.

iv. The PHP shall respond to any additional requests for information pursuant to this subsection as directed by the Department.

v. The PHP shall submit the current PHP Operating Plan to the Department for review and approval:
    a) Within thirty (30) days after award;
    b) Annually, on June 30 of the calendar year; and
    c) Within three (3) business days after request from the Department.

vi. The PHP must provide written notice to the Department within ten (10) business days of any material changes to the PHP Operating Plan.
    a) Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
    b) At the Department's discretion, the PHP will be subject to a reevaluation and readiness review prior to approval of the amended PHP Operating Plan.
    c) The PHP may be responsible for any cost to the Department of such review.

3. National Committee for Quality Assurance (NCQA) Accreditation

a. The PHP shall achieve accreditation by NCQA by the end of Contract Year 3.

b. The PHP shall achieve NCQA LTSS Distinction by the end of Contract year 3.

c. In accordance with, 42 C.F.R. § 438.332(b)(1) - (3), the PHP shall submit accreditation information to the Department, including:
    i. Accreditation status;
    ii. Accreditation level;
    iii. Accreditation survey type, if applicable;
    iv. Accreditation results (corrective action plans, summaries of findings), if applicable; and
    v. Accreditation expiration date.

d. The PHP shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO for all accredited PHPs.

4. PHPs and Related Providers

a. The Department expects the PHP to collaborate with other PHPs and with providers to advance the health of North Carolinians. The payment strategy of the PHP to its owned or related providers has the potential to introduce behaviors that may be considered anti-competitive or self-dealing and, therefore, detrimental to both North Carolina's health care delivery system, generally, and Medicaid Managed Care, specifically.

b. The PHP shall not pay for similar services rendered by any provider or subcontractor that is "related to" the PHP more than the PHP pays to providers and subcontractors that are not "related to" the PHP.
    i. In this context, "related to" is defined as providers or subcontractors:
        a) With a direct or indirect ownership interest or ownership or control interest in the PHP,
        b) An affiliate of the PHP, or
        c) The PHP's management company with a direct or indirect ownership interest or ownership or control interest in a provider or subcontractor.

c. Any payments made by the PHP to owned or related providers that exceed the limitations set forth in this Contract shall be considered non-allowable expenses for covered services and will be excluded from medical expenses reported in the Medical Loss Ratio (MLR) report and future capitation rate calculations.

5. Implementation

a. The Department intends to use this competitive procurement process to partner with PHPs best suited to meeting the Medicaid Managed Care administrative functions and provide high quality care to North Carolina Medicaid and NC Health Choice Members. The Department requires the PHP to have the resources, expertise, and technology to support the Department's Medicaid Managed Care implementation schedule and the ongoing operations and clinical objectives.

b. The PHP shall have a fully assembled implementation team ready to begin work at Contract Award. The team should include an implementation manager and separate implementation resources for, at a minimum, the following work streams:
    i. Account and Project Management;
    ii. Members;
    iii. Benefits (including contact for transition of care);
    iv. Care Management;
    v. Providers;
    vi. Quality and Value;
    vii. Stakeholder Engagement;
    viii. Program Operations;
    ix. Claims and Encounter Management;
    x. Financial Requirements;
    xi. Compliance; and
    xii. Technology.

c. Additional resources to support the implementation of all workstreams identified as part of the services and requirements of the RFP must be added to the implementation team no later than twenty (20) calendar days after the Contract Award.

d. PHP shall be responsible for developing Business Requirements documents, Implementation Plans and test plans for each work stream. Documents must be approved by Department. The Assistant Secretary for Medicaid Transformation or designee is authorized to approve these documents for the Department.

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; and
xii. Other administrative supports.

6. Readiness Requirements

a. The Department is committed to ensuring the PHP is prepared and able to serve as a good administrator of Medicaid Managed Care. The Department will engage in a thorough readiness review of the following functions immediately after Contract Award through the first six (6) months, or a different period as determined by the Department, after Medicaid Managed Care launch. The Readiness Review shall include all areas identified in 42 C.F.R. 438.66 and others to be identified by the Department.

b. The Department and its partners will conduct a readiness review to verify the PHP, its staff, providers, subcontractors and other individuals and organizations are prepared to provide Medicaid Managed Care services on behalf of the Department prior to opening new lines of business, accepting new eligibility populations or at the Department's discretion.

c. The PHP shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a readiness review.

    i. The PHP shall participate in readiness review(s) conducted by the Department to review the PHP's readiness to begin and sustain operations throughout the term of the contract.
        a) The requirements covered within the readiness review shall be determined by the Department and communicated to the PHP at least fifteen (15) calendar days prior to the readiness review.
        b) The PHP must meet these readiness review requirements and contract requirements in the time frame specified by the Department.
    ii. Readiness reviews must include, but are not limited to, onsite reviews, desktop reviews, policy reviews, system demonstrations, staff interviews and self-audit evaluations.

d. The Department maintains the discretion to conduct readiness reviews 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.

e. Readiness reviews are different and distinct from program integrity, program audits, quality reviews or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.

f. Based upon results of the readiness review(s), the Department reserves the right to:

i. Offer acceptance to allow the PHP to commence full operations;
ii. Offer conditional acceptance to allow the PHP to commence operations if the PHP is found not to meet certain requirements of the readiness review(s) upon receipt of a corrective action plan from the PHP which demonstrates how it will meet readiness review criteria within the timeframe specified by the Department;
iii. Offer limited acceptance to limit PHP's level of participation in Medicaid Managed Care based on the results of the readiness review and any resulting corrective action plans; or
iv. Terminate this Contract in accordance with the termination provisions of the Contract.

g. Prior to allowing a PHP to participate in open enrollment or be assigned membership through the auto-assignment function, the PHP shall demonstrate compliance with the Department's licensure and solvency requirements specified in the Prepaid Health Plan Licensing Act.[1] If the PHP used the services of a TPA, the TPA shall be licensed no later than ninety (90) Calendar Days after Contract Award.

h. The PHP shall submit to the Department all policies and procedures that require review and/or approval as requested by the Department within this RFP and defined in the Contract.

7. Non-discrimination

a. The PHP shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:
   i. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
   ii. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
   iii. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
   iv. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
   v. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
   vi. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
   vii. Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;
   viii. The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;
   ix. The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;

[1] Section 1 of Session Law 2018-49 codifies the Prepaid Health Plan Licensing Act in Article 93 of Chapter 58 of the General Statutes.

x. The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and

xi. Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017 by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression.

b. The PHP shall not discriminate against Members, providers, or employees, or in the provision of services or administration of the program.

c. The PHP shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3)

d. The PHP shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.

i. At a minimum, the non-discrimination policy shall include:

a) The definition of discrimination under federal law and regulation, as amended;

b) How the PHP will collaborate with all of the Department's thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (example: DSDHH);

c) How the PHP's policy will apply to clinical, marketing, and care management programs offered to Members;

d) The PHP's internal complaint process for Members and employees including penalties;

e) The legal recourse, investigative, and complaint process available for Members through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and

f) Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.

ii. The PHP shall make the non-discrimination policy available for Department review, upon request.

iii. The PHP shall make updates to its non-discrimination policy as necessary, and, at a minimum, the PHP shall review its non-discrimination policy for updates annually.

iv. The PHP shall make the non-discrimination policy available to Members and employees of the PHP.

8. Advance Directives

a. The PHP shall comply with all state and federal laws and regulations related to advanced directives, including Article 23 of Chapter 90 of the General Statutes.

b. The PHP shall reflect changes in state law in its written advance directives information as soon as possible, but no later than ninety (90) days after the effective date of the change. 42 C.F.R. § 438.3(j)(4)

c. The PHP shall maintain written policies and procedures on advance directives for all adult Members receiving medical care by or through the PHP. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a).

d. The PHP shall not prohibit from conditioning the provision of care or otherwise discriminating against an Member based on whether or not the Member has executed an advance directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).

e. The PHP shall educate staff concerning their policies and procedures on advance directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).

f. The PHP shall provide adult Members with written information on advance directives policies, and include a description of applicable state law. 42 C.F.R. § 438.3(j)(3).

9. Staffing and Facilities

a. The PHP shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The PHP shall provide qualified persons in numbers appropriate to the PHP's size of enrollment and consistent with the requirements to successfully operate Medicaid Managed Care.

b. Unless otherwise specified, the PHP may combine or split the listed responsibilities among the PHP's personnel if the PHP demonstrates that the responsibilities are being met and that someone is accountable. Similarly, the PHP may contract with a third party (subcontractor) to perform one or more of these responsibilities.

c. The PHP shall be responsible for screening all employees and subcontractors to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
    i. The PHP shall not employ or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610 (a) and (b)].

d. Key PHP Personnel
    i. The PHP shall hire Key Personnel to be assigned, unless otherwise indicated, exclusive to the North Carolina Medicaid market and for the duration of this Contract. Key Personnel shall be identified and mapped to the Staffing Roles provided in Attachment O.6 PHP Key Personnel. The PHP shall include the name of the proposed individual to perform each role. The PHP shall identify the name of the individual filling the role of Director of Population Health and Care Management within 20 calendar days award of Contract to Offeror resulting from issuance of RFP 30-190029-DHB if any such award is made unless a different timeframe is approved by the Department.
    ii. Key personnel include the following as identified in Section V.A.9.d.ii-Table 1. Key personnel requirements:

Section V.A.9.d.ii - Table 1. Key Personnel Requirements			
Role		***Duties and Responsibilities of the Role***	***Minimum Certifications and/or Credentials Requested by the Department***
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program Director	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	• Must reside in North Carolina
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program	Individual responsible for accounting and finance operations, including all audit activities	• Must reside in North Carolina
3.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program	Individual to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to Members, developing clinical practice standards and clinical policies and procedures	• Must reside in North Carolina • Physician, licensed to practice in NC and in good standing (Exception: Medical Director in the event that the CMO is not licensed to practice in NC) • Minimum experience of five (5) years in a health clinical setting and two (2) years in managed care
4.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program	Individual to oversee and manage all fraud, waste, and abuse and compliance activities	• Must reside in North Carolina
5.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	• Must reside in North Carolina • Bachelor's Degree in Information Security or Computer Science • CISSP and one of the following certifications: CISM, CISA or GSEC

Section V.A.9.d.ii - Table 1. Key Personnel Requirements			
Role		***Duties and Responsibilities of the Role***	***Minimum Certifications and/or Credentials Requested by the Department***
6.	Quality Director of North Carolina Medicaid Managed Care Program	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances.	• Must reside in North Carolina • More than 5 years of demonstrated quality management/quality improvement experience in a large healthcare corporation serving Medicaid beneficiaries • NC licensed clinician (e.g. LCSW, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred
7.	Provider Network Director of North Carolina Medicaid Managed Care Program	Individual responsible for providers services and provider relations, including all network development and management issues	• Must reside in North Carolina • At least five (5) years of combined network operations, provider relations, and management experience
8.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the PHP pharmacy benefits and services.	• Must reside in North Carolina • NC-registered pharmacist with a current NC pharmacist license • Minimum of three working years of Medicaid pharmacy benefits management experience
9.	Behavioral Health Director of North Carolina Medicaid Managed Care Program	Individuals responsible for providing oversight and leadership of integrated behavioral health benefit, including UM program, network development and care management.	• Must reside in North Carolina • NC-licensed psychiatrist or psychologist • Minimum experience of five (5) years in a BH clinical setting and two (2) years in managed care
10.	Director of Population Health and Care Management	Individual responsible for providing oversight and leadership of all prevention/population health, care management and care	• Must reside in North Carolina • More than 5 years of demonstrated care management/population health experience in a large

Section V.A.9.d.ii - Table 1. Key Personnel Requirements			
Role		***Duties and Responsibilities of the Role***	***Minimum Certifications and/or Credentials Requested by the Department***
		coordination programs, including Local Care management plan, AMH model and care management delivered by Local Health Departments.	healthcare corporation serving Medicaid beneficiaries • NC licensed clinician (e.g. LCSW, RN, MD, DO)

iii. The PHP shall:
   a) Ensure that Key Personnel hold no more than one (1) position that is required by the Contract.
   b) Ensure all Key Personnel reside in North Carolina.
   c) Ensure the CMO:
      1. Is fully licensed to practice in NC;
      2. Has a minimum of five (5) years' experience in a health clinical setting; and
      3. Has a minimum of two (2) years' experience in managed care.
   d) Ensure the Behavioral Health Director:
      1. Is fully licensed, as a psychiatrist or psychologist, by the State of North Carolina;
      2. Has a minimum of five (5) years' experience in a behavioral health clinical setting; and
      3. Has a minimum of two (2) years' experience in managed care.

iv. Key Personnel shall be available to meet at the Department's requested location within twenty-four (24) hours' notice from the Department.

v. The Department may, at its sole discretion, reject a potential candidate or require the removal of any Key Personnel providing services under this Contract.

vi. The PHP shall not substitute Key Personnel to the performance of this Contract without prior written approval by the Department. The PHP shall inform the Department in writing within seven (7) calendar days of staffing changes in Key Personnel. The PHP shall fill Key Personnel roles with permanent qualified replacements within ninety (90) calendar days of the departure of the former staff member. At no time, however, shall a Key Personnel Role be vacant. It is the PHP's responsibility to keep the role filled until the Department approves a substitution.

vii. Upon filling a Key Personnel vacancy, the PHP shall demonstrate that PHP staff proposed as Key Personnel have the proper credentials and experience to perform all duties and responsibilities of that role. The PHP shall include:
   a) Name;
   b) Role;
   c) Experience relevant to the services to be provided under this Contract;
   d) Resume;
   e) Proof of North Carolina Residency (when applicable); and

f) Any certifications, licenses or credentials for the role where requested by the Department.

e. Organization Roles and Positions
   i. The PHP shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Attachment A. PHP Organization Roles & Positions.*
   ii. Member Services Staffing
      a) The PHP shall adequately staff and operate its Member Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related with North Carolina Medicaid Managed Care.
      b) The PHP shall ensure that unlicensed Member Services staff are prohibited from providing health-related advice to Members requesting clinical information and instead shall triage/refer such requests to staff with appropriate clinical expertise in treating the Member's condition or disease.
   iii. Fraud, Waste and Abuse Staffing
      a) The PHP shall establish a single point of contact to serve as a liaison with the Department and MID and to facilitate timely response to Department requests for information, including claims data.
      b) The PHP shall establish a custodian of records to authenticate the business records of the PHP, provide the business records of the PHP to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:
         1. Made at or near the time of the events by a person with knowledge;
         2. Kept in the normal course of regularly conducted business activity; and
         3. Made in the regular practice of the PHP's business activity.

f. The PHP shall submit resumes for any employee or subcontracted employee upon request by the Department.

g. The PHP shall provide, upon request, a detailed Staffing Contingency Plan in the event of public health emergencies, natural disasters, or sudden and unexpected increases in enrollment, with a description on how the plan shall be implemented and coordinated with the Department.

h. Physical Presence in North Carolina
   i. The PHP shall have a physical presence in North Carolina by having one or more offices located in the State.
      a) The PHP shall establish an office in North Carolina at least ninety (90) days after Contract Award that shall be maintained for the duration of the contract.
      b) The PHP shall establish call center(s) and staff in North Carolina at least ninety (90) days after Contract Award.
      c) The Department requires the PHP establish an office in each of the six (6) Regions that is serves to support in care management functions and member, provider and stakeholder engagement requirements of the Contract by the beginning of Medicaid Managed Care.
   ii. Additionally, the following personnel, at a minimum, shall be located in and operate from within the State of North Carolina:
      a) Behavioral Health (BH) Managers;
      b) Care Management Managers, Supervisors and Staff;
      c) Member Complaint, Grievance, and Appeal Coordinator;
      d) Member Services and Service Line Staff;

e) Provider Relations and Service Line Staff;
f) Quality Assessment and Improvement and Utilization Management Coordinator;
g) Tribal Provider Contracting Specialist;
h) Liaison to the Division of Mental Health;
i) Liaison to the Division of Social Services;
j) Liaison between the Department and the North Carolina Attorney General's Medicaid Investigation Division;
k) Care Management Housing Specialist;
l) Utilization Management Managers; and
m) Pharmacy and Service Line Staff.

i. Conflict of Interest
   i. The PHP shall verify that its employees, directors, and contractors comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C.
   ii. The PHP shall undertake reasonable actions to verify that employees or contractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the Medicaid Managed Care, North Carolina Medicaid or NC Health Choice programs, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.
   iii. The PHP and its employees and directors shall:
      a) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee (or such employee's spouse or minor child) 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.
      b) Not promise or give a gift to any Department employee or any family member of a Department employee.
      c) Fully and completely disclose to the Department any situation that may present a conflict of interest.
      d) Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.
      e) Not solicit or obtain from the Department any non-public information relating to the Department's criteria or processes for evaluating bids to enter into or renew a PHP contract.
   iv. The PHP shall ensure that financial considerations do not influence decisions to provide medically appropriate care.
   v. The PHP shall validate that all its employees, directors, subcontractors or owners who are licensed providers abide by their professional obligations to their patients and Members and shall not take any actions which conflict with such obligations.
   vi. The PHP shall not serve as a legal guardian for any of its Members.
   vii. As required by N.C. Gen. Stat. § 143B-139.6C, the PHP shall not use a former Department employee, director, or contractor in the administration of its PHP contract for six (6) months after such person's employment or contract with the Department is terminated, if such person personally participated in the following activities:
      a) The award of the contract to the PHP,
      b) An audit, decision, investigation, or other action affecting the PHP, or
      c) Regulatory or licensing decisions that applied to the PHP.

viii. The PHP shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices.
ix. The PHP shall submit its written Conflict of Interest Policy for its employees to the Department for review.

B. Members

1. Eligibility for Medicaid Managed Care

a. Pursuant to Session Law 2015-245, as amended, the Department was directed to transition certain North Carolina Medicaid and NC Health Choice populations from a Medicaid Fee-for-Service structure to a Medicaid Managed Care structure. The Department will maintain authority in determining North Carolina Medicaid and NC Health Choice eligibility and defining populations to be transitioned into Medicaid Managed Care.

b. The Department shall maintain sole authority for performing, managing, and maintaining all eligibility and cost sharing determinations.

c. The PHP shall be responsible for adhering to eligibility and cost sharing determinations made by the Department.

d. Medicaid Managed Care eligibility:
   i. The Department shall be responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt, or mandatory at any point in time.
   ii. The PHP shall be responsible for adhering to Medicaid Managed Care eligibility and enrollment determinations made by the Department.
   iii. In accordance with Section 4.(5) of Session Law 2015-245, as amended,[2] the following populations shall be excluded from Medicaid Managed Care:
      a) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
      b) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
      c) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
      d) Medically needy Medicaid beneficiaries;
      e) Presumptively eligible beneficiaries, during the period of presumptive eligibility;
      f) Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program;
      g) Beneficiaries enrolled under the Medicaid Family Planning program;
      h) Beneficiaries who are inmates of prisons;
      i) Beneficiaries being served through the Community Alternatives Program for Children (CAP/C);
      j) Beneficiaries being served through Community Alternative Program for disabled Adults (CAP/DA) (includes beneficiaries receiving services under CAP/Choice); and
      k) Beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE).[3]

[2] Section 4.(5) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, Section 5.(a) of Session Law 2018-49, and Session Law 2018-48.
[3] The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to Section 4.(4)d. of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, which excludes all PACE program services from Medicaid Managed Care.

iv. In accordance with Section 4.(5)e. of Session Law 2015-245, as amended,[4] the following population shall be exempt from Medicaid Managed Care:
    a) Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI).
v. In accordance with Section 4.(5)m. of Session Law 2015-245, as amended,[5] the following populations are temporarily excluded, for a period not to exceed five (5) years from Contract Year 1, and shall be treated as excluded until the Department includes them in Medicaid Manage Care:
    a) Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA. If an individual enrolled in a PHP resides in a nursing facility for ninety (90) days or more, such individual shall be disenrolled from the PHP on the first day of the month following the ninetieth (90th) day of the stay and enrolled in the Medicaid Fee-for-Service program.
        1. The Department considers (i) beneficiaries residing in a state-owned Neuro-Medical Center operated by the Division of State Operated Healthcare Facilities (DSOHF) or a Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) at Medicaid Managed Care implementation and (ii) beneficiaries determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation to be temporarily excluded until the beneficiary is discharged and determined eligible for Medicaid Managed Care.
        2. For Members of a PHP determined eligible for and transferred for treatment to a state-owned Neuro-Medical Center or Veterans Home after Medicaid Managed Care implementation, the PHP shall disenroll the Member in accordance with the Medicaid Managed Care Enrollment policy and the Contract.
    b) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding beneficiaries served through CAP/DA.
vi. In accordance with Section 4.(5). of Session Law 2015-245, as amended,[6] the following populations shall be exempt from Medicaid Managed Care until such point that Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plans (TP) are available:
    a) Beneficiaries with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact (except beneficiaries enrolled in the foster care system, formerly enrolled in foster care system up to age 26, or receiving Title IV-E adoption assistance, who will be excluded from Medicaid Managed Care during this time).
vii. All other North Carolina Medicaid and NC Health Choice populations shall be mandatorily enrolled in Medicaid Managed Care during Contract Year 1.
viii. Pursuant to Section 4.(5a) of Session Law 2015-245, as amended by Session Law 2018-49, populations excluded from Medicaid Managed Care or populations who have been temporarily excluded from Medicaid Managed Care may be enrolled at any time, as

[4] Section 4.(5) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121.
[5] Section 4.(5) of Session Law 2015-245, as amended by Section 5.(b) of Session Law 2018-49.
[6] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

determined by the Department, if eligible to receive a service that is not available in Medicaid Fee-for-Service but is offered by the PHP.

ix. At any time during the Contract Term, the Department reserves the right to amend the contract based on an increase or decrease in covered populations included in the Medicaid Managed Care program based on federal or state law or regulatory changes, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes.

2. Medicaid Managed Care Enrollment and Disenrollment

a. The Department has sole authority to direct enrollment and disenrollment of beneficiaries into and out of Medicaid Managed Care. In partnership with an Enrollment Broker, the Department will educate beneficiaries on Medicaid Managed Care, support their selection of a PHP, and transmit enrollment selections and approved disenrollment requests to the PHP to effectuate.

b. All information related to North Carolina Medicaid and NC Health Choice eligibility and cost sharing shall be transmitted to the PHP via the standard Medicaid Managed Care eligibility file format to be defined by the Department.

c. The PHP shall to accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1)

d. The PHP shall have staff with sufficient knowledge about the North Carolina Medicaid and NC Health Choice programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment Member information as defined by the Department.

e. The PHP shall notify the Department within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. 42 C.F.R. § 438.608(a)(3).

f. The PHP shall ensure automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).

g. The PHP shall only process enrollment for beneficiaries who are Medicaid Managed Care mandatory or exempt.
   i. The PHP shall notify the Department of the receipt of enrollment information for any beneficiary that is excluded or delayed.

h. The PHP shall adhere to the Department's Medicaid Managed Care enrollment approach as defined in *Attachment M. 1. North Carolina Medicaid Managed Care Enrollment Policy* and consistent with federal regulations, including but not limited to:
   i. PHP enrollment processes; and
   ii. PHP auto-assignment algorithm.

i. PHP auto-assignment:
   i. Pursuant to 42 C.F.R. § 435.54, Members who do not select a PHP as part of the North Carolina Medicaid or NC Health Choice application process will be auto-assigned to a PHP.
   ii. The PHP shall adhere to the PHP auto-assignment logic as defined by the Department.
      a) The Department will share the auto-assignment logic with the PHP annually and any time there is a material change to the logic methodology.
      b) The Department, at its sole discretion, may choose to modify or choose to not use the auto-assignment algorithm.

j. The PHP shall direct the beneficiary to the NC FAST online portal or perform a warm transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.) other than choice of PHP or AMH/PCP or, if applicable, prescriber.
    i. The PHP shall ensure as outlined in *Section V.G. Program Operations*. that its telephone system will have the capacity to transfer beneficiaries and authorized representatives from the call center to local DSS office without disconnecting the call.
    ii. If a Member's demographic information is not updated during the next Member reconciliation cycle with the PHP and the Department, the PHP shall follow up with Members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.

k. The PHP shall, if a Member contacts the PHP to change their PHP, perform a warm transfer to the Enrollment Broker.

l. Beneficiary Disenrollment
    i. The PHP shall adhere to the Department's Medicaid Managed Care disenrollment approach as defined in *Attachment M. 1 NORTH CAROLINA MEDICAID MANAGED CARE ENROLLMENT POLICY* and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
        a) Member disenrollment requests;
        b) PHP disenrollment requests; and
        c) PHP disenrollment processes (including special populations transitions out of Medicaid Managed Care).
    ii. In limited instances and consistent with Medicaid Managed Care Enrollment Policy and federal law, the PHP, with approval from the Department, shall be allowed to request Member disenrollment from the PHP in limited instances as defined in the Medicaid Managed Care Enrollment Policy and consistent with federal requirements under 42 C.F.R § 438.56(b)(2).
    iii. The PHP will be accountable to use all information available to the PHP, including beneficiary self-referral, when making waiver program referrals.

m. The PHP shall accept and process all PHP enrollment and disenrollments within twenty-four (24) hours of receipt of the standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.

n. The PHP shall comply with the Department's membership reconciliation process as defined in *Section V. K. Technical Specifications*.

o. The PHP shall develop and maintain a Member enrollment and disenrollment policy ninety (90) days after the Contract Award to be submitted to the Department for review and approval. The PHP shall submit to the Department for review any material updates to the policy.

3. Member Engagement

a. Members, their families, and caregivers need support in the transition to Medicaid Managed Care and as Members in the Medicaid Managed Care program. The PHP will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting Members and their families with understanding Medicaid Managed Care, navigating the health care system, improving overall Member health through various avenues including maintaining a

Member Services department, conducting Member and community outreach, and providing education before, during, and after Medicaid Managed Care implementation. The Department strongly encourages the PHP to develop innovative approaches, including the use of electronic mechanisms for Member education and outreach.

b. The PHP shall be responsible for engaging Members and their authorized representatives to provide assistance with understanding Medicaid Managed Care and their rights and responsibilities and accessing available benefits and services in-person, telephone, by mail, and online/electronically. 42 C.F.R. 438.10(c)(7).

c. The PHP shall utilize various engagement strategies and communication mediums to engage, educate, and assist Members. The engagement strategy shall include the operation of a dedicated Member Services Department which, at a minimum, shall:
   i. Maintain a Member call center and a Member services website;
   ii. Engage with local community and county organizations;
   iii. Provide written and oral educational materials, activities and programs; and
   iv. Collaborate with other entities operating within the Medicaid Managed Care delivery system.

d. The PHP shall use standard managed care terminology in all communications with Members and potential Members as defined in *Attachment L: Managed Care Terminology Provided* to PHPs pursuant to 42 C.F.R. § 438.10.

e. Member Services Department
   i. The PHP shall have and implement Member Services policies and procedures that address all Member Services activities.
   ii. The PHP shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to Members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
   iii. The Member Services staff shall be responsible, at a minimum, for the following functions:
      a) Explaining operation of the PHP, including the role of the PCP and what to do in an emergency or urgent medical situation;
      b) Assisting with arranging non-emergency transportation for Members;
      c) Assisting Members in selecting or changing AMH/PCP;
      d) Educating and assisting Members with obtaining services under Medicaid Managed Care, including out-of-network services;
      e) Explaining transition of care requirements and care management services offered by the PHP;
      f) Fielding and responding to Members' questions and complaints;
      g) Clarifying information in the Member Handbook;
      h) Advising Members of and assisting Members with the appeals, grievance, and State Fair Hearing processes;
      i) Referring Members to the Department's Enrollment Broker if an individual requests information regarding how to enroll in or select a new PHP; and
      j) Referring Members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues.
   iv. The PHP shall operate and maintain the following three (3) Member facing Service Lines:
      a) Member Services Line,
      b) Behavioral Health Crisis Line, and
      c) Nurse Line.

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 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 provider 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.

f. Member Services Website
    i. The Department encourages the PHP to utilize processes, procedures or technology which improve the member experience and effectively reduce or ease administrative burdens on the Member.
    ii. The PHP shall develop and maintain a dedicated, interactive North Carolina Medicaid and NC Health Choice Member services website that, at a minimum, has the functionality to allow the Member to search for in-network providers and search through the drug formulary.
    iii. The PHP shall also include on its website within two (2) "clicks" from the homepage, at a minimum:
        a) An up-to-date copy of the Member Handbook;
        b) Information on hours of operation;
        c) How to contact the Member Services staff, and care managers;
        d) Appeals, grievances, and State Fair Hearing policies and processes;
        e) Information regarding the Ombudsman program;
        f) Health promotion and educational materials;
        g) Any specific prevention, population health, or care management programs offered by the PHP; and
        h) Other information the PHP believes would support Member and their families.
    iv. The PHP shall meet the same literacy standards identified for written materials in any materials made available electronically.
    v. The PHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
    vi. The PHP website shall be accessible via mobile devices.
    vii. The PHP website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's Systems that impact the ability for the website to operate correctly.
        a) The PHP shall notify the Department and Members in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
        b) The PHP shall notify the Department and Members of unscheduled downtime within one (1) hour and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the PHP.

g. Communications with Members and Potential Members

i. The PHP shall ensure all contacts with Members/authorized representatives are culturally competent and provides effective communication, with deference to the method requested by the Member, to the Member, including sign language interpreters, and occurs in a timely manner that protects the privacy and independence of the individual with a disability.

ii. The PHP shall ensure that Members and potential Members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and N.C. Gen. Stat. § 58-3-191(b)(5) in a culturally competent manner and format that may be easily understood and is readily accessible.

iii. The PHP shall address the following in the development of Member materials:
   a) The population size and geographic/regional needs and differences throughout each of the PHP's Region(s);
   b) Language proficiencies;
   c) Types of disabilities;
   d) Literacy levels;
   e) Cultural needs of the Member population;
   f) Age and age-specific or other targeted learning skills or capabilities; and
   g) Ability to access and use technology.

iv. The PHP shall be permitted to provide information required to be communicated to Members and potential Members in the following manner:
   a) Mailing a printed copy of the information to the Member's mailing address is the default absent an explicit preference stated by the Members or their authorized representative;
   b) Emailing the information, after receiving the Member's or potential Member's express consent to receive information via email and obtaining a valid, up to date email address;
   c) Posting the information on the PHP's website and advising the Member or potential Member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a Member may request communication accommodations; and
   d) Providing the information by any other method that can reasonably be expected to result in the Member receiving the information. 42 C.F.R. § 438.10(g)(3).

v. The PHP shall not construe requirement herein to limit or alleviate the PHP's obligation to communicate directly with the Member, a Member's authorized representative, parent or guardian, or potential Member as required under the Contract or under federal or state law or regulation.

vi. The PHP shall provide information in the Member's preferred format upon request at no cost (e.g., a Member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).

vii. The PHP shall consult with and comply with practices of the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.

h. Written and Oral Member Materials

i. The PHP shall provide Member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which addresses information requirements related to written and oral information provided to Members.

ii. The PHP shall provide all written materials to Members and potential Members consistent with the following:
   a) Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).

b) Use a san serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.
c) Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or limited English proficiency.
d) Include a large print (i.e., font size no smaller than 18 point) tagline and information on how to request auxiliary aids and services, including materials in alternative formats. 42 C.F.R. § 438.10(d)(6)(iii).
e) Written in accordance with Associated Press Style and Department-specific style guide.
f) Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
g) Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the PHP's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:
    1. Spanish,
    2. Chinese,
    3. Vietnamese,
    4. Korean,
    5. French,
    6. Arabic,
    7. Hmong,
    8. Russian,
    9. Tagalog,
    10. Gujarati,
    11. Mon-Khmer (Cambodia),
    12. German,
    13. Hindi,
    14. Laotian, and
    15. Japanese.

iii. The PHP shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to Members in their original format.
iv. The PHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
v. The PHP shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on user agents, such as mobile devices.

i. Mailing Materials to Members
    i. The PHP shall verify addresses against a United States Postal Service approved product or service on all Members enrolled in the PHP prior to mailing materials, at no additional cost to the Department or the Member.

a) The PHP shall make all reasonable attempts to identify the correct mailing address and mail information to the Member within applicable timeframes, as required under the Contract.
b) The PHP shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
c) The PHP shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.

ii. The PHP shall notify the Department, or the local DSS office as directed by the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.

iii. If the PHP identifies a new, updated address, the PHP shall resend only Member specific information at no additional cost to the Department or the Member.

iv. All materials mailed to potential Members, Members, and, when applicable, authorized representatives, shall be sent via first class mail.

v. The PHP shall consider cost-effective methods for controlling postage costs when producing Member materials for mailing.

vi. The PHP shall develop a Member Mailing Policy, subject to Department review and approval. The PHP shall submit to the Department ninety (90) days after Contract Award.

j. Translation and Interpretation Services

i. The PHP shall make interpretation services available to all potential Members and Members. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).

ii. The PHP shall notify its Members of the availability of interpretation services and inform them of how to access such services, including providing the following information:
a) That oral information is available for any language and written translation is available in prevalent languages free of charge to each Member. 42 C.F.R. § 438.10(d)(4); and
b) That auxiliary aids and services are available upon request and at no cost for Members with disabilities. 42 C.F.R. § 438.10(d)(5).

iii. The PHP shall offer qualified interpreter services available for oral contacts with Members and authorized representatives whose primary language is not English.

iv. The PHP shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.

v. The PHP shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with Member audiences.

vi. The PHP shall make interpretation services available free of charge to each Member. 42 C.F.R. § 438.10(d)(4).

vii. The PHP shall staff Member facing Service Lines with fluent Spanish speakers to converse with Members who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the Member or the Department. Oral interpretations must be available in all languages as required by regulation or determined by the Department.

viii. Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:

a) Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
b) Translation of materials into Spanish and up to three additional languages, as required by the Department.

ix. The PHP shall notify the Department in writing within five (5) business days each time the PHP or its subcontractor charges a Member, potential Member, authorized representative or guardian for interpreter or translation services.

x. The PHP shall notify the Department of any change in the language preference for Members in an electronic format and frequency as defined by the Department.

k. Member Welcome Packet

i. The PHP shall send a Welcome Packet to the Member within seven (7) calendar days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment.
a) For Members who participate in the crossover open enrollment period, the PHP shall send the Welcome Packet within seven (7) Calendar Days of receipt of Member enrollment information or within seven (7) Calendar Days of the close of open enrollment, whichever is earlier. The PHP shall ensure a Member does not receive two welcome packets.
b) For all new Members enrolled after the open enrollment period, the PHP shall send the Welcome Packet within seven (7) calendar days of receipt of a Member enrollment information.

ii. The PHP shall include the following in the initial Member Welcome Packet and upon Redetermination:
a) A welcome letter that notifies the Member of their enrollment in the PHP and provides:
1. The effective date from which the PHP shall assume health coverage for the Member;
2. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
3. Information on how to change a PHP;
4. The toll-free service line numbers which a Member may call for the Member Services Line, Behavioral Health Crisis Line, and Nurse Line;
5. Information on how to inquire about accessing care management services;
6. The role of an AMH/PCP in Medicaid Managed Care;
i. How to select or change an AMH/PCP;
ii. Why a Member might be auto-assigned an AMH/PCP;
7. How to arrange for non-emergency transportation;
8. An offer of assistance in arranging initial visit to his or her AMH/PCP; and
9. Contact information for the Ombudsman Program.
b) Member identification card; and
c) A current Member Handbook.

iii. Initially and annually thereafter, the PHP shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within ninety (90) calendar days of Contract Award.

l. Member Identification Cards

i. The PHP is required to generate an identification card for each Member enrolled in the PHP with the following printed information:
a) The Member's North Carolina Medicaid or NC Health Choice identification number

1. The Member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and
2. The Member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the PHP.

b) The PHP's name, mailing address and Member Portal.
c) The Member's AMH/PCP name, physical address and phone number.
d) The toll-free help line numbers for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
e) The North Carolina Department of Justice Medicaid Investigations Division (MID), fraud, waste and abuse hotline with the following language:
   1. *If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call (919) 881-2320.*
f) Information regarding Medicaid Managed Care carved-out services.

ii. The PHP shall provide the Member identification card with the Welcome Packet. A replacement identification cards shall be provided upon request by the Member or the Member's authorized representative or upon AMH/PCP change, at no charge to the Member.

iii. The PHP shall submit the Member identification card to the Department for review and approval ninety (90) days after Contract Award, at the direction of the Department, or when changes are made to the card layout or content.

m. Member Handbook

i. The PHP shall ensure that each Member receives a Member Handbook, which serves as a summary of benefits and coverage, within seven (7) calendar days after the PHP receives notice of the Member's enrollment in the PHP. 42 C.F.R. § 438.10(g)(1).

ii. The PHP shall use the Department's model Member Handbook as guidance in the development of the PHP's Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii).

iii. The PHP shall ensure that all Member Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, cultural competency and literacy standards.

iv. In accordance with 42 C.F.R. § 438.10(g) and N.C. Gen. Stat. §§ 58-3-190(f), 58-51-38(b), and 58-67-88(j), the PHP shall ensure that the Member Handbook includes sufficient information that enables the Member to understand how to effectively use Medicaid Managed Care. This information shall include at a minimum:
   a) Covered benefits provided by the PHP.
   b) Member enrollment and disenrollment policy, including Information on the Member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract.
   c) How and where to access any benefits provided by the Department, including carved out services, cost sharing, and how non-emergency transportation is provided.
   d) List of counseling or referral services that the PHP does not cover because of moral or religious objection, instructions for how the Member can obtain information from the Department about how to access those services, and notification that the PHP's failure to cover a service based on moral or religious objection is a with cause reason for Member disenrollment.
   e) The amount, duration, and scope of benefits available under the PHP in sufficient detail to ensure that Members understand the benefits to which they are entitled.

f) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's AMH/PCP.
g) Information on the EPSDT benefits, for Medicaid Managed Care Members, including:
    1. The benefits of preventive health care;
    2. Services available under the EPSDT program and where and how to obtain those services;
    3. That EPSDT services are not subject to cost-sharing; and
    4. That PHP will provide scheduling and transportation assistance for EPSDT services upon request by the Member.
h) The extent to which, and how, after-hours and emergency coverage are provided, including:
    1. What constitutes an Emergency Medical Condition and emergency services;
    2. The fact that prior authorization is not required for emergency services; and
    3. The fact that, subject to 42 C.F.R. § 438.10, the Member has a right to use any hospital or other setting for emergency care.
i) Any restrictions on the Member's freedom of choice among in-network providers and out-of-network providers.
j) The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the PHP cannot and shall not require a Member to obtain a referral before choosing a family planning provider.
k) Cost sharing, if any, imposed on North Carolina Medicaid or NC Health Choice beneficiaries.
l) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract.
m) The process of selecting and changing the Member's AMH/PCP, including, but not limited to:
    1. The number and frequency limitations of AMH/PCP changes;
    2. Information on the two (2) annual without cause AMH/PCP changes; and
    3. The with cause reasons for switches beyond the two (2) without cause changes.
n) Grievance, appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
    1. The right to file grievances and appeals;
    2. The requirements and timeframes for filing a grievance or appeal or State Fair Hearing;
    3. The availability of assistance in the filing process;
    4. The right to request a State Fair Hearing after the PHP makes a decision on the Member's appeal which is adverse to the Member; and
    5. The fact that, when requested by the Member, benefits that the PHP seeks to reduce or terminate will continue if the Member files a request within the timeframes specified for filing and that the Member may be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the Member.
o) How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).
p) An overview of its continuation of benefits policy and define when, why and how a Member or a Member's authorized representative may file for a continuation of benefits.

q) How to access auxiliary aids and services, including additional information in alternative formats or languages.
r) The toll-free help line numbers for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
s) Information on how to report suspected fraud, waste or abuse.
t) Information about Opioid Misuse Prevention Program.
u) Information on the PHP Transition of Care Policy.
v) Information about the PHP's prevention and population health programs.
w) Contact information for beneficiary support systems, including the Ombudsman Program and the Enrollment Broker.

v. The PHP shall make the Member Handbook available for review by the Department, upon request.

vi. The PHP shall provide the Department for review any changes to the Member Handbook forty-five (45) calendar days prior to the intended effective date of the change.

vii. The PHP shall notify each Member, using Department-developed templates, of any significant change to the Member Handbook at least thirty (30) calendar days before the intended effective date of the change.

n. Member Education and Outreach

i. The PHP shall provide education and outreach to Members and potential Members including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department, the Enrollment Broker, Ombudsman Program and/or local health departments may be present.

ii. The PHP shall develop educational materials to be used by the Enrollment Broker to support PHP and AMH/PCP selection. The materials are subject to review and approval by the Department at least ninety (90) calendar days prior to use with Members, potential Members, and/or authorized representatives.

iii. The PHP shall provide information regarding its planned Member education efforts to the Department for review and approval sixty (60) days after Contract Award and annually thereafter.

iv. Any outreach or education related to the proposed Member Incentive Program must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater Member engagement will not be approved.

o. Engagement with Consumers

i. The PHP must have a strong understanding of and capability to meet the needs of its Members. To that end, the PHP shall establish a Member Advisory Committee to garner Member and stakeholder input and advice regarding the PHP's programs and policies.

a) Committee members may include Members themselves, their family members, representatives or guardians, and/or representatives of consumer advocacy organizations.

ii. The Member Advisory Committee shall reflect the geographic, racial, and cultural diversity of each Region covered by the PHP or their representatives, and include a majority (51%) of Member, consumer and family representatives. Topics for discussion shall include but should not be limited to:
a) Medical, pharmacy, and behavioral health benefits
b) Opportunities for Health priority domains
c) Care management
d) Enhanced Case Management Pilots (if applicable)

iii. The PHP shall consult with the Member Advisory Committee at least on a quarterly basis.

p. Engagement with Beneficiaries Utilizing Long Term Services and Supports
   i. The PHP must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. To that end, the PHP shall establish a LTSS Member Advisory Committee that garners stakeholder input and advice regarding the LTSS covered under the PHP contract, and meets all provisions noted in 42 C.F.R. § 438.110.
   ii. The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the PHP or their representatives and include:
      a) Members accessing LTSS;
      b) Representatives of LTSS Members;
      c) LTSS providers; and
      d) PHP staff involved in the authorization of LTSS and/or care management of LTSS users.
   iii. The PHP shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.

q. Health Education and Promotion Programs
   i. The PHP shall develop Member health education and promotion programs that addresses prevention, wellness, and early intervention of illness and disease.
   ii. The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.
   iii. The PHP shall make the health education and promotion programs available to Members through various communication mediums including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
   iv. The Department may select specific educational and health promotion topics for the PHP to implement that align with the Department's priorities or the annual update to the Quality Strategy.

r. Member Incentive Program
   i. The PHP may offer healthy behavior incentive programs to Members, provided that the following criteria is met:
      a) The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy.
      b) The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
      c) The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed $75.00.
   ii. Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
   iii. Prior to implementation, the PHP shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the QAPI.
   iv. The PHP shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (1) the program meets the requirements of 1112(a)(5) of the

Social Security Act; and (2) the program meets the criteria determined by the Department.

4. Marketing

a. The Department views PHP marketing activities as a method to help publicize Medicaid Managed Care and educate potential Members about health plan options, while ensuring the protection of Members from coercive or misleading practices.

b. The PHP shall comply with all marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the PHP to ensure that Members receive accurate oral and written information to make an informed decision on whether to enroll or reenroll in the PHP.

c. The PHP shall not market nor distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i).

d. The PHP shall ensure that marketing materials are accurate and does not mislead, confuse, or defraud Members or the Department. 42 C.F.R. § 438.104(b)(2).

e. The PHP shall establish and maintain, a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented shall be the responsibility of the PHP.

f. If the PHP chooses to market, the PHP shall distribute marketing materials to the entire region served by the PHP. 42 C.F.R. 438.104(b)(1)(ii).

g. The PHP shall ensure that all marketing materials comply with the language, accessibility, and cultural competency requirements and the Member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.

h. The PHP shall ensure that all marketing materials and marketing strategies shall abide by the PHP's Non-discrimination Policy. In addition, the PHP shall not discriminate against Members or potential Members who may:
   i. Live or receive health care in rural or underserved areas; or
   ii. Experience income disparities.

i. The PHP shall assign a unique marketing code to all marketing materials distributed Members.

j. Marketing Materials and Activities
   i. Permissible Marketing Activities
      a) The PHP may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health Fairs, and Public Libraries and other state-approved community-based marketing events or locations.
      b) The PHP may participate in community-based marketing events or activities (e.g., health fairs, community events).
      c) The PHP may sponsor outreach activities and events, including as a financial sponsor.
      d) The PHP may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.

e) The PHP may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.

ii. Prohibited Statements, Claims, and Activities (Written or Oral)

a) The PHP shall not claim that a Member must enroll in the PHP to obtain benefits or to not lose benefits. 42 C.F.R. § 438.104(b)(2)(i).

b) The PHP shall not claim that the PHP is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).

c) The PHP shall not use the Department or State logo in marketing materials.

d) The PHP shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.

e) The PHP shall not reference competing PHPs or other contractors of the Department, list or reference providers who are not part of the plan network, or include negative information about the Department or other PHPs in any of its marketing materials.

f) The PHP shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).

g) The PHP shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.

h) The PHP shall not market materials or activities that are discriminatory or that target potential Members based on health status, geographic residence, location of the provision of possible services or income.

i) The PHP shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.

j) The PHP shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.

k) The PHP shall not engage in activities that seek to target Members currently enrolled in other PHPs.

l) The PHP shall not offer choice counseling or seek to enroll potential Members in the PHP. This is the sole responsibility of the Department and the Enrollment Broker.

m) The PHP shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.

n) The PHP shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.

iii. References to Studies and Statistics

a) The PHP shall not use irrelevant facts or inaccurate statistical information in any marketing materials, and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.

b) If references to a study or statistics are in included in any marketing material, the PHP shall provide reference information (e.g., publication, date, page number) and information about the PHP's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.

iv. Nominal Gifts

a) The PHP may conduct giveaways and distribute nominal gifts to Members and potential Members.
b) The PHP shall ensure the following for nominal gifts offered by the PHP:
1. The gifts do not exceed ten dollars ($10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
2. The gifts are made available to the public and are not in any way connected to enrollment.
3. The gifts are distributed via in-person contacts only (e.g., community events).

v. Marketing of Multiple Lines of Business
a) The PHP shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.
b) The PHP shall be permitted to co-market QHPs and Medicaid products, to the extent the PHP is participating in both markets in the State.
c) The PHP shall be permitted to provide information about a QHP to potential Members who could enroll in such a plan as an alternative to Medicaid Managed Care due to a loss of Medicaid eligibility.

k. Department Approval of Marketing Materials
i. The PHP shall submit marketing materials to the Department for review at least ninety (90) calendar days before the proposed use of the material.
ii. If the PHP makes a significant change to marketing materials that have been previously approved by the Department, the PHP must resubmit the materials, in accordance with this section, for Department review and approval.

l. The PHP may engage in marketing activities beginning eight (8) weeks prior to the start of open enrollment for Phase 1 of Medicaid Managed Care and shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the PHP's marketing activities in accordance with *Section VI. Contract Performance.*

5. Member Rights and Responsibilities

a. The Department expects the PHP to treat Members with dignity and respect, to protect Members' rights, to inform Members of their responsibilities as Members of the plan, and ensure each Member is not subject to any unlawful discrimination in the course of obtaining or receiving services from the PHP or any network provider of the PHP.

b. The PHP shall establish and maintain written policies and procedures that are designed to protect the rights of Members and describe the responsibilities of each Member. The PHP shall develop and submit to the Department for review a Member Rights and Responsibilities Policy ninety (90) calendar days after Contract Award.

c. The PHP shall include a written description of the rights and responsibilities of Members in the Member Welcome Packet provided to new Members and in Member Handbook.

d. The PHP shall provide a copy of its Member Rights and Responsibilities Policy to all PHP employees and network providers.

e. In accordance with 42 C.F.R. § 438.100(b), the PHP shall ensure its written policies and procedures, at a minimum, afford Members the right to:
i. Receive information in accordance with 42 C.F.R. § 438.10;

ii. Be treated with respect and with due consideration for his or her dignity and privacy;
iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
iv. Participate in decisions regarding his or her health care, including the right to refuse treatment;
v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
vi. If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
vii. Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.

f. The PHP shall not attempt to influence, limit, or otherwise interfere with the Member's decision to exercise his or her rights as provided in this Contract.

g. The PHP shall ensure that Members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the PHP or its network providers treat the Member. 42 C.F.R. § 438.100(c).

h. The PHP shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against Members in the course of obtaining or receiving services from the PHP or any network provider of the PHP. 42 C.F.R. § 438.100(d).

6. Member Grievances and Appeals

a. The Department is committed to ensuring that Members understand and can freely exercise their appeal and grievance rights and resolve issues efficiently with minimal burden to the Member or their authorized representative. The PHP shall educate the Member on their rights and provide reasonable assistance with understanding and navigating the appeals and grievances processes.

b. Member Grievances and Appeals General Requirements
i. The PHP shall establish and maintain a grievance and appeals system for reviewing and resolving Member grievances and appeals. Components of the system shall include a grievance process, a plan level appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F.
ii. The PHP shall, while adhering to the required Utilization Management Program, employ strategies to resolve grievance and appeals at lowest level of escalation that meets a Member's needs and in a manner that does not discourage Member's from exercising their rights.
iii. The PHP shall provide Members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section V.F.3. Integration with other Department Partners*.
iv. The PHP shall provide Members reasonable assistance in completing forms and taking other procedural steps related to a plan grievance or appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a).
v. The PHP shall ensure that the individuals making decisions on grievances and appeals:

a) Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
b) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).
c) If deciding an appeal of a denial is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal that involves clinical issues, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).
d) Take into account all comments, documents, records, and other information submitted by the Member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).

vi. The PHP shall allow an authorized representative (including providers) or legal guardian, with the Member's written consent, to request an appeal or file a grievance on behalf of a Member. 42 C.F.R.§ 438.402(c)(ii).
vii. The PHP shall use Department developed templates for all Member notices related to the Member grievance and appeals processes that meet applicable notification standards, including but not limited to, the notice of adverse benefit determination, the plan appeal request form, the State Fair Hearing appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii).
viii. The PHP shall define an appeal, adverse benefit determination, and grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400.
ix. The PHP shall provide the information specified in 42 C.F.R. §§ 438.10(g)(xi) on its grievance, appeals, and State Fair Hearing procedures to all providers and applicable subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.

c. Member Grievance Process
i. The PHP shall develop and maintain a Member Grievance Policy subject to Department review and approval.
ii. The PHP shall allow a Member or authorized representative to file a grievance with the PHP, orally or in writing, at any time. 42 C.F.R. §§ 438.402(c)(2)(i)(ii), 438.408; 438.402(c)(2)(i), and 438.402(c)(3)(i).
iii. The PHP's Member grievance process shall include acknowledgement, in writing, within five (5) calendar days of receipt of each grievance. 42 C.F.R. § 438.406(b)(1).
iv. If a grievance relates to the denial of an expedited appeal request, the PHP shall acknowledge receipt of the grievance, in writing via trackable mail, within twenty-four (24) hours of receipt the grievance.
v. The PHP shall use the Department-defined Notice of Acknowledgement of Receipt of Grievance to notify the Member of receipt of the grievance.
vi. The PHP shall provide written notice of resolution of the grievance to the Member and, as applicable, the Member's authorized representative within thirty (30) calendar days from the date the PHP receives the grievance. 42 C.F.R. § 438.408(b)(1).
vii. If a grievance relates to the denial of an expedited appeal request, the PHP shall resolve the grievance and provide notice to the Member and, as applicable, the Member's authorized representative within five (5) calendar days from the date the PHP receives the grievance. 42 C.F.R. § 438.408(b)(1).

viii. Consistent with 42 C.F.R. § 438.408(c)(1)(i) - (ii), the PHP may extend the timeframes for resolution of a grievance by up to fourteen (14) calendar days if:

a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest.

b) If the timeframe is extended other than at the Member's request, the PHP shall do the following:

1. Make reasonable efforts to give the Member oral notice of the delay;
2. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
3. Resolve the grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).

c) The PHP shall notify Members of their opportunity to submit a complaint with the Department if the Member is dissatisfied with the PHP's resolution of a grievance.

d. Notice of Adverse Benefit Determination

i. The PHP shall give the Member and provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.404.

ii. Each notice of adverse action shall conform with 42 C.F.R. § 431.210, contain and explain:

a) The action the PHP has taken or intends to take. 42 C.F.R. § 438.404(b)(1);

b) The reasons for the action, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);

c) The Member's right to file an appeal, including information on exhausting the PHP's one (1) level of appeal and the right to request a State Fair Hearing if the adverse action is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);

d) Procedures for exercising Member's rights to file a grievance or appeal. 42 C.F.R. § 438.404(b)(4);

e) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and

f) The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).

iii. The PHP shall use the Department-defined template for the Notice of Adverse Benefit Determination.

iv. The PHP shall provide the Member with a Department-developed appeal request form in conjunction with the Notice of Adverse Benefit Determination.

v. Timing of the Notice of Adverse Benefit Determination.

a) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PHP shall give written notice to the Member, and when applicable, an authorized representative at least ten (10) calendar days before the date of the adverse benefit determination is to take effect, except as provided in this Section. C.F.R. § 438.404(c)(1).

b) For termination, suspension, or reduction of previously authorized Medicaid-covered services the PHP shall provide written notice as expeditiously as possible and no later than five (5) calendar days before the date of the action if:

1. The PHP has facts indicating that action should be taken because of probable fraud by the Member; and
2. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).

c) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PHP shall provide written notice no later than by the date of the action when any of the following occurs:
1. The PHP has factual information confirming the death of the Member;
2. The PHP receives a signed, written statement from the Member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
3. The Member is admitted to an institution where he or she is ineligible under the plan for further services;
4. The Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
5. The PHP establishes the fact that the Member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
6. A change in the level of medical care is prescribed by the Member's physician. 42 C.F.R. §§ 431.213 and 438.404(c).

d) For denial of payment, the PHP shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 C.F.R. § 438.404(c)(2).

e) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the PHP shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).

f) The PHP shall have a contingency plan to notify the Member of an adverse benefit determination notification to a Member or legally responsible person regarding termination or reduction of previously authorized Medicaid-covered services no later than the date of the benefit determination if the Member's address is unknown and mail directed to him/her has no forwarding address.

vi. Internal Plan Appeals

a) The PHP shall have an established internal Member appeal process for standard and expedited resolution of appeals requests.

b) The PHP shall have only one level of appeal for Members. 42 C.F.R. § 438.402(b).

c) The PHP shall include the Member and his or her representative or the legal representative of a deceased Member's estate as parties to the appeal. 42 C.F.R. § 438.406(b)(6).

d) The PHP shall provide Members a reasonable opportunity, by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the appeal. For requests for expedited resolution, the PHP shall inform the Member of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)

e) The PHP shall provide Members and his or her authorized representative the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PHP (or at the direction of the PHP) in connection with

the appeal. The PHP shall provide the information to the Member free of charge and sufficiently in advance of the appeal resolution timeframe. 42 C.F.R. § 438.406(b)(5).

f) The PHP shall consider all comments, documents, records, and other information submitted by the Member or, his or her authorized representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

g) The PHP shall require Members to exhaust the plan appeal process before requesting a State Fair Hearing. However, if the PHP fails to adhere to the notice and timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, Members will be deemed to have exhausted the PHP's internal appeal process and can request a State Fair Hearing. 42 C.F.R. § 438.402(c)(1).

h) Request for Plan Appeals

1. The PHP shall allow Members, or an authorized representative, sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination to file a request, orally or in writing, for an appeal with the PHP. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).
2. The PHP shall do the following if the Member makes an oral request for appeal:
    i. At the time the oral request is made, instruct the Member to submit a signed Appeal Request Form within sixty (60) Calendar Days of the date on the notice of adverse benefit determination, unless the Member requests an expedited resolution, and offer assistance with completing the Form.
    ii. Constitute the date of the oral filing as the date of receipt of the appeal. The PHP shall not be required to proceed with evaluating the appeal request until a written signed appeal is received by the PHP from the Member.
    iii. Acknowledge, in writing, receipt of the oral request within five (5) Calendar Days of receipt of the request in accordance with 42 C.F.R. §438.406(b)(1).
    iv. Attempt to contact the Member if a signed Appeal Request Form is not received within five (5) Calendar Days of the expiration of the period to appeal.
    v. If an oral appeal request is made and the Member does not submit a signed Appeal Request Form within sixty (60) Calendar Days of the date on the Notice of Adverse Benefit Determination, the PHP is not required to process the appeal. The PHP shall notify the Member is writing within five (5) Calendar Days of the decision to not process an oral appeal request and provide the reason for the decision.
3. The PHP shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard appeal request, whether received orally or in writing, within five (5) calendar days of receipt of the request. 42 C.F.R. § 438.406(b)(1).
4. Standard resolution of appeals
    i. The PHP shall provide written notice of resolution of the appeal to the Member and/or authorized representative as expeditiously as the Member's health condition requires and within thirty (30) calendar days of receipt of a standard appeal request. 42 C.F.R. § 438.408(b)(2).
    ii. The PHP shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing appeal request form consistent with. 42 C.F.R. § 438.408(e).
5. Extension of standard resolution of appeal

i. The PHP may extend the timeframes for standard resolution of an appeal request by up to fourteen (14) calendar days if
   a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
      i. If the timeframe is extended other than at the Member's request, the PHP shall do the following:
         a. Make reasonable efforts to give the Member oral notice of the delay;
         b. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
         c. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).

ii. The PHP shall use a Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution. The Notice shall include:
   a) The timeframe for extension;
   b) The reason for extension;
   c) A statement on the Member's right to file a grievance if he or she disagrees with the extension; and
   d) A statement regarding the availability of assistance with the appeals process and the ability to call the PHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).

iii. The PHP shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language. The PHP shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).

vii. Expedited Resolution of Plan Appeals
   a) The PHP shall establish, maintain and communicate to Members an expedited appeal resolution process for plan appeals for use when there is an immediate need for health services because a standard appeal could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).
   b) The PHP shall allow Members or an authorized representative to file an expedited appeal resolution request either orally or in writing within sixty (60) calendar days of the date on the adverse benefit determination notice.
   c) The PHP shall not require any additional written follow-up for oral requests for expedited appeal resolution requests. 42 C.F.R. § 438.406(b)(3).
   d) For expedited appeal requests made by providers on behalf of Members, the PHP shall presume an expedited appeal resolution is necessary and grant the request for expedited resolution. The PHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(a)-(b).

e) The PHP shall acknowledge, in writing, receipt of each expedited appeal request within twenty-four (24) hours of receipt. 42 C.F.R. § 438.406.
f) The PHP shall use a Department-developed template for the written Notice of Acknowledgement of Receipt of an expedited appeal resolution request and adhere to timelines for sending the notice to Members.
g) If the PHP denies the request for an expedited plan appeal, it shall immediately transfer the appeal to the timeframes for standard resolution timeframe and provide written notice to the Member, and when applicable, an authorized representative, of the denial of the expedited resolution request. 42 C.F.R. 438.410(c).
h) For expedited resolution of appeals, the PHP shall make a determination as expeditiously as the Member's health condition requires but shall provide written notice, and make reasonable effort to provide oral notice, of resolution no later than seventy-two (72) hours of receipt of the expedited appeal request. 42 C.F.R. §§ 438.408(b)(2) and 431.230(b).
i) PHP shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing appeal request form.
j) Extension of expedited appeal resolution
    i. The PHP may extend the timeframes for expedited resolution of an appeal request by up to fourteen (14) calendar days if:
        a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest.
        b) If the timeframe is extended other than at the Member's request, the PHP shall do the following:
            i. Make reasonable efforts to give the Member oral notice of the delay;
            ii. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
            iii. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
    ii. The PHP shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
        a) The timeframe for extension;
        b) The reason for extension;
        c) A statement on the Member's right to file a grievance if he or she disagrees with the extension; and
        d) A statement on the availability of assistance with the appeals process and the ability to call the PHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).

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. Notwithstanding the Timely Request for Continuation of Benefits process, the PHP shall reinstate 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 Member files for continuation of benefits after the Timely Request for Continuation of Benefits period, but within thirty (30) calendar days of the date on the notice of the adverse benefit determination or the notice of resolution issued by the PHP;
c) The appeal involves the termination, suspension or reduction of previously authorized services; and
d) The services were ordered by an authorized provider.

iii. If the PHP continues or reinstates 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, in writing;
b) The Member does not request a State Fair Hearing within ten (10) calendar days from when the PHP mails an adverse PHP decision regarding the Member's PHP appeal;
c) A State Fair Hearing decision adverse to the Member is made; or
d) The authorization expires or authorization service limits are met. 42 C.F.R. §§ 438.420(c)(1)-(3) and 438.408(d)(2).

iv. 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).

v. 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.

vi. 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.

f. State Fair Hearing Process
   i. PHP shall comply with Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
   ii. The PHP shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.
   iii. The PHP shall allow Members or, an authorized representative, one hundred and twenty (120) calendar days from the date on the Notice of Resolution issued by the PHP upholding, in whole or in part, the adverse benefit determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f).
   iv. The parties to the State Fair Hearing shall include the PHP and the Member or, when applicable, the Member's authorized representative. 42 C.F.R. § 438.408(f)(3).
   v. The PHP shall designate a mailing and email address with the OAH for all fair-hearing-related communications from OAH and any party to the State Fair Hearing.
   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 inform Members that if the Member voluntarily elects to participate in mediation and fails to attend without good cause, OAH will dismiss his or her case.
      d) The PHP shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
   vii. Effectuation of Reversed Appeal Resolutions
      a) If the PHP, during the plan appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).
      b) If the PHP, during the plan appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the Member received the disputed services while the appeal was pending, the PHP shall pay for those services in accordance with the terms of the Contract. 42 C.F.R. § 438.424(b).

g. Appellate Responsibilities
   i. The PHP shall notify the Department within five (5) calendar days of being served notice of a Member's request for judicial review, or other appeal, following an adverse ruling in a State Fair Hearing.

ii. The PHP is responsible for responding to the request for judicial review, or other appeal, as well as PHP's attorney's fees and costs.

iii. If Department is also a party, the Department is responsible for its response to the request for judicial review. The PHP will cooperate fully with Department in its response and defense. To the extent no conflict of interest exists or arises, the PHP and Department may agree to joint defense.

iv. The PHP is responsible for satisfying any judgement, including, payment of benefits, that result from a Court's ruling or order in favor of the Member and against the PHP. The Department will seek indemnification in accordance with the terms of this Contract for any ruling against the Department.

h. NC Health Choice Member Grievances and Appeals

i. The PHP shall allow Members who are NC Health Choice beneficiaries enrolled in the PHP to file grievances in the same manner as Members who are North Carolina Medicaid beneficiaries as specified in this Contract. 42 C.F.R. § 457.1260.

ii. In accordance with 42 C.F.R. §§ 457.1260 and 457.1130(b), the PHP shall allow NC Health Choice Members enrolled in the plan to file appeals in the same manner as Members who are North Carolina Medicaid beneficiaries as specified in this Contract, except that the PHP shall not provide continuation of benefits to NC Health Choice Members during the pendency of an appeal. 42 C.F.R. § 457.1260.

iii. Notwithstanding requirements within this Section, if the sole basis for the PHP's decision to delay, deny, reduce, suspend, or terminate health services, in whole or in part, is a provision in the NC Health Choice State Plan or in federal or North Carolina law requiring an automatic change in coverage under the health benefits package that affects all Members or a group of Members without regard to their individual circumstances, the PHP shall not be required to provide the Member with an opportunity for review of the matter. 42 C.F.R. § 457.1130(c).

i. Appeals and Grievances Recordkeeping and Reporting

i. The PHP shall maintain records of all Member grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's Quality Strategy. 42 C.F.R. § 438.416(a).

ii. The record of each grievance and appeal shall contain, at a minimum, the following:

a) The name of the person for whom the appeal or grievance was filed;
b) A general description of the reason for the appeal or grievance;
c) The date received;
d) The date of each review or, if applicable, review meeting;
e) Resolution at each level of the appeal or grievance, if applicable;
f) Date of resolution at each level, if applicable;
g) Date of appeal decision and mail date of appeal decision;
h) Whether the appeal was an expedited request, if applicable;
i) Who conducted the review of the appeal or grievance and made the determination; and
j) Whether an extension of appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b).

iii. The PHP shall maintain records accurately in a manner accessible to the Department and available upon request to CMS. 42 C.F.R. § 438.416(c).

iv. The PHP shall retain appeal and grievance records consistent with the record retention terms of the Contract following the final decision or the close of the appeal or grievance. If any litigation, claims negotiation, audit, or other action involving the records has been

started before the expiration of the retention period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular period, whichever is later.

v. Medicaid Appeals and Grievance Clearinghouse
    a) The PHP shall conduct daily uploads of each adverse benefit determination issued to Members and each grievance received from Members to the Medicaid Clearinghouse.
    b) The PHP shall include each of the following data points for each adverse benefit determination in the submission, at minimum:
        i. DMA Form Type (2001, 2001A, 2001E, etc.);
        ii. Member identifiers (Medicaid ID, First/Last Name);
        iii. Date of adverse decision (mailing date to Member);
        iv. City and official county code of Member's residence;
        v. Date service request received;
        vi. Service code(s) (i.e., CPT / HCPCS);
        vii. Initial or concurrent authorization;
        viii. Current authorization end date (if concurrent authorization); and
        ix. Waiver type, if applicable.
    c) The PHP shall include, at minimum, each of the following data points for each grievance in the submission:
        i. Member Identifiers (Medicaid or NC Health Choice ID, First/Last Name);
        ii. A general description of the reason for the grievance;
        iii. The date grievance was received;
        iv. The date of each review or, if applicable, review meeting;
        v. Resolution of the grievance; and
        vi. Mail date for resolution notice.

C. Benefits and Care Management

1. Medical and Behavioral Health Benefits Package

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. Services shall be delivered within the standard of care and meet Department quality standards and expectations.
    i. Medicaid benefits is inclusive of LTSS services, including Nursing Facility Services, Home Health Services, Private Duty Nursing Services, Personal Care Services, and Hospice Services.

b. The PHP shall:
    i. Cover all services in the North Carolina Medicaid and NC Health Choice State Plans with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended;[7] as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract.
    ii. Use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;

[7] Section 4.(4) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186, and Session Law 2018-48.

iii. Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the Member's diagnosis, type of illness or condition;

iv. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. (42 C.F.R. § 438.210(a)(2));

v. Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i).

vi. Develop a comprehensive Utilization Management Program inclusive of a subset of Medicaid Fee-for-Service clinical coverage policies as defined in this Contract; and

vii. Implement and adhere to all Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) policies and protocols as defined in *Section V.C.2. Early and Periodic Screening, diagnosis and Treatment (EPSDT)*.

c. Covered services:

i. The PHP shall cover all services as defined in the Medicaid and NC Health Care State Plans with the exception of services carved out under Section 4.(4) of Session Law 2015-245, as amended;[8] as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid and NC Health Choice State Plan covered services are described in *Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid and NC Health Care State Plan);

ii. The PHP shall not be responsible for providing carved out services to Members as defined in S*ection V.C. Table 2: Services Carved Out of Medicaid Managed Care*;

iii. Consistent with Session Law 2015-245, as amended,[9] the PHP shall be responsible for covering behavioral health services that are defined as *Section V.C. Table 3: Behavioral Health Services for Standard Plans*.

iv. The PHP shall implement changes to covered or carved-out services within thirty (30) calendar days after notification by the Department, unless otherwise indicated.

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY MEDICAID	COVERED BY NCHC
Inpatient hospital services	Services that – 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 - (i) Is maintained primarily for the care and treatment of patients	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. § 440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E	YES	YES

[8] Ibid.
[9] Ibid.

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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. Inpatient hospital services include: 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. 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). 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	NC Health Choice State Plan, Section 6.2.1 NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive 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. 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. 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. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval.			

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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			
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that— Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and 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. 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	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Health Choice State Plan, Section 6.2.2	YES	YES
Early and periodic screening, diagnostic and treatment	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	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r)	YES	NO

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
services (EPSDT)	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].	North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions *Section V.C.2.: Early and periodic screening, diagnostic and treatment services (EPSDT)* of the Contract		
Nursing facility services	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. 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	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. § 440.40 42 C.F.R. § 440.140 42 C.F.R. § 440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities	YES	YES
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.	North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 3A		
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. 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. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h NC Health Choice State Plan, Section 6.2.3 NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. Injections are excluded when oral drugs may be used in lieu of injections. 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.	NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services 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		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		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 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		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		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 NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-41, Office-		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) NC Clinical Coverage Policy 1B-2, Rituximab (Rituxan) NC Clinical Coverage Policy 1B-3, Intravenous Iron Therapy		
Rural health clinic services	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). The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics		
Federally qualified health center services	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. 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). The specific health care encounters that constitute a core service include the following face to face encounters: 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;	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics		
Telemedicine	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.	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telemedicine and Telepsychiatry	YES	YES
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.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 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 NC Health Choice State Plan, Section 6.2.8 NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services		
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.	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Health Choice State Plan Section 6.2.9 NC Clinical Coverage Policy 1E-7, Family Planning Services	YES	YES
Certified pediatric and family nurse	(a) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
practitioner services	either paragraphs (b)(1) or (b)(2) of this section. If the State specifies qualifications for pediatric nurse practitioners, the practitioner must - 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. 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 - 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. (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. If the State specifies qualifications for family nurse practitioners, the practitioner must - Be currently licensed to practice in the State as a registered professional nurse; and Meet the State requirements for qualification of family nurse	North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and 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	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.	NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15		
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 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	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		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 *Section V.C.3. Pharmacy Benefits* of the Contract		
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 not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or	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

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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			
Physical therapy	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.	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages7c, 7c.15 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
Occupational therapy	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	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	and orthotic devises. 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.	NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)		
Speech, hearing and language disorder services	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.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
Limited inpatient and outpatient behavioral health services	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
defined in required clinical coverage policy	preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Please refer to NC Clinical Coverage Policies and services listed.	NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): Mobile Crisis Management Diagnostic Assessment Partial Hospitalization Professional Treatment Services in Facility-based Crisis Ambulatory Detoxification 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	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		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		
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; (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	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5	YES	NO

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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; (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			
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."	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care	YES	YES
Optometry services	Medicaid and NCHC shall cover the following optical services when provided by ophthalmologists and optometrists: a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	Opticians may dispense approved visual aids.	NC Health Choice State Plan Section 6.2.12 G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21		
Chiropractic services	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. 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.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services	YES	YES
Private duty nursing services	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. 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	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty	YES	NO

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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. 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. 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 Carolina Board of Nursing and employed by a licensed home care agency. 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.	Nursing for Beneficiaries Under 21 years of Age		
Personal care	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	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A,	YES	NO

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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. 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. 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.	Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)		
Hospice services	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	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3D, Hospice Services	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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. 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. 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). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.			
Durable medical equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home:	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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	NC Health Choice State Plan Section 6.2.12, 6.2.13 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics		
Prosthetics, orthotics and supplies	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. 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.	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, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics	YES	YES
Home infusion therapy	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: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN)	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy			
Services for individuals age 65 or older in an institution for mental disease (IMD)	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.	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services	YES	NO
Inpatient psychiatric services for individuals under age 21	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.	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Health Choice State Plan Section 6.2.10 NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services	YES	YES
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.	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for		

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multi-visceral Transplants		
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.	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
Allergies	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. 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.	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy	YES	YES
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. c. The clinical management of the patient unconscious from whatever cause. d. The evaluation and management of acute or chronic pain. e. The management of problems in cardiac and respiratory resuscitation. f. The application of specific methods of respiratory therapy. g. The clinical management of various fluid, electrolyte, and metabolic disturbances	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)	YES	YES
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.	Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement		
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

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
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 Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit	YES	NO
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions NC Clinical Coverage Policy 1E-3, Sterilization Procedures	YES	NO

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home		
Ophthalmological Services	General ophthalmologic services include 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. 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. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services	YES	YES
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter-Products	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administration 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		
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision	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.	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	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21		

Section V.C. Table 2: Services Carved Out of Medicaid Managed Care[10]
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
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

[10] Section 4.(4) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186, and Session Law 2018-48.

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 Both SPs and BH I/DD TPs	**BH, I/DD and TBI Services Covered Exclusively by BH I/DD TPs** **(or LME-MCOs Prior To Launch)**
Enhanced behavioral health services are italicized	
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • *Research-based intensive behavioral health treatment* • *Diagnostic assessment* • EPSDT • Non-hospital medical detoxification • Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization (ADATC) • IMD-ILOS	**State Plan BH and I/DD Services** • Residential treatment facility services for children and adolescent • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • *Psychiatric residential treatment facilities* • *Assertive community treatment* • *Community support team* • *Psychosocial rehabilitation* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded BH and I/DD Services** **State-Funded TBI Services**

v. The PHP shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.

vi. The PHP shall, in accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA), provide protections to patients who choose to have breast reconstruction relating to a mastectomy, including coverage of:
   a) All stages of reconstruction of the breast on which the mastectomy has been performed;
   b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

vii. The PHP shall provide long term services and supports in a setting that complies with 42 C.F.R. § 441.301(c)(4) requirements for home and community based settings. 42 C.F.R. § 438.3(o).

viii. The PHP shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a Member enrolling in the PHP.

ix. The PHP shall encourage primary care providers, who serve Members under age 19, to participate in the Vaccines for Children (VFC) program, that allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
   a) The PHP shall require that primary care providers administer vaccines consistent with the AAP/Bright Future periodicity schedule.
   b) The PHP shall only pay for the vaccine administration fee for VFC eligible children.
   c) Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
   d) Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. The PHP shall reimburse the provider for both the vaccine and administration fee for NC Health Choice Members.
   e) The PHP shall adhere to additional VFC requirements as defined in *Section V.C.7. Prevention and Population Management Health Programs.*

x. Pursuant to 42 C.F.R. § 457.410(b)(1), the PHP shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
   a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents" including:
      1. Screening for developmental delay at each visit through the 5th year;
      2. Screening for Autistic Spectrum Disorders per AAP guidelines;
   b) Comprehensive, unclothed physical examination;
   c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
   d) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
   e) Health education and anticipatory guidance for both the child and caregiver.

xi. Changes to Covered Benefits

a) The PHP shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans, except to the extent the service is carved out of Medicaid Managed Care or may only be covered by a BH I/DD Tailored Plan in accordance with North Carolina law.

b) In accordance with Section 11H.13(c) of Session Law 2018-5, as amended by Section 3.13 of Session Law 2018-97, the Department is seeking approval from CMS to amend the Medicaid State Plan to add optical coverage for adults, effective January 1, 2019. The PHP shall be responsible for providing optical coverage to Members consistent with this Contract and any approved State Plan Amendments (SPA), except to the extent that services covered under the SPA are carved out of Medicaid Managed Care pursuant to Section 4.(4) of Session Law 2015-245, as amended. Contingent on statutory authority, the PHP shall not be responsible for eyeglass fittings provided to Members in conjunction with fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames.

xii. IMD-SUD Services

a) Under North Carolina's 1115 waiver authority, the PHP shall provide coverage for Substance Use Disorder services for Members aged twenty-one (21) to sixty-four (64) in an Institute for Mental disease (IMD), as well as any other State Plan services for which they may be eligible during their stay in the IMD.

b) The PHP shall provide the Department with a weekly report on members utilizing IMD-SUD services as defined in Section VII.J. Reporting Requirements. The report shall be submitted to the Department by each Friday and no later than 14 calendar days from the applicable admission or discharge date.

d. Medical Necessity

i. For North Carolina Medicaid and NC Health Choice Members, the PHP shall cover all medically necessary services in accordance with *Section V.C. Benefits and Care Management*.

ii. The PHP shall provide medically necessary services to all Medicaid Managed Care Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or behavioral health, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.

iii. The PHP may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.C.1.e. Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.

iv. The PHP shall work with providers to ensure that providers identify an appropriate new level of care for a Member who no longer meets the medical necessity criteria for an existing service.

v. The PHP shall determine whether a service is medically necessary on a case by case basis.

e. Utilization Management

i. The PHP shall develop a utilization management (UM) program for medical, behavioral health, and pharmacy services that is based on nationally-recognized evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.

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

iii. The PHP shall use a standardized prior authorization request form developed by the Department.

iv. Subject to Department review and approval, the Utilization Management (UM) Program, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
    a) Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
    b) Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
    c) Authorize LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
    d) Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
    e) Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
    f) Protecting Members from discouragement, coercion, or misinformation about the amounts of Services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a Service.
    g) Mechanisms for detecting instances of overutilization, underutilization, and misutilization;
    h) Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the PHP;
    i) Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act.
    j) Dissemination of guidelines to all affected providers and, upon request, to Members and potential Members; and
    k) Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member.

v. The PHP shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or Member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.
    a) Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less

intensive type of service, or to modify a SNAP (score for neonatal acute physiology) for neonatal acute physiology) score or other clinical assessment.

b) Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH appeals is prohibited.

c) The care management process shall not be used to improperly influence, change or prevent a request for a prior approval.

d) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.

vi. The PHP shall not retract a service authorization after the services, supplies, or other items have been provided, except as provided in N.C. Gen. Stat. § 58-3-200(c).

vii. The PHP shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).

viii. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).

ix. The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §§ 438.3(e)(1)(ii) and 438.910(b)-(d).

a) Annually, the PHP shall submit a completed standardized parity analysis workbook, developed by the Department, to demonstrate compliance.

x. The PHP shall have the option of using the Department's Medicaid Fee-for-Service clinical coverage policies as the basis for the UM program or developing its own.

a) A chart of all North Carolina Medicaid and NC Health Choice clinical coverage policies is found in *Attachment B. Clinical Coverage Policy List.*

xi. For a limited number of services, the PHP shall incorporate existing North Carolina Medicaid and NC Health Choice Fee-for-Service clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.C. Table 4: Required Clinical Coverage Policies.*

a) The Department reserves the right to require the PHP to follow additional Fee-for-Service clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	**SCOPE**
Behavioral Health and Intellectual/ Developmental Disability	8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): i. Mobile Crisis Management ii. Diagnostic Assessment iii. Partial Hospitalization iv. Professional Treatment Services in Facility-based Crisis v. Ambulatory Detoxification vi. Non-hospital Medical Detoxification

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	**SCOPE**
	vii. Medically Supervised or ADATC Detox Crisis Stabilization viii. Outpatient Opioid Treatment 8A-2: Facility-based Crisis Services for Children and Adolescents 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers 8Q [DRAFT}: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder
Obstetrics and Gynecology	1E-7: Family Planning Services
Physician	1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment 1A-23: Physician Fluoride Varnish Services 1A-36: Implantable Bone Conduction Hearing Aids (BAHA) 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair 13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	As defined in *Section V.C.3. Pharmacy Benefits*

xii. The Department will allow "proprietary" utilization management policies under limited circumstances, with prior approval by the Department.

xiii. As part of the UM program, the PHP shall adhere to the following Prior Authorization requirements.

a) To effectively manage the care of its Members, the PHP shall establish and maintain a referral and prior authorization process with the Member-selected or PHP-assigned AMH/PCP at its center.

b) The PHP shall conduct prior authorization reviews using current clinical documentation, and must consider the individual clinical condition and health needs of the Member.

c) The PHP may require a referral for any medical services not provided by the AMH/PCP except where specifically provided in the Department-PHP contract and in federal and state statute and regulations.

d) The PHP must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for the first ninety (90) days after implementation to ensure continuity of care for Members. For the first sixty (60) days after Medicaid Managed Care launch, the PHP shall pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers until end of episode of care or the 60 days, whichever is less.

e) The PHP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial.

f) Consistent with 42 C.F.R. § 438.206, the PHP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:

1. Emergency services
    i. In accordance with 42 C.F.R. § 438.114, the PHP shall not require Members to obtain a referral or prior authorization before receiving emergency services.
    ii. The PHP shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
    iii. The PHP shall not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's AMH/PCP or PHP of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services.
    iv. The PHP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the PHP's network.
    v. The PHP shall not hold a Member with an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
    vi. The PHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the PHP to seek emergency services.
2. Family planning services
    i. The PHP shall not require Members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 C.F.R. 438.206(b)(3).
    ii. The PHP shall not restrict the Member's free choice of family planning services and supplies providers. 42 C.F.R. § 431.51(b)(2).
    iii. The PHP shall not hold Members liable for payment for family planning services or supplies that are not in the PHP's network.
    iv. Services provided by women's health specialists in accordance with 42 C.F.R. § 438.206(b)(2) and N.C. Gen. Stat. § 58-51-38.
    v. The PHP shall not require female Members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.
    vi. The PHP shall allow female Members direct access to a women's health specialist in addition to the Member's designated source of primary care if that source is not a women's health specialist.
    vii. The PHP shall not require providers to obtain prior approval for any obstetrical ultrasound.
    viii. Women's routine and preventive health care services may include but are not limited to: initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for

services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases.

3. Children's screening services
   i. The PHP shall not require Members to obtain a referral or prior authorization for children's screening services.
   ii. The PHP shall not require Members to obtain a referral or prior authorization for Local Health Department services.
4. Behavioral Health services
   i. The PHP shall not require Members to obtain a referral or prior authorization for the first mental health or substance dependence assessment completed in a twelve (12) month period.
   ii. The PHP shall make available to all Members a complete listing of its participating mental health and substance use disorder providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.
5. Primary Care services: the PHP shall not require enrollees to obtain a referral or prior authorization for primary care services.
6. School-based clinic services: The PHP shall not require enrollees to obtain a referral or prior authorization for services rendered at school-based clinics.

g) The PHP shall ensure Members have and are aware of having direct access to services for which the Department does not allow the PHP to require referral or prior authorization, as defined in this Section.

xiv. For behavioral health services, the PHP shall require providers to use the following behavioral health screening tools at part of the PHP's UM Program:

a) The PHP shall use the American Society for Addiction Medicine (ASAM) for substance abuse services for medical necessity reviews for all populations except children ages zero (0) through six (6). The PHP shall use EPSDT criteria when evaluation requests for service for children;
b) The PHP shall use the Level of Care Utilization System (LOCUS) scores for mental health services for medical necessity reviews for Members eighteen (18) and older;
c) The PHP shall use the Child and Adolescent Level of Care Utilization System (CALOCUS) scores for mental health services for medical necessity reviews for children and adolescents six (6) through seventeen (17) years old.
d) The PHP shall use either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers to determine medical necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.
e) The PHP shall use the Supports Intensity Scale (SIS) for I/DD services for medical necessity reviews for Members five (5) years old and older.
   1. The SIS Children's version shall be used for Members from the ages of five (5) through sixteen (16).
   2. The SIS Adult version shall be used for Members ages seventeen (17) and up.

xv. UM Program Policy:

a) The PHP shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review ninety (90) calendar after Contract Award,
b) The PHP shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM

Program Policy no less than sixty (60) calendar days before such changes go into effect.

c) The PHP shall post the UM Program Policy on their publicly available website for providers and Members, or in other forms as requested by the provider or Member, at no cost. The PHP shall include a prominent reference to the web address of the UM Program Policy in both its provider and Member Handbooks.

d) The PHP shall conduct training and education with providers and prescribers on changes to the UM program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.D.2. Provider Relations and Engagement*.

xvi. The PHP shall make the CMO or designee available to discuss and report on the Utilization Management Program, as requested by the Department.

f. Telemedicine

i. The PHP shall provide services via telemedicine to Medicaid and NC Health Choice Members as an alternative service delivery model in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

The services provided via telemedicine shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. 42 C.F.R. § 438.210(a)(2).

ii. The PHP may use telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the PHP's network.

iii. The PHP shall not require a Member to seek the services through telemedicine and must allow the Member to access a face-to-face service through an out-of-network provider, if the Member requests.

iv. As part of the UM Program Policy, the PHP shall develop and submit a Telemedicine Coverage Policy to the Department.

a) The Telemedicine Coverage Policy shall include:

1. Eligible providers who may perform telemedicine;
2. Telemedicine modalities covered by the PHP;
3. Telemedicine modalities not covered by the PHP;
4. Requirements for and limitations on coverage;
5. Description of each covered modality, including:
   i. Evidence base;
   ii. Compliance with local, state and federal laws, including HIPAA; and
   iii. Process to ensure security of protected health information.

2. Reimbursement mechanism (i.e. flow of funds from PHP to all relevant providers and facilities) for each covered modality; and
3. Billing guidance for providers. PHP shall submit a revised Telemedicine Policy to the Department whenever there is a material change to the Policy.

v. The PHP shall pay at least the in-person rate for the same service delivered via telemedicine (i.e. payment parity).

vi. For all consultations that include two-way, real-time interactive audio and video communication, the PHP shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

vii. The PHP shall pilot new approaches to telemedicine and value-based payment and shall support providers in optimizing the use of telemedicine in their practices.

For purposes of any telemedicine pilot, the PHP may propose, for the Department's review and approval, a waiver of telemedicine payment parity requirements.

g. In Lieu of Services
   i. The PHP may use In Lieu of Services (ILOS), services or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plans, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)i-iv.
   ii. The PHP shall submit the ILOS Service Request Form, in a format to be defined by the Department, prior to implementation to the Department for approval.
      a) In no instance shall the PHP reduce or remove ILOS service without approval by the Department concurrent within a contract year.
      b) If changes, reduction, or removal of ILOS services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.
      c) The PHP shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.
   iii. The PHP shall post ILOS policies on its publicly available Member and provider websites.
   iv. The PHP shall monitor the cost-effectiveness of each approved In Lieu of Service by tracking utilization and expenditures (see *Attachment J. Reporting Requirements* for more detailed requirements).
   v. The PHP may offer the following In Lieu Of Service:
      a) Institute for Mental Disease (IMD): The PHP may contract and pay for services for members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered setting for no more than fifteen (15) calendar days within a calendar month. 42 CFR 438.6(e).
         1. To provide the service, the PHP must submit an ILOS request form, as defined by the Contract.
         2. If the PHP does not provide the ILOS request form for review and approval, capitation payments may be adjusted accordingly.
         3. If the PHP provided the ILOS, the PHP shall provide the Department with a weekly report on members utilizing IMD services as defined in Section VII.J. Reporting Requirements. The report shall be submitted to the Department by each Friday and no later than 14 calendar days from the applicable admission or discharge date.
   vi. The PHP shall not require the Member to utilize an ILOS.
   vii. ILOS previously approved by the Department are outlined in *Attachment C. approved Behavioral Health In Lieu of Services.*

h. Value-Added Services
   i. The PHP may offer Value-Added services as approved by the Department.
   ii. For each Value-Added service, the PHP shall submit to the Department for approval, in a format defined by the Department, the following information:
      a) Definition and description of the Value-added Service, including if prior authorization is required;
      b) Definition of the criteria to be eligible for proposed Value-Added service;
      c) Types of providers eligible to provide the Value-Added services;

d) Description of how and when providers and Members will be notified about the availability of the proposed Value-Added service;
e) Duration for which Value-Added services will be provided; and
f) Description of if, and how, the services will be identified in encounter data.

iii. The PHP shall submit to the Department for approval any changes to Value-Added services.
a) In no instance may the PHP reduce or remove value added service without approval by the Department during a contract year.
b) If changes, reduction, or removal of Value-Added services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.

iv. Value-Added services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).

i. Cost Sharing
i. The PHP shall impose the same cost-sharing amounts as specified in North Carolina's Medicaid and NC Health Choice State Plans.
ii. The PHP shall not require Members to pay for any covered services other than the co-payment amounts required under the State Plans.
iii. The PHP shall not hold Member's responsible for any of the following:
a) PHP's debts in the event of PHP insolvency;
b) Covered services provided to the Member for which:
1. The Department does not pay the PHP, or
2. The Department, or PHP, does not pay the individual or health care provider that furnished the services under a contractual referral or other arrangement;
c) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the PHP covered the services directly. 42 C.F.R. § 438.106.
iv. The PHP shall track cost-sharing obligations of each Member and provide to the Department in a format and frequency to be defined by the Department.
v. Exceptions for cost sharing:
a) Pursuant to 42 C.F.R. § 457.505(d)(1), all NC Health Choice Member receive well-child visits and age-appropriate immunizations at no cost to their families.
b) Consistent with 42 C.F.R. § 447.56, Medicaid cost-sharing does not apply to subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
c) Consistent with 42 C.F.R. Part 457, Subpart E, NC Health Choice cost-sharing does not apply to members of federally-recognized American Indian tribes/Alaska Natives.
d) The PHP shall not impose cost-sharing on behavioral health services, as defined by the Department.

Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	**ANNUAL ENROLLMENT FEE**	**SERVICE**	**COPAY**
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency Visit in Hospital ER	$3/visit $3/visit $3/visit $3/script $2/visit $2/visit $3/visit $3/visit
North Carolina Health Choice (NCHC)			
NCHC beneficiaries with family income is < 159% FPL	None	Office visits Generic Prescription Brand Prescription when no generic available Brand prescription when generic available Over-the-counter medications Non-emergency emergency room visits	$0/visit $1/script $1/script $3/script $1/script $10/visit
NCHC beneficiaries with family income > 159% and < 211% FPL	$50 per child or $100 maximum for two or more children	Office visit Outpatient hospital Generic Prescription copay Brand Prescription (when no generic available) Brand prescription (when generic available) Over-the-counter medications Non-emergency emergency room visits	$5/visit $5/visit $1/script $1/script $10/script $1/script $25/visit

j. Noticing Requirements

i. The PHP shall provide written notice, using the Department-developed template, to Members on decisions related to authorization of services. The written notice shall include the following:

a) The bases for such decisions; and

b) Sufficient details that inform Members of the decision, which will provide them with information necessary to determine if they wish to appeal.

ii. The PHP shall provide written notice to Members of any Department-initiated changes to the Medicaid or NC Health Choice benefits package or cost sharing requirements.

Notification to Members shall be provided at least thirty (30) calendar days in advance of the effective date of such change.

iii. The Department shall provide written notice to Members of the aggregate family limit on cost sharing.

The Department shall provide written notice to the PHP and Members when a Member incurs out-of-pocket expenses up to the aggregate household limit and individual household Members are no longer subject to cost sharing for the remainder of the quarter.

iv. For standard authorization decisions, the PHP shall provide notice as expeditiously as the Member's condition requires and no later than fourteen (14) calendar days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).

v. The PHP may receive a possible extension of up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.

If the PHP extends the timeframe beyond fourteen (14) days, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.

vi. For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the PHP shall provide notice no later than seventy-two (72) hours after receipt of the request for service.

a) The PHP may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.

b) If the PHP extends the timeframe beyond seventy-two (72) hours, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.

k. Electronic Verification System

i. The PHP must utilize an Electronic Visit Verification (EVV) system to verify personal care services prior to releasing payment.

ii. The PHP must utilize an EVV system to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:

a) Type of service performed;
b) Individual receiving the service;
c) Date of the service;
d) Time that the service begins;
e) Location of service delivery;
f) Individual providing the service; and
g) Time that the service ends.

iii. If the PHP utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.

iv. The PHP shall ensure that utilization of an EVV system for Personal Care Services (as part of the State Plan) is in effect at Medicaid Managed Care launch and by January 1, 2023 for Home Health Care Services.

l. Moral and Religious Objection
   i. The PHP is not required to provide, reimburse for, or provide coverage of, a counseling or referral services if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R 438.102(b) have been met.
   ii. If the PHP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PHP shall furnish information about the services it does not cover to the Department, and to any other Department partner as directed by the Department, whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).

2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

a. The PHP shall cover services, products, or procedures for a Medicaid Member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

b. The PHP shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under Fee-for-Service and as defined in the Department's EPSDT policies.

c. The PHP shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.

d. The PHP shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for Medicaid Members under twenty-one (21) years of age.

e. 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.

f. Upon conclusion of an individualized review of medically necessary services, the PHP shall cover medical necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The PHP shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the PHP responsible for delivery of the referred service, product, or treatment.

g. The PHP may provide medically necessary services in the most economic mode possible, if
   i. The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner,
   ii. The determination process does not delay the delivery of the needed service, or
   iii. The determination does not limit the Member's right to a free choice of providers within the PHP's network.

h. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, utilization management policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

   Note that visits to dentists shall not be billed to the PHP but shall be billed to the Medicaid Fee-for-Service program.

i. The PHP shall:
   i. Require all in-network primary care providers to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule.
   ii. Require all in-network primary care providers to refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.
   iii. Require that participating primary care providers include all of the following components in each medical screening.
      a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents".
         1. Screening for developmental delay at each visit through the 5th year; and
         2. Screening for Autistic Spectrum Disorders per AAP guidelines.
      b) Comprehensive, unclothed physical examination.
      c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
      d) Laboratory testing (including blood lead screening appropriate for age and risk factors).
      e) Health education and anticipatory guidance for both the child and caregiver.

j. The PHP shall ensure and verify that network BH providers coordinate with primary care providers and specialists conducting EPSDT screenings.

k. The PHP shall not require prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age. The PHP may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.

l. The PHP shall comply with the Department's standards for the timely provision of EPSDT services.

m. The PHP shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or Member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

n. The PHP shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:
    i. Regular preventive care, and
    ii. Scope of services, products and treatments available when medically necessary to corrector or ameliorate a health condition or problem.

o. The PHP shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) calendar days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in *Section V.B.3. Member Engagement.*

p. The PHP shall perform outreach to Members who are due or overdue for an EPSDT screening service monthly.

q. The PHP shall effectively inform Members and/or their parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the *Section V.B.3. Member Engagement*.

r. The PHP shall not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per EPSDT criteria.

s. While an EPSDT request is under review, the PHP may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as the PHP makes clear that the Member has the right to request authorization of the services he or she wants to request.
    i. The PHP shall not request that providers or Members withdraw or modify a request for EPSDT services to accept a less number of hours, or less intensive type of service, or to modify a SNAP (score for neonatal acute physiology) or other clinical assessment.
    ii. Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH appeals is prohibited.
    iii. Nothing in this Section should be construed to prevent clinical or treatment discussions.

s. The PHP shall offer assistance with scheduling appointments for EPSDT services, upon a Member's request.

t. The PHP shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services) for referrals. The PHP shall also make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.

u. The PHP shall develop and maintain a EPSDT Policy. The PHP shall submit the EPSDT Policy to the Department for review ninety (90) days after Contract Award and annually thereafter.

v. Educational and Training Materials
    i. The PHP shall develop written and oral educational materials on EPSDT, including educational materials for Members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
        a) The PHP shall submit the materials to the Department for review and approval as defined in *Section V.B.3. Member Engagement.*

b) The PHP may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.

ii. As part of the Provider Training Plan defined in *Section V.D.2. Provider Relations and Engagement*, the PHP shall provide training to all network providers where EPSDT is relevant to the providers' area of practice on an annual basis. Training must include information related to:
   a) EPSDT benefits;
   b) EPSDT medical necessity review per federal criteria: standards and processes;
   c) AAP/Bright Futures Periodicity Schedule;
   d) Immunizations;
   e) Required components of an EPSDT screening service;
   f) Providing or arranging for all required lab screenings;
   g) Medical transportation services available to Members;
   h) Outreach activities related to EPSDT provided by the PHP;
   i) Necessary documentation required for reimbursement of EPSDT services; and
   j) Into the Mouths of Babes/Physician Fluoride Varnish Program.

3. Pharmacy Benefits

a. Prescription drugs play a significant and increasing role in maintaining health and treating illnesses, giving Members the opportunity to become healthier and improve their quality of life. Through current pharmacy program management strategies, the PHP shall implement a pharmacy benefit which ensures Members and providers access to therapeutically needed medications that will provide the best overall value to Members, providers and the Department.

b. The PHP shall:
   i. Cover all covered outpatient drugs for which the manufacturer has a Centers for Medicare and Medicaid Services (CMS) rebate agreement and for which the Department provides coverage. 42 C.F.R. § 438.3(s)(1);
   ii. Adhere to the Department's defined preferred drug list (PDL); and
   iii. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. 42 C.F.R. § 438.210(a)(2).

c. Drug Formulary and Preferred Drug List
   i. The PHP shall not be allowed to maintain a closed formulary as defined in N.C. Gen. Stat. § 58-3-221(c)(1).
   ii. In accordance with Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, the PHP shall use the same drug formulary established by the Department.
   iii. The drug formulary shall, at minimum, include:
      a) All drugs included the North Carolina Medicaid and NC Health Choice Preferred Drug List (PDL) as posted on the Department's website. The PHP shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid and NC Health Choice PDL.
      b) All other covered drugs in drug classes not listed on the Department's PDL; and
      c) Outpatient drugs that are not excluded through state or federal policy, as defined in 42 C.F.R. § 438.3(s)(1).
   iv. The PHP may substitute a brand drug with a generic drug when the drug is considered bio-equivalent and clinically efficacious unless the brand drug is preferred on the Department's PDL.
   v. Beginning in Contract Year Two (2), the PHP may submit additional information or requests for the inclusion of additional drug classes in the Department's PDL for the Department's review and approval.
      a) The PHP will adhere to the Department defined uniform review and approval process for requests for the inclusion of additional drug classes in the Department PDL.
      b) The PHP shall use the same drug formulary established by the Department, until provided written approval by the Department.
   vi. In accordance with 42 C.F.R. § 438.10(h)(4)(i), the PHP shall make available to Members and providers in a machine-readable electronic file and paper format, the following information about the drug formulary:
      a) List of all covered drugs (including over the counter, brand name, and generic prescription drugs); and
      b) Each covered drug's tier (i.e. PDL preferred, PDL non-preferred, and non-PDL).
   vii. Drug formulary updates:
      a) The PHP will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC

included on the North Carolina Medicaid and NC Health Choice PDL. The PHP shall update their pharmacy claim system within one (1) calendar day of file receipt of the PDL file from Department's PDL vendor.

b) The PHP shall implement routine PDL changes within thirty (30) calendar days of notification of changes to the PDL by the Department (i.e. annual or quarterly updates based on the Department's routine PDL review).

c) The PHP shall, at the direction of the Department, perform off-cycle PDL file updates within one (1) calendar day of file receipt of the PDL file from Department's PDL vendor.

d. Utilization management:

i. As defined herein, the PHP shall develop a Utilization Management (UM) program, inclusive of pharmacy benefits.

ii. For pharmacy services, the PHP shall follow the existing Medicaid and NC Health Choice Fee-for-Service clinical coverage policies and prior authorization (PA) criteria into the UM Program as described in:

a) Clinical Coverage Policies: *Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies* below.

b) PA Criteria: Drugs and/or drug classes requiring prior approval are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies
9: Outpatient Pharmacy
9A: Over-the-counter products
9B: Hemophilia Specialty Pharmacy Program
9D: Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17
9E: Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
1B: Physician Drug Program

iii. Consistent with N.C. Gen. Stat. § 108-68.1, the PHP shall not require PA for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.

iv. The UM program shall include prior authorization (PA) processes, as defined within Section 1927(d)(5) of the Social Security Act and 42 C.F.R. § 438.3(s)(6), including but not limited to:

a) The PHP shall process pharmacy PA requests within twenty-four (24) hours from when the request is received.

b) The PHP shall notify the prescriber of the decision by electronic means within twenty-four (24) hours from when the request was received, unless it is necessary for the PA request to be pended to obtain additional information (in which case, the PHP shall have twenty-four (24) additional hours from the receipt of additional information).

c) The PHP shall allow a Member direct access to a drug requiring prior authorization if the physician certifies that the Member has previously used an alternative drug not requiring prior authorization and/or the alternative drug has been determined

detrimental to the Member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the Member's health or ineffective in treating the condition again. The PHP shall not void or refuse to renew a provider contract because the provider has provided a certification for a medically necessary drug.

d) The PHP shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement and the prescriber cannot be reached, the pharmacist may dispense a seventy-two (72)-hour emergency supply of the prescription.
e) The PHP shall not require a pharmacy to dispense a seventy-two (72)-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber.
f) The PHP shall allow the pharmacy to bill consecutive seventy-two (72) hour supplies if the prescriber remains unavailable.
g) The PHP shall reimburse the pharmacy for dispensing the temporary supply of medication and the pharmacy shall only receive one dispensing fee per month for each medication dispensed.
h) The PHP shall develop and maintain an Emergency Preparedness Protocol, consistent with Clinical Coverage Policy 9: Outpatient Pharmacy, to prevent a significant disruption in medication access during a state of emergency or disaster.
i) The PHP shall align prior authorization requirements as defined in the Opioid Misuse Prevention Program.

v. The PHP shall implement prior authorization policies and procedures and pharmacy point of service edits process consistent with the A+KIDS program as part of its UM program to prevent overprescribing and inappropriate prescribing of antipsychotics in Members under the age of eighteen (18).
vi. As new drugs are approved to the market, the PHP may require PA for those drugs based on the drug's FDA approved indication(s) and use(s) until the Department determines the need for and establishes clinical coverage and PA criteria.
vii. Beginning in Contract Year Two (2), the PHP, after consultation with its, or its vendor/subcontractor's, P&T committee consistent with N.C. Gen. Stat. § 58-3-221(a)(1), may submit alternative pharmacy clinical coverage and PA criteria to the Department for review and approval. The PHP shall:
    a) Adhere to the Department defined uniform review and approval process to request alternative clinical coverage and PA criteria.
    b) Seek the Department's approval of alternative prior authorization criteria prior to implementing the criteria.
viii. Pharmacy Prior Authorization Process
    a) The PHP shall develop web-based PA processes, which provides an electronic review system accessible to providers and the Department's staff.
    b) The PHP shall utilize a common PA request form(s), developed by the Department, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.
    c) The PHP's pharmacy claim processing system shall have the ability to integrate Member pharmacy claims and diagnosis history to automate the adjudication of pharmacy claims requiring PA based on criteria requiring the existence of diagnosis or prior pharmacy claims history.

e. Pharmacy services website

i. The PHP shall maintain its own pharmacy services web page available to providers and Members with information regarding the drug formulary and Utilization Management Policy.
ii. The PHP shall post to their pharmacy services web page, at a minimum:
    a) The drug formulary,
    b) Utilization Management Policy, including pharmacy clinical coverage and PA criteria; and
    c) PA request form(s).
iii. All additions or changes to the drug formulary, UM Policy and PA request form shall be posted thirty (30) calendar days prior to the effective date of the requirement or revision.
iv. If the PHP utilizes a Pharmacy Benefits Manager (PBM), the PHP's pharmacy services web page may direct providers and Members to their PBM's pharmacy services web page which shall adhere to all the same requirements outlined in this Section.

f. Pharmacy Benefit Managers
    i. The PHP may contract with a pharmacy benefits manager (PBM) to administer the pharmacy benefit.
    ii. If the PHP utilizes a PBM, the PHP shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor pharmacy benefit manager performance, and ensure the confidentiality of Member information and the Department information that is not public.
    iii. The PHP shall report all financial arrangements between the PHP/subcontractors and all drug-related companies to the Department on an annual basis. Drug-related companies include manufacturers, labelers, compounders, and benefit managers in a manner to be specified by the Department.
    iv. If the PBM is owned wholly or in part by a retail pharmacy participating provider, chain drug store or pharmaceutical manufacturer, the PHP shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of Member and the Department proprietary information.
    v. The PBM shall provide a liaison with whom the Department will communicate with directly. The PBM liaison shall be available for direct communication with pharmacy providers to resolve issues, and to work with the Department to resolve rebate issues resulting from the PHP's encounter and drug utilization files.

g. Pharmacy Programs:
    i. The PHP shall develop and maintain the following pharmacy programs.
        a) Drug Utilization Review
            1. As required by 42 C.F.R. § 438.3(s)(4), the PHP shall operate a drug utilization review (DUR) program that includes Prospective DUR, Retrospective DUR, and an educational program for prescribers and pharmacists and complies with 42 C.F.R. part 456, subpart K and Section 1927(g) of the Social Security Act.
            2. The Prospective DUR program shall:
                i. Operate at pharmacy point of sale.
                ii. Include, but not be limited to the following:
                    a) Screening for potential drug therapy problems due to therapeutic duplication,
                    b) Drug-disease contraindications,

c) Drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs),
d) Incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and
e) Clinical abuse or misuse; and
f) Include other parameters as appropriate.

3. The Retrospective DUR program shall, at a minimum:
   i. Address the following:
      a) Therapeutic appropriateness,
      b) Over- and under-utilization,
      c) Appropriate use of generic products,
      d) Therapeutic duplication, drug-disease contraindication,
      e) Drug-drug interaction,
      f) Incorrect drug dosage,
      g) Incorrect duration of drug treatment, and
      h) Clinical abuse or misuse;
   ii. At least a quarterly review of paid drug pharmacy and medical claims utilization data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and Members; and
   iii. Address other programs and initiatives as directed by the Department.
4. The Educational Program within the DUR for prescribers and pharmacists that includes, at a minimum, the following:
   i. Written, oral, or electronic reminders containing patient-specific or drug utilization review-specific information (or both) and suggested changes in prescribing or dispensing practices;
   ii. Face-to-face discussions, with follow up discussions when necessary, between health care professionals who are experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices;
   iii. Intensified review or monitoring of selected prescribers or pharmacists; and
   iv. Other educational activities as appropriate. 42 C.F.R. 456 subpart K.
5. The PHP shall implement DUR programs to address opioid misuse. The Department reserves the right to require the PHP to develop DUR programs for other targeted populations, drug classes and/or disease states.
6. The PHP shall provide a detailed description of its DUR program activities to the Department on an annual basis. 42 C.F.R. § 438.3(s)(5).
7. The PHP shall report DUR program data to the Department in a format consistent with the Department' reporting format for the CMS annual report no later than ninety (90) calendar days prior to the CMS due date.

b) Opioid Misuse Prevention Program is defined in *Section V.C.7. Prevention and Population Health Management Programs*.

h. Pharmacy Reimbursement
   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 the same rate as the Medicaid and NC Health Choice Fee-for-Service dispensing fee as determined by a 2015 cost of dispensing (COD) study. The COD study determined the pharmacy dispensing fee to be $10.24.
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.

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 may elect to reimburse pharmacies using a flat dispensing fee or use a tiered dispensing fee based upon a pharmacy's generic dispensing rate.

iv. The PHP shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.

v. 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.

vi. 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.

vii. 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.

i. Drug Rebates

i. The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid and NC Health Choice Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid or NC Health Choice Program to a PHP. The PHP or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid and NC Health Choice program. If the PHP or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid and NC Health Choice covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.

ii. The PHP shall submit outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims encounter data to the Department or its Encounter Data Processing vendor on a weekly basis, no later than seven (7) calendar days following the date on which the PHP or its Subcontractor adjudicated the claims for drug rebate invoicing as defined in *Section V.H.2 Encounters.*

iii. The PHP shall submit all pharmacy and medical drug encounter data for rebate invoicing in a format determined by the Department or its Drug Rebate vendor. At a minimum, the data should be at claims level and include the total number of units by strength by National Drug Code (NDC) of each covered outpatient pharmacy drug, outpatient hospital drug and physician administered drug paid for by the PHP or its Subcontractor. 42 C.F.R. § 438.3(s)(2)

iv. The PHP shall submit drug encounters using a HCPCS/CPT code with the following:
    a) An NDC that is appropriate for the HCPCS/CPT code based on the drug description, strength and date of service.
    b) HCPCS/CPT units and NDC units reported represent a medically appropriate dosing and package size.
    c) Date of service that is not past the termination date of the drug.
    d) An NDC that is from a rebate-eligible manufacturer on the date of service of the claim. 42 C.F.R. § 438.3(s)(2)

v. 340B covered entities:
    a) The PHP pharmacy provider contracts shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit national Council for Prescription Drug Programs (NCPDP) code "8" in Basis of Cost Determinations filed 423-DN or in Compound Ingredient Basis of Cost Determination filed 490-UE or a '20' in the submission clarification code field (NCPDP D.0 field 420-DK) at the point of sale to identify claims submitted for drugs purchased through the 340B program.
    b) The PHP pharmacy provider contracts shall require 340B covered entities to identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3).
    c) The PHP pharmacy provider contracts shall require that 340B covered entities' written agreements with contracted pharmacies specify that contract pharmacies comply with the point of sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3).
    d) The PHP pharmacy provider contracts shall require contract pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).
    e) The PHP shall report to the Department the commencement, conclusion and final results of all HRSA audits.
    f) The PHP shall review 340B covered entities' HRSA audits and coordinate with the Department to ensure the prevention of duplicate discounts.

vi. The PHP shall disclose to the Department all financial terms and arrangements for remuneration of any kind that apply between the PHP and other entities identified in the PHP Operating Plan and any drug manufacturer, labeler or pharmacy benefit manager (PBM) including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.
    a) The Department shall maintain the confidentiality of information disclosed by the PHP pursuant to this Section, to the extent that the information is confidential under North Carolina or federal law.
    b) The Department may audit financial terms and arrangements for remuneration of any kind that apply between the PHP and any drug manufacturer or labeler.

vii. The PHP shall support the Department with drug rebate dispute resolution processes within the timeframe requested by the Department.
    a) The PHP or its Subcontractor shall assign a single point of contact to research any encounters that are denied on submission to the Department or identified as a dispute by the drug manufacturers and within thirty (30) calendar days shall resolve.
    b) The PHP or its Subcontractor shall provide an explanation of such disputes to the Department at the encounter claim level in a spreadsheet.

c) If the encounter claim information is found to be in error, the encounter shall be voided within five (5) business days of the determination.

4. Transition of Care

a. The PHP shall develop policies, processes and procedures to support Members transitioning between PHPs or between delivery systems.

b. Immediately following the Department's notification to the PHP to proceed with contract services, the PHP shall provide the Department with a contact person for transition of care coordination on behalf of the PHP.

c. Regarding transition of care for newly enrolled Members transitioning to the PHP from Medicaid Fee-for-Service or another PHP and for Members transitioning out of a PHP to another PHP, the PHP shall follow the Department's Transition of Care Policy and, at a minimum, carry out the following responsibilities:

i. The PHP shall identify newly enrolled Members, as defined in the Managed Care Enrollment Policy, who are transitioning from another PHP or from Medicaid Fee-for-Service/LME/MCO.

ii. Provide for the transfer of relevant Member information, including medical records, care management records, open service authorizations, prescheduled appointments (including NEMT) and other pertinent materials, to another PHP, LME/MCO or Fee-for-Service program upon notification of establishment of care such that the transition of care shall be with minimal disruption to Members' established relationships with providers and existing care treatment plans.

a) If a Member enrolls with the PHP from another PHP, the PHP shall, within five (5) business days from the date of the Department's notification to the PHP of the Member's anticipated enrollment date, contact the Member to determine the name of the other PHP to request relevant Member information from the other PHP.

b) If the PHP is contacted by a Member's new PHP requesting relevant Member information, the PHP shall provide such data to the PHP within five (5) business days of receiving the request.

c) If the PHP becomes aware that a Member will transfer to another PHP, the PHP shall contact the other PHP within five (5) business days of becoming aware of the Member's transfer and shall share relevant Member information and respond to questions regarding the Member's care needs and services.

d) If the PHP receives new Members who were previously Members in the Fee-for-Service program, the PHP must contact the Member's AMH/PCP or the Department's designated Fee-for-Services Care Management vendor within five (5) business days of the Department's notification to the PHP of the Member's anticipated enrollment date, to request the necessary medical records and information.

iii. Ensure that any Member entering the PHP is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.

iv. The PHP shall allow a Member to complete an existing authorization period established by their previous PHP, LME/MCO or Medicaid Fee-for-Service. The PHP shall assist the Member in transitioning to an in-network provider at the end of the authorization period.

v. The PHP shall, in instances in which a Member transitions into a PHP from Medicaid Fee-for-Service, another PHP, or another type of health insurance coverage and the Member is in Ongoing Course of Treatment or has an ongoing special condition permit the Member

to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g).

vi. Allow pregnant Members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.

vii. The PHP shall continue to bear the financial responsibility of an enrolled Member who is admitted to an inpatient facility while covered by the PHP 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; and
8. 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 the Contract Award.

d. Transition of Care with Change of Providers

i. The PHP shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated from the PHP's network.

a) Provider Termination, Expiration or Nonrenewal of the Contract. In instances in which a provider leaves the PHP's network for expiration or nonrenewal of the contract and the Member is in Ongoing Course of Treatment or has an ongoing special condition, the PHP shall permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

b) Provider Termination for Reasons Related to Quality of Care or Program Integrity. In instances in which a provider leaves the PHP's network for reasons related to quality of care or program integrity, the PHP shall notify the Member in accordance with this Section and assist the Member in transitioning to an appropriate in-network provider that can meet the Member's needs.

ii. Member Notification of Provider Termination

a) The PHP shall provide written notice of termination of a network provider to all Members who have received services from the terminated provider within the sixty (60) calendar day period immediately preceding the date of notice of termination. 42 C.F.R. § 438.10(f)(1).

b) The PHP shall provide the written notice of termination of a network provider to Members within fifteen (15) calendar days of the provider termination, except if a terminated provider is an AMH/PCP for a Member. 42 C.F.R. § 438.10(f)(1).

c) If a terminated provider is an AMH/PCP for a Member, the PHP shall notify the Member within seven (7) calendar days of the following:
   1. Procedures for selecting an alternative AMH/PCP.
   2. That the Member will be assigned to an AMH/PCP if they do not actively select one within thirty (30) calendar days.

d) If a terminated provider is an AMH/PCP for a Member, the PHP shall validate that the Member selects or is assigned to a new AMH/PCP within thirty (30) calendar days of the date of notice to the Member and notifies the Member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.

e) The PHP shall use a Member notice consistent with the Department-developed model Member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).

iii. The PHP shall hold the Member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.

iv. The PHP shall establish a Provider Transition of Care Policy.

a) The Provider Transition of Care Policy shall include processes and procedures for:
   1. Coordination of care for Members who have an ongoing special condition;
   2. Coordination for Members discharged from a high level clinical setting;
   3. Coordination for Members seeing a provider that leaves the PHP's network;
   4. Coordination for Members needing to select a new AMH/PCP after a provider termination; and
   5. Other requirements as defined in this Section.

b) The PHP shall submit the Provider Transition of Care Policy to the Department for review and approval ninety (90) calendar days after the Contract Award.

5. Non-Emergency Medical Transportation

a. The PHP shall provide non-emergency medical transportation (NEMT) services to ensure that Members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid and NC Health Choice-enrolled providers.

b. The PHP shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program.

c. The PHP shall provide non-emergency medical transportation (NEMT) services for all enrolled Members:
   i. By the least expensive mode available and appropriate for the Member;
   ii. To the nearest appropriate medical providers; and
   iii. For a Medicaid covered service, including services carved out of Medicaid Managed Care, provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider).

d. When providing NEMT services, the PHP shall use the most appropriate form of transportation to meet the needs of the Member.

e. NEMT services shall include:

i. NEMT transportation vendors including public transportation, taxis, van, wheel-chair vans, mini-bus, mountain area transports, or other transportation systems and non-medically necessary ambulance transportation.
ii. Other Transportation Services including volunteers, family members and friends, attendant expenses, ancillary costs and attendant pay, and non-emergency air travel.
iii. Travel related expenses including food parking fees/tolls, transportation vouchers (i.e. taxis, ride sharing services, public transit), and mileage.

f. The PHP shall guarantee the following rights to Members:
   i. To be informed of the availability of Medicaid non-emergency medical transportation;
   ii. To be informed that there is no cost to the Member;
   iii. To be informed of who may accompany a Member without cost;
   iv. To be informed that a Member under the age of eighteen (18) does not have to ride alone;
   v. To have the PHP's NEMT Policy, as defined below, explained including:
      a) How to request or cancel a trip;
      b) Limitations on transportation;
      c) Advanced notice requirements; and
      d) Expected Member conduct and procedures for no-shows.
   vi. To be transported to medical appointments if unable to arrange or pay for transportation and by means appropriate to circumstances;
   vii. To arrive at provider in time for the scheduled appointment; and
   viii. To request an appeal, as defined in the Contract, if the request for transportation assistance is denied.

g. The PHP shall not require Members to make transportation requests more than two (2) business days in advance.

h. The PHP shall ensure that an attendant is present with:
   i. Members under the age of eighteen (18), unless emancipated, at no additional cost to the Member or attendant. The attendant may or may not be the parent.
   ii. Members with special medical, physical or mental impediments, at no additional cost to the Member or attendant. The attendant may or may not be the parent.

i. The individuals included in *Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the PHP.

Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services	
North Carolina Health Choice Members	Not a covered benefit (unless offered by the PHP as a Value-Added benefit)
Members in a nursing home	The facility is responsible for providing transportation to their patients.
In patient hospitals/stays	Not a covered benefit

j. The PHP shall develop a network of NEMT providers sufficient to fulfill the requirements as outlined in this Section.
k. The PHP shall provide copies of its contract(s) with subcontractor(s) providing NEMT services upon Contract Award or within fourteen (14) calendar days of signing any new agreement or modification with the PHP's NEMT subcontractor(s).

l. The PHP shall develop, submit and maintain a NEMT Policy. The PHP shall submit the Policy ninety (90) days after Contract Award and annually thereafter, for use with Members.
   i. The Policy shall include, at a minimum, the following:
      a) Transportation options available to Members;
      b) Methods and process by which to request transportation;
      c) Driver and vehicle requirements;
      d) Process for transportation assessment;
      e) Member rights and responsibilities; and
      f) Hours of operation.
   ii. The Policy shall adhere to the following:
      a) Transportation shall be scheduled so that the Member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one (1) hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;
      b) Members cannot be required to make transportation requests in person;
      c) Urgent transportation services are exempt from any advance notice requirement;
      d) The Department's requirements for written materials; and
      e) All other requirements defined in this Section.

6. Care Management

a. Care Management and Care Coordination
   i. The Department seeks a PHP to provide access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care, pharmacies, and community-based resources. Members with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan. The PHP shall ensure that it operates a care coordination and care management program that meets the requirements of this Section and the Department's Care Management Policy and helps to improve patient care and health outcomes while reducing inappropriate hospitalization and other unnecessary costs.
   ii. The PHP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision for care management, including the capability to analyze data to identify patients who would benefit from care management; the capabilities to share data with practices through data transmission and a data portal; a care management IT platform that enables care managers to access all Member clinical data in support of care management activities and to store care management assessments and care plans.
   iii. Care Coordination for All Members
      a) The PHP shall ensure that each Member has an ongoing source of care appropriate to his or her needs. The PHP shall establish policies and procedures to deliver care to, and coordinate services for, all Members, regardless of risk or need, including meeting all provisions noted in 42 C.F.R. § 438.208.
      b) The PHP shall ensure that each provider furnishing services to Members maintains and shares, as appropriate, a Member health record in accordance with professional standards and state and federal law.
      c) The PHP shall establish policies and procedures for coordination between physical and behavioral health providers and between mental health and substance use providers.

d) The PHP shall establish policies and procedures to coordinate with services provided by community and social support providers, and to provide linkages with community resources. 42 C.F.R. § 438.208(b)(2)(iv).

e) For Members with identified unmet health-related resource needs, the PHP shall, as part of care coordination:

1. Coordinate services provided by community and social support providers to address Members' unmet health-related resource needs;
2. Link Members to local community resources and social supports; and
3. Modify their approaches based on tracking of outcomes, as needed.

iv. Identification of High-Need Members Needing Care Management

a) Care Needs Screening

1. The PHP shall undertake best efforts to conduct a Care Needs Screening of every member within ninety (90) calendar days of the effective date of enrollment. The PHP shall expedite this screening process for all newly enrolled members in the Aged, Blind, Disabled (ABD) Category of Aid who have not otherwise been identified as a High Need members. 42 CFR 438.208(b)(3).
    i. The purpose of the Care Needs Screening shall be to provide the PHP with general information about Members' health and to identify Members with unmet health-related resource needs who may require a Comprehensive Assessment, as defined by the Contract, for care management.
    ii. The Department defines "best efforts" as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful. The PHP shall develop processes and procedures to maximize rate of response on the screening.
2. Each PHP shall establish an evidence-based or evidenced-supported tool to conduct the Care Needs Screening. At a minimum, the tool shall identify:
    i. Chronic or acute conditions;
    ii. Chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
    iii. Behavioral health needs, including opioid usage and other substance use disorders;
    iv. Members at risk of requiring LTSS;
    v. Medications—prescribed and taken; and
    vi. Other factors or conditions (e.g., pregnancy) about which the PHP would need to be aware to arrange available interventions for the Member.
3. The PHP shall include standardized unmet health-related resource need questions to be provided by the Department for use in all Care Needs Screenings, covering four (4) priority domains:
    i. Housing;
    ii. Food;
    iii. Transportation; and
    iv. Interpersonal Safety.
4. The PHP shall verify that any Care Needs Screenings conducted by designated care management entities are completed in a timely manner and results of the screenings are routed back to the PHP.
5. The PHP shall share the results of the Care Needs Screening with each Member's assigned AMH/PCP within seven (7) calendar days of screening, or

within seven (7) calendar days of assignment of a new AMH/PCP, whichever is earlier.

6. The PHP shall share with any other Designated Care Management Entity who may be serving the Member the results of the Care Needs Screening within seven (7) calendar days of screening.
7. If a Member's eligibility is reinstated to Medicaid and it has been more than ninety (90) days from the Member's previous eligibility, the PHP shall conduct the Care Needs Screening again within ninety (90) days.
8. In the event that the Care Needs Screening identifies a Member as part of a priority population for care management, a Comprehensive Assessment shall be conducted to determine that Member's care management needs.
9. The PHP must attempt a Care Needs Screening at least annually for individuals not engaged in care management.

b) Identification of Priority Populations through Risk Scoring and Stratification

1. The PHP shall use risk scoring and stratification to identify Members who are part of priority populations for care management and should receive a Comprehensive Assessment to determine their care management needs.
2. The Department defines "priority populations" as populations likely to have care management needs and benefit from care management, including the following:
    i. Individuals with Long Term Services and Supports (LTSS) needs;
    ii. Adults and children with Special Health Care Needs;
    iii. Individuals identified by the PHP as at Rising Risk;
    iv. Individuals with high unmet health-related resource needs, as defined at a minimum to include:
        a) Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
        b) Members experiencing or witnessing domestic violence or lack of personal safety; and
        c) Members showing unmet health-related needs in three or more Opportunities for Health domains on the Care Needs Screening;
    v. At-Risk Children (age 0-5);
    vi. High-Risk Pregnant Women; and
    vii. Other priority populations as determined by the PHP (i.e. Members with complex conditions like HIV, Hepatitis C, or Sickle Cell).
3. Each PHP's risk scoring methodology and stratification methodology shall take into account, at a minimum, the following information:
    i. Care Needs Screening results, including the content of the screening assessing unmet health-related resource needs;
    ii. Claims history;
    iii. Claims analysis;
    iv. Pharmacy data;
    v. Immunizations;
    vi. Lab results;
    vii. Admission, Discharge, Transfer (ADT) feed information;
    viii. Provider referrals;
    ix. Referrals from social services
    x. Member's zip code
    xi. Member's race and ethnicity; and

xii. Member or caretaker self-referral.

4. In the event that the PHP identifies a Member as part of a priority population for care management, the PHP shall conduct a Comprehensive Assessment to determine that Member's care management needs.

c) Comprehensive Assessment to Identify High-Need Members

1. The PHP shall perform a Comprehensive Assessment for every Member who is:
   i. Identified through Care Needs Screening and/or risk stratification as being within a priority population, including members at risk of requiring LTSS;
   ii. Referred to the PHP for care management by a provider, Member (self-referral), family member, or other person or entity, including social services.
2. The Comprehensive Assessment shall identify ongoing special conditions that require a course of treatment or regular care monitoring
3. The Comprehensive Assessment shall be a person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive care management and will inform the Member's ongoing care plan and treatment.
4. The PHP shall develop and deploy Comprehensive Assessments tailored to Members that include, at a minimum, the following content
   i. Member's immediate care needs;
   ii. Member's current services;
   iii. Other state or local services currently used;
   iv. Physical health conditions, including dental conditions;
   v. Current and past mental health and substance use status and/or disorders;
   vi. Physical, intellectual, or developmental disabilities;
   vii. Medications – prescribed and taken;
   viii. Available informal, caregiver, or social supports, including peer support
   ix. Current and past mental health and substance use status and/or disorders;
   x. Four priority unmet health-related resource domains;
   xi. Any other ongoing special conditions that require a course of treatment or regular care monitoring;
   xii. At the PHP's option, for adults only exposure to adverse childhood experiences (ACEs) or other trauma;
   xiii. Risk factors that indicate an imminent need for LTSS; and
   xiv. Care giving-related needs of member's unpaid, information caregiver.
5. The PHP shall develop methodologies and tools for conducting the Comprehensive Assessment, as appropriate for differing Member demographics and needs.
6. The PHP shall undertake best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more priority populations or having received a referral for care management.
7. The PHP shall conduct the Comprehensive Assessment in a location that meets the Member's needs.

8. The PHP shall not withhold necessary services for Members while awaiting completion of the Comprehensive Assessment.
9. The PHP shall ensure that a Comprehensive Assessment is completed or re-completed for all Members, including re-assessment for Members already assigned to care management:
    i. At least annually;
    ii. When the Member's circumstances or needs change significantly; and/or
    iii. At the Member's request.
10. The PHP shall share the results of the Comprehensive Assessment with the Member, Member's AMH/PCP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law.
11. In situations where the AMH/PCP develops the Comprehensive Assessment, the AMH/PCP shall share the results of the Comprehensive Assessment with the Member's PHP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law
12. If the Comprehensive Assessment determines that the Member does not require care management, the PHP shall document that determination and will not be required to develop a Care Plan.
13. The PHP's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.

d) Treatment of Members needing LTSS: All Members identified as needing LTSS or at risk of requiring LTSS, shall be categorized as high-need Members and shall therefore receive care management.

v. Provision of Care Management for High-Need Members

a) Development of Care Plan

1. Using the findings of the Comprehensive Assessment, the PHP shall develop a Care Plan for each high-needs Member. 42 C.F.R. § 438.208(c)(3).
2. The PHP shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.
3. The PHP shall undertake best efforts to complete each Care Plan within thirty (30) calendar days of completion of the Comprehensive Assessment and in accordance with any applicable state quality assurance and utilization review standards.
4. The PHP shall ensure that development of the Care Plan does not delay the provision of needed services to a Member in a timely manner, even if that Member is waiting for a Care Plan to be developed.
5. The PHP shall ensure that each Care Plan incorporates findings of the Care Needs Screening (including unmet health-related resource need questions), claims analysis and risk scoring, the Comprehensive Assessment, any available medical records, and other sources as needed.
6. Each Care Plan shall contain, at a minimum:
    i. Measurable goals;
    ii. Medical needs including any behavioral health or dental needs;
    iii. Interventions including addressing medication management, including adherence;

iv. Intended outcomes;
v. Social, educational, and other services needed by the Member.

7. The PHP shall ensure that the Care Plan is regularly updated to address gaps in care, incorporating input from care team Members and Member, as part of care management; and that the Care Plan will be comprehensively updated:
   i. At minimum every twelve (12) months;
   ii. When a Member's circumstances or needs change significantly;
   iii. At the Member's request; and/or
   iv. When a re-assessment occurs
8. The PHP shall ensure that each Care Plan is documented and stored and made available to the Member and care team members, including the Member's AMH/PCP.

b) Care Management Services

1. The PHP shall provide care management, according to the Care Plan developed, to each high-need Member or through a contracted AMH, consistent with local care management requirements.
2. The PHP shall ensure that care management includes:
   i. Coordination of physical, behavioral health and social services;
   ii. Medication management, including regular medication reconciliation and support of medication adherence;
   iii. Progress tracking through routine care team reviews;
   iv. Referral follow up;
   v. Peer support;
   vi. Training on self-management, as relevant; and
   vii. Transitional care management (as described below), as needed.
3. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum:
   i. Use the "NC Resource Platform" to identify community-based resources and connect Members to such resources, to the extent the "NC Resource Platform" is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1.
      a) The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources.
      b) The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.
   ii. Provide in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, at a minimum to:
      a) Food and Nutrition Services;
      b) Temporary Assistance for Needy Families;
      c) Child Care Subsidy; and
      d) Low Income Energy Assistance Program.

iii. Have a housing specialist on staff or on contract who can assist individuals who are homeless in securing housing; and
iv. Provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.

4. The PHP shall provide every high-need Member with a designated care manager.
5. The PHP shall establish a multi-disciplinary care team for each high-need Member that consists of, where applicable depending on Member needs:
   i. The Member;
   ii. Caretaker(s)/legal guardians;
   iii. AMH/PCP;
   iv. Behavioral health provider(s);
   v. Specialists;
   vi. Nutritionists; and
   vii. Pharmacists and Pharmacy Techs.
6. The PHP shall ensure timely communication across the care team.
7. The PHP shall ensure that each high-need Member is informed of:
   i. The nature of the care management relationship;
   ii. Circumstances under which information will be disclosed to third parties;
   iii. The availability of the grievance and appeals process as described in *Section V.B.6. Member Grievances and Appeals*; and
   iv. The rationale for implementing care management services.
8. The PHP shall develop policies and procedures to close out the Care Plan process, should the care team determine that the Member no longer requires an ongoing Care Plan. Policies and procedures for closeout shall include Member notification processes.
   i. Upon termination of an LTSS service that results in the member no longer meeting the LTSS definition, a PHP shall continue to provide care management to the member for a time determined by individual circumstance and documented in the care plan to minimize disruption and ensure continuity of care after the service termination.

c) Transitional Care Management
1. The PHP shall manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. 42 C.F.R. § 438.208(b)(2)(i).
2. As specified in the Department's Transitions of Care Policy, the PHP shall manage transitions of care for identified Members transitioning between PHPs or between payment delivery systems.
3. The PHP shall develop policies and procedures for transitional care management consistent with the requirements provider here and in the Department's Transitions of Care Policy.
4. The PHP shall develop a methodology for identifying Members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:
   i. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;

ii. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
iii. NICU discharges; and
iv. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the PHP may prioritize.

5. As part of transitional care management, the PHP shall:
   i. Outreach to the Member's AMH/PCP and all other medical providers;
   ii. Facilitate clinical handoffs;
   iii. Obtain a copy of the discharge plan and verify that the care manager of the Member receives and reviews the discharge plan with the Member and the facility;
   iv. Ensure that a follow up outpatient and/or home visit is scheduled within a clinically appropriate time window;
   v. Conduct medication management, including reconciliation, and support medication adherence;
   vi. Ensure that a care manager is assigned to manage the transition;
   vii. Ensure that the assigned care manager rapidly follows up with the Member following discharge; and
   viii. Develop a protocol for determining the appropriate timing and format of such outreach.
6. The PHP shall ensure that Comprehensive Assessment is completed and current for all enrollees upon completion of transitional care management, including re-assessment for enrollees already assigned to care management.
7. The PHP shall have access to an ADT data source that correctly identifies when Members are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.
8. As part of transitional care management, the PHP shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
   i. Real time (minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
   ii. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted to the hospital;
   iii. Additional outreach within several day days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED (e.g. to assist with scheduling appropriate follow up visits or medication reconciliations post discharge).

d) HIV Case Management Providers
   1. The PHP may contract with existing HIV Case Management providers, at their discretion.
   2. The PHP shall coordinate with local Ryan White HIV case management programs and providers.

e) Care Management for individuals receiving or at risk of requiring Long Term Services and Support (LTSS)
   1. The PHP shall meet all general care management requirements for Members with LTSS needs and shall meet additional requirements for Members with LTSS

needs as described in this subsection and in accordance with 42 C.F.R. § 438.208.

2. The PHP shall conduct a Comprehensive Assessment for all Members identified as needing LTSS. The PHP shall use a Comprehensive Assessment tool to conduct such assessments that meets all requirements for Comprehensive Assessments given above.
3. The PHP shall ensure that the care manager may elect to put an interim plan in place to ensure that the Member's needs are met while the Care Plan is developed.
4. The PHP shall provide transitional care management for Members with LTSS from a nursing facility or other institution that includes outreach to a Member's prior care managers, Member's PCP and all other medical providers. The PHP shall define transition out of an institution as a change in Member circumstance and cause for re-assessment.
5. The PHP's transitional housing specialist shall ensure that Members using LTSS transitioning from nursing facilities to the community are connected to appropriate housing options as needed.
6. The PHP shall re-assess Member needs for Members with LTSS needs, and review and revise a Member's care accordingly, at least every twelve (12) months, at the request of the Member, or when the Member's circumstances change. A change in Member circumstances could include an increased need for care, decreased need for care, transition into or out of an institution, loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance. The PHP shall participate in Department sponsored webinars, trainings and continuing education opportunities about LTSS-related practices and requirements as identified by the Department.

vi. Care Manager Qualifications and Training

a) The PHP shall ensure that the clinician leading the care team has the minimum credentials of RN or LCSW.
b) The PHP shall engage appropriate staff on the care team to meet the needs of the Members including medical and behavioral health specialists, pharmacists and pharmacy technicians, peer specialists, navigators, and community health workers.
c) The PHP shall require that care management staff show competency in areas including:
    1. Person-centered needs assessments and care planning;
    2. Motivational interviewing;
    3. Self-management;
    4. Trauma informed care;
    5. Cultural competency;
    6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
    7. Understanding and addressing Adverse Childhood Experiences (ACEs) and trauma.
d) Qualifications for care managers for Members with LTSS needs shall meet the minimum requirements defined within this Contract for all other care managers herein and shall additionally include, at a minimum:
    1. Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience;

2. Prior experience with social work, geriatrics, gerontology, pediatrics, or human services.

e) The PHP shall ensure that care manager training include at a minimum:
   1. Self-management, including medication adherence strategies;
   2. Motivational interviewing or comparable training;
   3. Person-centered needs assessments and care planning;
   4. Integrated and coordinated physical and behavioral health care;
   5. Execution of Comprehensive Assessments of Members;
   6. Services available only through BH I/DD TPs, BH I/DD TP eligibility criteria, and the process for a Member who needs a service that is available only through BH/IDD Tailored Plans to transfer to a BH I/DD Tailored Plans;
   7. BH crisis response (for care managers with assigned Members with BH needs);
   8. Transitional care management;
   9. Cultural competency, including considerations for Tribal population for PHPs that enroll Tribal members;
   10. Understanding and addressing ACEs, Trauma, and Trauma Informed Care; and
   11. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level.

f) The PHP shall train care managers for Members with LTSS needs in the training listed herein and additionally in LTSS care management including:
   1. Person-centered needs assessment and care planning related to populations with LTSS needs;
   2. Cultural competency for populations with LTSS needs;
   3. Independent living;
   4. Methods for supporting applicable Member to prepare for pending Medicare eligibility and enrollment;
   5. Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission; and
   6. Methods for effectively coordinating with school-related programming and transition-planning activities.

g) The PHP shall ensure that care managers remain conflict-free, which shall be defined as not being related by blood or marriage to a Member, financially responsible for a Member, or with any legal power to make financial or health related decisions for a Member.

b. Local Care Management and Related Programs

i. The Department seeks a Contractor that has the ability to provide a robust system of local care management—care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible. Local care management is the preferred approach to care management. The PHP shall have an established system of care management through Advanced Medical Home (AMH), and defined in *Attachment M. 2. Advanced Medical Home Program Policy*, and Local Health Departments that will provide high quality care to Members. The Department's AMH framework, is intended to be a minimum initial framework laying out basic requirements on top of which PHPs and AMHs are encouraged to innovate around payment and delivery models according to their strategies, capabilities, and preferences – and, most importantly, the needs and

preferences of Medicaid beneficiaries. Aspects of the Department's AMH model, including further definition around AMH Tier 4, will evolve over time based on experiences in the market and input from stakeholders.

ii. General Requirements for Local Care Management

a) The PHP shall ensure that the majority of its high-need Members in each Region receive care management services through local care management, which includes care management provided by AMHs or LHDs as well as care management provided by the PHP that is delivered locally.

b) To facilitate the implementation of local care management, the PHP shall designate care management responsibility to AMH Tier 3 practices, as defined in *Attachment M. 2. Advanced Medical Home Program Policy*, and Local Health Departments.

c) The PHP shall remain responsible for care management delivered through local care management and shall be responsible for oversight of AMH Tier 3 practices and Local Health Departments.

d) The PHP shall ensure that any care management and care coordination requirements that apply to the PHP will also apply to the PHP's AMH Tier 3 practices, as applicable. Specific program requirements for Care Management for High Risk Pregnancy and Care Management for At-Risk Children are found in *Attachment M. 4. Care Management for High-Risk Pregnancy Policy* and *Attachment M. 5. Care Management for At-Risk Children Policy*.

e) For At-Risk Children (age 0-5) with complex medical needs, the PHP shall coordinate with the Member's assigned AMH to lead the provision of care management for that Member. The PHP may also involve the LHD for support for unmet health-related resource or care coordination needs identified in the Care Plan.

f) The PHP shall ensure that the elements of care management described below are conducted by a consistent entity and care manager/care team, to the maximum extent possible.

g) In the event that a Member is receiving care management from more than one entity, the PHP shall ensure that the Member's care plan(s) document respective, non-overlapping roles and responsibilities between the PHP, AMH Tier 3 practices and/or Local Health Departments.

h) The PHP shall develop and implement policies and procedures, within parameters established by the Department, to verify that AMH Tier 3 practices and Local Health Departments meet all federal and state requirements related to their designated services.

iii. Local Care Management Provided by AMH Tier 3 Practices

a) The PHP shall contract with all AMH Tier 3 practices located in each PHP region.

b) The PHP shall designate each AMH Tier 3 practice as holding primary responsibility for conducting the comprehensive assessment, providing care management, and providing transitional care management for such practice's high-needs Members.

c) The PHP shall permit the AMH Tier 3 to take on additional care management functions, subject to AMH Tier 3 and PHP mutual agreement.

d) The PHP shall coordinate with, and provide support to, the AMH Tier 3 practice in performance of care management responsibilities and any additional, mutually agreed upon AMH Tier 3 care management functions.

iv. Advanced Medical Home Contracting

a) General Requirements

1. The PHP shall only contract with a PCP as an AMH provider if the PCP has been certified as an AMH by the Department.

2. PHPs shall not be required to contract with any particular entity to meet Advanced Medical Home requirements.
3. The PHP shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices, as applicable based on if a practice is AMH Tier 1, 2 or 3, and as noted in *Attachment M. 2. Advanced Medical Home Program Policy.*
4. The PHP shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the AMH practice and the PHP.
5. The PHP shall be required to participate in Department-led meetings involving the AMH program, including providing appropriate clinical and operational leadership in meetings.
6. The PHP shall be required to track all Department-led AMH programmatic changes, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP operations and AMH contracts, as applicable, and within Department-specified timelines.
7. Nothing in this Section shall be interpreted to preclude the PHP from developing additional relationships or agreements related to care management.

b) Advanced Medical Home Quality Metrics
   1. Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for PHPs, the PHP shall compile and calculate each of the AMH quality metrics for each AMH practice and share them with the Department.
   2. The PHP shall provide feedback on quality scoring results to each AMH practice.
      i. The Department will provide the PHP with AMH measure set and reporting schedule at award.
   3. The PHP shall develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics.

c) Advanced Medical Home Data and Information Sharing
   1. In cases where the Department establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department.
      i. In order to support care management activities, the PHP shall provide the following information to all AMH practices and LHDs providing care management of high risk pregnancy and at -risk children, at a minimum:
      ii. Member Assignment Files to include:
         a) Point-in-time assignment information on at least a monthly basis.
         b) Projected assignment information for the following month (to the extent information is available).
         c) Information about newly-assigned Members to the PHP, within seven (7) business days of enrollment (more rapid notification may be required for assignment of newborns).
         d) Notifications of any ad-hoc changes in assignment as they occur, within seven (7) business days of each change.
      iii. Risk Stratification information
         a) The PHP shall share PHP-furnished risk scoring results with all AMH practices (regardless of tier), including (where possible and relevant) Member-level information about cost and utilization outliers.

b) The PHP shall notify AMHs when Members fall into required Department priority population categories (i.e. "Special Health Care Needs").
c) The PHP is encouraged to share types or categories of risk stratification model inputs (i.e. frequent hospital utilization) that can inform specific actions by the AMH.

iv. Initial Care Needs Screening information
a) The PHP shall share the results of all available Initial Care Needs Screenings with primary care providers in all AMH tiers within seven (7) days of screening, or within seven (7) days of assignment of a new PCP or AMH, whichever is earlier.
b) The PHP shall identify Members they have not been able to contact for Initial Care Needs Screenings to primary care providers in all AMH tiers within seven (7) days of the end of the screening window.

v. Quality measure performance information at the practice level
a) The PHP shall provide feedback on quality scoring results to each AMH practice on both an annual and an interim basis as specified by the Department, and in a format to be defined by the Department.

vi. Encounter and Other Data
a) The PHP shall provide encounter data directly to AMH Tier 3 and 4 practices or to their designated CINs or third-party partners, as appropriate, using the same specifications that the PHP will use to share encounter data with the Department.
b) Data flows from the PHP to AMHs, CINs or delegated partners of AMH Tier 3 and 4 practices shall only include attributed Member assigned to the receiving (or delegating) practices or groups of practices.
c) The PHP shall provide encounter, provider and Member data at least monthly, or more frequently as requested by the Department.
d) The PHP shall deliver pharmacy data at least weekly, or more frequently as requested by the Department.

2. The PHP shall participate in a Department-led Advisory Committee around AMH data sharing.
3. The PHP shall adopt standardized data sharing formats and protocols as they are developed by the Advisory Committee.
4. The PHP shall develop a strategy to share data with beneficiaries, in a format that is secure, takes into account varying levels of health literacy, and promotes Member engagement in care.

d) Advanced Medical Home Oversight
1. The PHP shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms.
2. In the event of underperformance by an AMH practice, the PHP shall send a notice of underperformance to the AMH practice and copy the Department.
3. In the event of continued underperformance (i.e. non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the PHP to stop paying the Care Management Fee and/or Medical Home Payment (as applicable based on Tier status) and downgrade the Tier status of the AMH for that PHP, only.

4. In the event that the PHP notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Payments that would otherwise be required by the Department, the PHP shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification.
5. In the event a practice is downgraded from Tier 3 to Tier 2, the PHP shall ensure that there are no gaps in care management functions for Members assigned to the practice.
6. The requirements of this subsection shall apply to all tiers of AMH practices, including Tier 3 AMHs providing Local Care Management and Tier 1 and Tier 2 AMHs that do not provide Local Care Management, unless otherwise specified.

v. Local Care Management Provided by Local Health Departments

a) General Requirements

1. In Contract Years 1-3, the PHP shall contract with each Local Health Department (LHD) in its Region(s) to provide care management services to High Risk Pregnant Women and At-Risk Children, to the extent that each LHD chooses to provide these services.
2. The PHP shall use standard contract language provided by the Department to contract with LHDs for the provision of care management services to High Risk Pregnant Women and At-Risk Children.
    i. The PHP shall incorporate all Department-defined care management practice standards for High Risk Pregnant Women and At-Risk Children into each of its contracts with LHDs, as noted in *Attachment M. 4. Care Management for High-Risk Pregnancy Policy* and *Attachment M. 5. Care Management for At-Risk Children Policy*.
    ii. The PHP shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the LHD and the PHP.
3. If an LHD in the PHP's Region(s) chooses not to provide care management services for High Risk Pregnant Women and/or At-Risk Children, then:
    i. The PHP shall be responsible for ensuring that those services are provided locally, either by another Local Health Department or in accordance with guidelines set by the Department; and
    ii. The PHP shall notify the Department and adhere to Department guidelines in securing coverage for the applicable county(ies).
4. In the event of underperformance by an LHD, the PHP shall follow standard procedures specified by the Department. In the event of continued underperformance by an LHD that is not corrected, the PHP shall be permitted to terminate the contract with that LHD with provider appeal rights to the PHP. The PHP shall notify the Department of underperformance or contract termination. The Department reserves the right to specify the timing and format of this notification.
5. The PHP shall be required to participate in Department-led meetings involving the High Risk Pregnant Women and Care Management for At-Risk Children program, including providing appropriate clinical and operational leadership in meetings.
6. The PHP shall be required to track all Department-led changes for the Care Management for High Risk Pregnant Women and the Care Management for At-Risk Children programs, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP

operations and LHD contracts, as applicable, and within Department-specified timelines.

b) Specific Requirements for Care Management for High Risk Pregnant Women
   1. Through contracting with LHDs using standard terms and conditions as described above, the PHP shall ensure that the functions of the Care Management for High Risk Pregnant Women that were in place prior to Medicaid Managed Care are performed for pregnant Members, including (but not limited to):
      i. Outreach;
      ii. Motivational interviewing;
      iii. Development of patient-centered care plans;
      iv. Identification of community resources available to meet the specific needs of the population; and
      v. Referrals to childbirth education, oral health, behavioral health or other needed services reimbursed by Medicaid.
   2. The PHP shall be permitted to add its own high-risk pregnancy care management functions and approaches in addition to the required Care Management for High Risk Pregnant Women program.
   3. The PHP shall identify high-risk pregnancies for referral to LHD Care Management and other high-risk pregnancy services that are available, through one or more of the following mechanisms:
      i. Standardized Risk Screening Tool conducted by providers;
      ii. Risk stratification by the PHP; and
      iii. Direct referral by providers, Members or families.
   4. The PHP shall send all screening information to the applicable LHDs or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancies in the Care Management of High Risk Pregnancies within one business day of Member's referral into care management.

c) Specific Requirements for Care Management for At-Risk Children
   1. Through contracting with LHDs using standard terms and conditions as described above, the PHP shall be required to ensure that the following functions are available to at-risk Members aged 0-5. These functions include, but are not limited to:
      i. Addressing unmet health-related resource needs;
      ii. Addressing family social needs; and
      iii. Forging and strengthening linkages with pediatric medical homes.
   2. The PHP shall be responsible for maintaining criteria already established for referrals for the following children:
      i. Children with Special Health Care Needs;
      ii. Children exposed to severe stress in early childhood, including:
         a) Extreme poverty in conjunction with continuous family chaos;
         b) Recurrent physical or emotional abuse;
         c) Chronic neglect;
         d) Severe and enduring maternal depression;
         e) Persistent parental substance abuse;
         f) Repeated exposure to violence in the community or within the family; and

g) Children in neonatal intensive care needing help transitioning to community/Medical Home care.

3. The PHP shall identify at-risk children for referral to Local Health Departments, by the following methods:
   i. Provider referrals;
   ii. Social service agency referrals (e.g. Care Management for High Risk Pregnant Women program, WIC, DSS);
   iii. Direct referral by Members or families; and
   iv. Risk stratification or other identification by the PHP.
4. When an at-risk child is identified for Care Management for At-Risk Children by an entity outside the PHP (e.g. pediatric practice), the PHP shall make the referral to a Local Health Department and inform that entity that the referral has been made.
5. The PHP shall send all screening information to the applicable LHDs or other applicable local care management entities that are contracted for the provision of providing care management services for at-risk children in the Care Management of At-Risk Children program within one business day of Member's referral into care management.

d) Pregnancy Management Program in Coordination with Care Management for High Risk Pregnant Women

1. The PHP shall be required to participate in Department-led meetings involving the PMP program, including providing appropriate clinical and operational leadership in meetings.
2. The PHP shall be required to track all Department-led PMP programmatic changes, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP operations and PMP contracts, as applicable, and within Department-specified timelines.
3. The PHP shall adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by the Department.
4. The PHP shall be responsible for receiving standardized screening tool results from PMP providers and for arranging intake into the Care Management for High Risk Pregnant Women program based on referrals by PMP providers.
5. When a high-risk pregnancy is referred to the PHP by a PMP provider, Member, family or other entity, the PHP is responsible for arranging intake of the Member into the Care Management for High Risk Pregnant Women program and shall inform the Member's PMP provider that the Member has entered the program.

c. AMH/PCP Choice and Assignment

i. Consistent with 42 C.F.R. § 438.3(l), the PHP shall ensure that each Member has a choice of AMH/PCP.

ii. The PHP shall, in instances in which a Member does not select an AMH/PCP at the time of enrollment, assign the Member to an AMH/PCP within 24 hours of effectuation date of enrollment in PHP. The PHP shall allow AMHs/PCPs to set limits on panel size and shall have a process for AMHs/PCPs to do so.

iii. The PHP's methodology for assigning Members to an AMH/PCP shall include the following components, in this order, to the extent that such information is available.
   a) Prior AMH/PCP assignment;
   b) Member claims history;

c) Family member's AMH/PCP assignment;
d) Family member's claims history;
e) Geographic proximity;
f) Special medical needs; and
g) Language/cultural preference

iv. In Contract Year 2 (or another date identified by the Department), the Department may direct the methodology to include AMH tier 3 status.

v. The Department reserves the right to adjust the AMH/PCP methodology for assigning Members to AMH/PCP as defined in this Contract and to audit the PHP's AMH/PCP auto-assignment logic upon request.

vi. When applicable, the PHP shall notify Members when they have been assigned to an AMH/PCP.

vii. Members can change their AMH/PCP without cause twice per year. Members shall be given thirty (30) days from receipt of notification of their AMH assignment to change their AMH/PCP without cause (1st instance) and shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance).

viii. In addition, Members shall be allowed to change their AMH/PCP with cause at any time.

ix. The Department shall consider the following as appropriate "cause" for Member AMH/PCP changes:
   a) The provider has failed to furnish accessible and appropriate medical care, services or supplies to which the Member is entitled under the terms of the contract under which the PHP has agreed to provide services. This includes, but is not limited to, the failure to:
      1. Provide primary care services;
      2. Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
      3. Arrange for consultation appointments;
      4. Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
      5. Arrange for services with qualified licensed or certified providers;
      6. Coordinate the Member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;
   b) The Member disagrees with a treatment plan;
   c) The Member and provider are not able to communicate due to a language barrier or other impediment to communication;
   d) The provider is not able to reasonably accommodate the Member's special needs;
   e) There is a change in the provider's practice, including but not limited to the following:
      1. The provider moves to a location that is not convenient for the Member;
      2. There is a significant change in the hours the provider is available and the Member cannot reasonably make appointments during the new hours;
      3. The provider no longer has hospital access.
   f) The Member and the provider agree that a change would be in the best interest of the Member; or
   g) The provider leaves the PHP's network.

x. The PHP shall allow PCPs to request removal of a Member from his/her panel and must submit to the Department their process for reviewing and approving such removal requests.

xi. The PHP shall allow Members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such Members direct access to a specialist as appropriate to the Member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).

d. The PHP shall develop a comprehensive Care Management Policy that outlines the PHP's approach to meet the requirements of this Section. The PHP shall submit the Policy for review and approval by the Department ninety (90) days after Contract Award and annually thereafter.
   i. The Care Management Policy shall include the PHP's policies and process for:
      a) Conducting Care Needs Screenings, including but not limited to:
         1. Care Needs Tool(s) Question used;
         2. Method for screening, including any tailoring for specific populations (including LTSS);
         3. Strategies to increase completion rates;
         4. Processes and timelines for reassessment based on PHP analytics or other best practices; and
         5. Strategies to use over time to screen Members for unmet health-related resource needs routinely, in addition to at initial enrollment.
      b) Other Member need identification methods including:
         1. Regular claims analysis and risk scoring;
         2. Provider referral (including communication to providers for how they may refer into care management); and
         3. Member self-referral (including communication to Members for how they may refer into care management).
      c) Risk scoring and stratification:
         1. Information and data to be utilized;
         2. Description of the methodology;
         3. Methodology for identifying members of priority populations;
         4. Number of risk strata;
         5. Criteria for each risk stratum (i.e. risking, high, low, medium risk);
         6. Approximate expected population and penetration rate in each stratum by priority population.
      d) Comprehensive Assessment, including but not limited to:
         1. Assessment Tools/Questions used;
         2. Variation in Comprehensive Assessment based on population (including LTSS);
         3. Expected volume of Comprehensive Assessment by priority population monthly and annually;
         4. Method of conducting the Comprehensive Assessment based on Member needs or other factors; and
         5. Approach to determining when high-need Members will receive face-to-face care management.
      e) Care plan development with Members including:
         1. Approach to identification of the threshold for high-need care management / care plans;
         2. Approach for involving multi-disciplinary care team;
         3. Approach for ensuring that care plans are individualized and person-centered and the Member and the Member's family, advocates, caregivers, and/or legal guardians are actively involved; and
         4. Process for and frequency of Care Plan updates.

f) Training and Qualification of care managers and other multidisciplinary team members including timing/frequency of training and ongoing continuing education;
g) Care coordination, including assigning ongoing source of care, coordination across settings of care, and coordination during Member transitions (including transitions from a Standard Plan to a BH I/DD TP, from Medicaid Fee-for-Service into Medicaid Managed Care, among managed care organizations, among payers, and between community and social support providers). The PHP shall conduct telephonic outreach to Members if they have been identified by the Department as eligible for a BH I/DD Tailored Plan and provide information about the process for transition to a BH I/DD Tailored Plan;
h) Linkages with community resources for all Members as needed, including for those identified as having unmet health-related resource needs;
i) Providing information and navigation regarding community providers of social services and tracking effectiveness of these interventions;
j) Transitional care management, including the approach to working with Members with LTSS needs;
k) Written Local Care Management Plan, including the approach to:
    1. Providing care management through local care management;
    2. Determining when care management should be conducted face to face;
    3. Working with LHDs;
    4. Contracting with at least eighty percent (80%) of Tier 3 AMH practices; and
    5. Working with AMH practices generally.
    6. Include the names and proposed service area of Designated Care Management Entity(s).
l) Requisite health IT infrastructure technologies and data privacy security policies.
m) Planned methodology and schedule for sharing patient data with AMH practices.
n) Methodology for AMH quality measurement incentive payments.

ii. The PHP shall modify Care Management Policy based on EQRO review, Department review, or care management improvement activities as part of the QAPI.

7. Prevention and Population Health Management Programs

a. The Department expects the PHP to use innovative methods to promote better health outcomes, such as rewarding Members and providers for improved outcomes and partnering with other agencies and organizations to work toward the aims of the Department's public health goals and Quality Strategy. The PHP must take a population-based approach to improving the overall health of Medicaid Members and work collaboratively with community partners on targeted public health initiatives (e.g. opioid crisis, infant mortality).

b. The PHP shall establish prevention and population health programs aligned with the Department's larger public health goals and Quality Strategy. The Department will provide population-level measures to the PHP, such as measures related to infant and maternal mortality, that are intended to inform the PHP about regional trends and assist the PHP in performance improvement efforts.

c. The Department's selected population health priorities as defined in the Quality Strategy, include:
    i. Diabetes;
    ii. Asthma;
    iii. Obesity;
    iv. Hypertension;

v. Tobacco cessation;
vi. Infant mortality;
vii. Low birth weight;
viii. Early childhood health and development; and
ix. Additional prevention and population health management programs to encourage improved health and wellness among Members.

d. The PHP shall identify individuals for prevention and population health programs through several mechanisms, including but not limited to:
   i. Care Needs Screenings;
   ii. Claims analysis and risk scoring;
   iii. Provider referral; and,
   iv. Member self-referral.

e. The PHP shall ensure that prevention and population health programs are available to all Members.

f. The PHP will be expected to engage as active partners in Healthy NC 2020 and 2030 planning, including thorough review and discussion of PHP-level data and quality performance consistent with *Section V.E.1. Quality Management and Quality Improvement.* The PHP should incorporate information from LHD Community Health Assessment in the development of their Population Health programs.

g. Tobacco Cessation Services
   i. The PHP shall contract with the Department's Quitline vendor at a minimum benefit level defined by the Department that promotes evidenced base standard of care for tobacco cessation.
   ii. The PHP shall ensure that Members are given complete information about the coverage of tobacco cessation items and services.
   iii. The PHP shall partner with the Department to, at a minimum:
      a) Promote the full Tobacco Cessation Benefit to Members;
      b) Partner with Department and the Department's Quitline vendor on outreach;
      c) Submit marketing and educational materials for review and approval consistent with the requirements pursuant to the Contract.

h. Opioid Misuse Prevention Program
   i. The PHP shall implement:
      a) A comprehensive Opioid Misuse Prevention Program.
      b) A Member Lock-In program.
      c) A cumulative maximum Morphine Milligram Equivalent (MME) dosage limit not subject to utilization management prior approval, as established by the Department in opioid clinical coverage criteria.
      d) Diagnosis codes, which may be established by the Department, exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM Program.
   ii. Opioid Misuse Prevention Program
      a) The Program shall:
         1. Align with the North Carolina Opioid Action Plan, including recommendations from NC Payers Council.
         2. Promote appropriate utilization of health care resources by monitoring potential abuse or inappropriate utilization of targeted medications, and

3. Contain interventions that support and promote safer prescribing of opioids, management of chronic pain with opioid sparing pharmacologic and non-pharmacologic modalities, early detection of opioid misuse and intervention, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and increased access to Naloxone and substance use disorder treatment, including Medication Assisted Therapy.

b) The Program shall incorporate requirements in the Strengthen Opioid Misuse Prevention (STOP) Act[11] including quantity limits, mandatory electronic prescribing, utilization of the Controlled Substances Reporting System, and reporting.

c) The Program shall describe goals and metrics as specified by the Department to report progress to goals on at least a bi-annual basis.

d) The PHP shall develop an Opioid Misuse Prevention Program Policy and submit to the Department for review and approval ninety (90) days after the Contract Award. The Policy shall be made available on a publicly available website and in the Provider Manual.

e) Member Lock-in Program

1. The PHP's Lock-In Program criteria shall comply with the Department Lock-In Program criteria as defined in N.C. Gen. Stat. § 108A-68.2.[12]
2. The PHP shall not require Members to be enrolled in the lock-in period for no more than two (2) years without reassessing for continued eligibility in the program.
3. The PHP shall provide care coordination for Members in the Lock-In Program in conjunction with the Member's AMH/PCP as described in *Section V.C.6. Care Management.*
4. The PHP shall report Lock-In program outcomes including, but not limited to, reduced emergency room visits and reduced opioid misuse in a format to be developed by the Department.
5. The PHP shall accept and enroll all individuals enrolled in the Fee-for-Service or another PHP lock-in program into the PHP's lock-in program for the remaining duration of the lock-in period.

i. Additional Prevention and Population Health Management Programs

i. The PHP shall actively participate and support the Department's public health initiatives and to coordinate with all existing public health and human services programs, including reporting, education, and care management activities. That includes coordination with the following:

a) Women Infant Children (WIC) Program

1. The PHP shall make referrals to the WIC program based on the following criteria:
   i. Pregnant women;
   ii. Women up to six (6) months postpartum;
   iii. Breastfeeding women up to one (1) year postpartum;
   iv. Infants; and
   v. Children under age five (5).
2. The PHP shall establish relationships with the WIC entities.

[11] The STOP Act, Session Law 2017-74, https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf was enacted by the NC General Assembly on June 29, 2017.

[12] See Section 3.(a) of Session Law 2018-49.

3. The PHP shall collaborate with the Office of the State WIC director to establish a plan to coordinate these activities and share data as needed to accomplish joint program goals.

b) Newborn Screening Programs
   1. Consistent with N.C. Gen. Stat. §§ 130A-125 and 130A-130.2, the PHP shall comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and shall assure that all lab testing for samples drawn for Newborn Screening under this statute be sent to the NC State Lab for processing.
   2. The PHP shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Attachment M. 7. Management of Inborn Errors of Metabolism Policy.*
   3. The PHP shall establish a joint plan with the Department to implement reporting, education, and care management activities regarding children who screen positive for Hereditary and Congenital Disorders, including sickle cell, during Contract Year 1 or time otherwise defined by the Department.

c) Hearing Screening Program
   1. Consistent with N.C. Gen. Stat. § 130A-125 and 10A NCAC 43F, the PHP shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program including reporting to the Early Hearing Detection and Intervention (EHDI) Program at https://wcs.ncpublichealth.com.
   2. The PHP shall establish a joint plan with the Department to implement the requirement of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or time otherwise defined by the Department.

d) Vaccines for Children (VFC) Program and NC Immunization Registry
   1. Pursuant to Section 317(j) of Public Health Service Act, 42 U.S.C. § 247b(j), the PHP shall provide education to providers on the VCF program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.
   2. The PHP shall educate providers on the use of the NC Immunization Registry.

e) NCDPH Early Intervention Program
   1. The PHP shall coordinate with the Department's Early Intervention Program specifically around services provided by the Children's Developmental Service Agencies (CDSAs).
   2. The PHP shall collaborate with local CDSAs to ensure smooth coordination and transition of care between children receiving service coordination through the CDSA and other services in the child's ISP (individualized service Plan) provided by the PHP network providers (i.e. CBRS, OT/PT, SL).
   3. The PHP shall coordinate with CDSA in each Region that it operates.
   4. The PHP shall detail the plan to ensure referral and coordination for all children who receive service coordination through the CDSA during Contract Year 1, or time otherwise defined by the Department, and annually thereafter.

j. Informing and Educating Members and Providers
   i. Members:

a) The PHP shall inform all Members through the Member Handbook and separately of the availability and accessibility of Prevention and Population Health Programs, including the use of program services.
b) The PHP shall provide Members with information regarding their participation eligibility, how to self-refer, and how to either accordingly "opt in" or "opt out" of a program.
c) The PHP shall have the option to notify the Member's PCP of the Member's participation in a Prevention and Population Health Program.

ii. Providers:
a) As part of the Provider Training Plan, the PHP is responsible for educating providers regarding the operation and objectives of all Prevention and Population Health programs. The PHP shall give providers instructions on how to access specific services and benefits.
b) For those Members receiving Prevention and Population Health Program support, the PHP will notify their AMH/PCP by letter, email, fax, or via a secure web portal of their patient's involvement, unless the Member notified the PHP not to inform their PCP as described above.

8. Opportunities for Health

a. The Department is committed to providing the opportunity for health for North Carolinians, while improving health outcomes and reducing health care costs, and addressing the conditions in which people live that directly impact health.

b. Working collaboratively with its PHPs, the Department envisions establishing North Carolina as a national leader in optimizing the health and well-being for all by effectively stewarding resources that bridge our communities and our health care system to address all factors that impact health.

c. The Department has identified four priority domains for Opportunities for Health and health-related resource needs: housing, food, transportation and interpersonal safety.

d. The PHP shall address these domains to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:
i. **Care Management**: The PHP shall establish care management competencies, workforce and procedures that enable the care team to comprehensively address unmet health-related needs, including screening for and addressing such needs through trauma informed care, navigation support and other strategies. For full Care Management requirements, see *Section V.C. Benefits and Care Management*.
ii. **Quality**: The PHP will focus on health outcomes and not only health care process measures. The PHP shall report on rates of completed screenings for unmet health-related resource needs. For full Quality requirements, see *Section V.E.1. Quality Management and Quality Improvement.*
iii. **Value-Based Payment**: The PHP shall submit a written plan to the Department that indicates how it will incorporate addressing Opportunities for Health into its value-based payment strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full Value Based Payment requirements, see *Section V.E.2. Value-Based Payments/Alternative Payments*.
iv. **In Lieu of Services**: The PHP is encouraged to use In Lieu of Services to finance services that improve health through connecting Members with resources, social services and other

supports upon receipt of the Department approval. For full In Lieu of Services requirements, see *Section V.C.1. Medical and Behavioral Health Package*.

v. **Contributions to Health-Related Resources**: The PHP is encouraged to make contributions to health-related resources that help to address Members' and communities' unmet health-related needs.

vi. **Enhanced Case Management Pilots**: The PHP shall participate in Enhanced Case Management Pilots operating in its region, as described below.

e. The PHP shall use North Carolina-developed tools to address the four priority domains for Opportunities for Health including:

i. **Standardized Screening Questions**: As part of care management, the PHP shall undertake best efforts to conduct a Care Needs Screening of every Member as defined in the Contract. The Screening shall include standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who required a Comprehensive Assessment for care management.

ii. **North Carolina Resource Platform**: The NC Resource Platform will be a telephonic, online, and interfaced IT platform providing: (a) a robust statewide resource database of community-based organizations and social service agencies, and b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, community members, and others to eventually refer and connect Members directly to community resources and track the connections and outcomes through "closed loop referral" capacity. The platform is being developed under the authority of the Foundation for Health Leadership and Innovation. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum:

a) Use the "NC Resource Platform" to identify community-based resources and connect high-need Members to such resources, to the extent the "NC Resource Platform" is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1.

1. The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources.
2. The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.

iii. **North Carolina "Hot Spot" Map**: The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. PHPs are encouraged to use this tool to strategically guide contributions to health-related resources in the regions and communities it serves (Available at: http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b)

f. PHP Contributions to Health-Related Resources

i. The PHP is encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves.

ii. The PHP that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V. I. 2. Medical Loss Ratio*.

iii. A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a Region to health-related resources may be awarded a preference in auto-assignment to promote enrollment in each Region in which the PHP contributes, contingent on the Department determining that the contribution meets the Department's Quality Strategy standards. The auto-assignment increase will take effect the next Contract Year, or at a date determined by the Department, after the contribution is made.

iv. The PHP is encouraged to identify opportunities to contribute to health-related resources in the Quality Assurance and Performance Improvement (QAPI) plan. See *Section V. E. 1. Quality Management and Quality Improvement.*

g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs

i. Through Enhanced Case Management Pilots, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) priority domains (housing, food, transportation, and interpersonal safety) can be delivered effectively to Medicaid Members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the pilots is to learn which evidence based interventions and processes are best matched for a specific population to improve health, lower health care costs, and to inform health care delivery statewide.

ii. Through a competitive procurement process, the Department will establish Enhanced Case Management pilots in up to four (4) areas of the State to provide a subset of high-need, high-risk, and emerging-risk Medicaid Members with information, services and benefits targeted to measurably improve health and lower costs. The pilots will employ evidence-based interventions addressing Members' needs in housing, food, transportation, and interpersonal safety. The PHP shall play a key role in executing the pilots in accordance with the roles and responsibilities enumerated below.

iii. A pilot Region is defined as at least three (3) counties, with a mix of urban and rural communities. A pilot region will not need to include all counties within a PHP Region, but cannot cross PHP Region boundaries.

iv. Each pilot will have a Lead Pilot Entity (LPE). The LPE's role is to develop, contract with and manage a network of pilot service providers (e.g., community based organizations) that can deliver the evidence-based interventions across each of the four (4) priority domains.

v. The PHP shall contract with any LPE operating within the PHP's Region(s).

vi. The PHP shall utilize care managers—employed by or under contract with the PHP or in a Tier 3 Advanced Medical Home (AMH)—to execute key pilot functions.

vii. The PHP shall ensure that the care manager screens Members using a forthcoming Department-developed "Pilot Qualification Screening Tool" to assess whether they meet pilot eligibility criteria.

viii. The PHP shall ensure that the care manager, in consultation with the LPE, develops a care plan and identifies the pilot services that a Member is eligible to receive based on Member need, the pilot services available in the Member's pilot region, and forthcoming DHHS-developed guidance.

ix. The PHP shall ensure that the care manager obtains Members' consent to enroll in the pilot based on forthcoming DHHS-developed guidance.

x. The PHP shall authorize enrollment into the pilot and the delivery of pilot services based on forthcoming Department guidelines, to be developed in collaboration with PHPs and LPEs prior to launching the pilots.

xi. The PHP shall ensure that the care managers communicate approved pilot service authorization to pilot enrolled Members

xii. The PHP shall ensure that the care manager connects Members approved for pilot enrollment to pilot providers in the LPE's network for approved pilot services, in partnership with the LPE.

xiii. The PHP shall ensure that the care manager conducts a reassessment for the mix of pilot services no less frequently than every three (3) months and for the eligibility for services no less frequently than every six (6) months.

xiv. The PHP shall ensure that the care manager is responsible for identifying information and data on pilot Members in accordance with forthcoming Department guidelines that support the State's oversight and evaluation efforts, including:

a) Pilot enrollment and referral source;
b) The identified needed pilot services in an individual's care plan;
c) Approved pilot services;
d) Denied pilot services; and
e) Number of reassessments and associated findings.

xv. The PHP will receive payments from the Department up to a PHP-specific capped allotment to fund pilot services based on the cost and volume of specified services authorized for the PHP's Members.

xvi. The PHP shall make payments to the Lead Pilot Entity to manage the delivery of pilot services.

xvii. The PHP shall manage total pilot funding against allocations for eligible populations, covered services, and Opportunities for Health domains, as developed by the LPE and approved by the Department.

a) Eligible populations include those that qualify for pilot services under Department determined health and resource need based risk eligibility criteria.
b) Covered services include those authorized by the PHP and that follow Department guidelines.

xviii. The PHP shall support the Department's efforts to evaluate the effectiveness of the pilots by reporting quarterly on a range of metrics, including:

a) Pilot enrollment;
b) Pilot service utilization;
c) Pilot expenditures;
d) Member health outcomes; and
e) Member cost and utilization metrics.

D. Providers

1. Provider Network

a. Providers are the backbone of North Carolina's Medicaid and NC Health Choice Program and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks PHPs which share and support that tradition.

b. The Department seeks a PHP with a robust Provider Network to meet the medical, behavioral health and pharmacy needs of all Members within its Region(s) including those with limited English proficiency, physical, or mental disabilities. The PHP shall demonstrate that its Network will meet Department's availability, access, and quality goals and requirements as well as the willingness of the PHP to act to continuously improve its delivery of health care services to Members.

c. Availability of Services (42 C.F.R. § 438.206)
   i. The PHP shall establish and maintain a Medicaid Managed Care Provider Network (Network), supported by written agreements with providers, that is sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner, including those Members with limited English proficiency or physical or mental disabilities.
   ii. The PHP shall meet all federal and state provisions for availability, including:
      a) Providing for a second opinion from a Network Provider, or arrange for the Member to obtain one outside the network at no cost to the Member if requested by the Member and subject to the Utilization Management Program requirements if applicable. PHP shall clearly state its procedure for obtaining a second opinion in its Member Handbook.
      b) Adequately and timely covering services out-of-network for a Member if the PHP's Network is unable to provide the covered service on a timely basis, taking into account the urgency of the need for services. PHP shall cover the Member's out-of-network services for the duration of the Network's inability to provide them in network.
      c) Coordinating out-of-network providers for payment of services and ensure the cost to the Member is not greater than it would be if the services were furnished within the network.
      d) Sufficient family planning providers to ensure timely access to covered services.
      e) Providing female Members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services; this shall be in addition to the Member's designated source of primary care if that source is not a women's health specialist.
   iii. Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)
      a) The PHP shall make good faith efforts to contract with IHCPs and demonstrate that sufficient number of IHCPs are participating in their networks to ensure timely access to contracted services for the tribal population.
      b) The PHP shall allow any Tribal member eligible to receive services from an Indian Health Care Provider (IHCP) to choose the IHCP as the Tribal member's PCP, if the IHCP has the capacity to provide PCP services at all times. The PHP shall consider any referral from such IHCP acting as the Member's PCP to a network provider as satisfying any coordination of care or referral requirement of the Contract.
      c) The PHP shall provide Tribal members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
      d) The PHP shall permit Tribal members to obtain services from out-of-network IHCPs from whom the Member is otherwise eligible to receive such services.
      e) If the PHP cannot provide timely access to necessary services in state and/or in-network for Tribal members, the PHP must provide access to out-of-state and/or out-of-network IHCPs.

f) The PHP must refer Tribal members to IHCPs and other sources of culturally competent care as determined by the Department. The PHP enrolling Tribal populations shall additionally provide training for culturally competent care among contracted providers.

g) The PHP shall permit out of network IHCPs to make referrals to contracted providers for any Tribal members without prior authorization or a referral from a contracted provider.

h) The PHP shall permit IHCPs to refer a Tribal member to any provider within the IHCP PRC network, even if the provider is not a contracted provider, without having to obtain prior authorization or a referral from a contracted provider

i) The PHP shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any Tribal member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

iv. Pharmacy Services

a) The PHP shall ensure its pharmacy network meets the time and distance standards defined in *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards*, as amended by the Department from time to time.

b) The PHP shall maintain a Pharmacy Provider Network Audit Program. The PHP shall submit the program to Department for approval ninety (90) days after Contract Award and annually thereafter.

c) The PHP shall not require Members to accept mail order pharmacy services unless mail order is the only dispensing channel for a drug. The PHP may allow Members to choose to receive prescribed drugs through mail order pharmacy services.

d) The PHP shall submit its Mail Order Program Policy including a sample of all Member mail order-related correspondence to the Department for approval ninety (90) days after Contract Award and annually thereafter. The PHP shall specifically identify any pharmacy service where mail order is the only dispensing channel for the drug.

1. The request for approval must be submitted in accordance with the Implementation Plan.
2. The PHP must submit any significant changes to its mail order program to Department for approval at least ninety (90) calendar days before implementation target date.

e) The PHP may contract with a limited specialty pharmacy network if the PHP demonstrates that:

1. A specialty drug is only available through a limited network of pharmacies; and
2. The specialty pharmacy has clinical and care coordination programs that improve medication adherence and drug therapy outcomes.

f) PHP may contract with 340B covered entities. Drugs purchased through the 340B program shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus dispensing fee as defined in *Section V. C.3. Pharmacy Benefits*.

v. Telemedicine Services:

a) The PHP may use telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the PHP's network and in accordance with the PHP Telemedicine Coverage Policy.

b) PHPs shall be permitted to leverage telemedicine in their Request for Exception to the Department's network adequacy standards, as appropriate.

c) PHP shall not require an Member to seek the services through telemedicine and must allow the Member to access a face-to-face service through an out-of-network provider, if the Member requests.
d) Access to telemedicine providers does not count toward meeting network adequacy standards, unless approved as part of an exception to Network requirements.

d. Furnishing of Services (42 C.F.R. § 438.206(c))
   i. The PHP shall meet the Network time and travel distance, and appointment wait time standards established by the Department as described in *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards,* unless otherwise approved by the Department in accordance with the requirements herein.
      a) The Department is studying the application of provider-patient ratios and may implement ratios by Region and hold the PHP accountable to those ratios upon one hundred twenty (120) calendar days prior notice.
      b) The Department may amend the Network time and travel distance, appointment wait time, or other adequacy standards from time-to-time. PHP shall comply with the new standards as directed, but with no less than a ninety (90)-day prior notice.
   ii. The PHP shall meet and require its network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services.
   iii. The PHP shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial Members or comparable to Medicaid Fee-for-Service, if the provider serves only Medicaid or NC Health Choice.
      a) The Department encourages after hours and weekend hours to address the needs of the Member.
   iv. The PHP shall make covered services available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
   v. The PHP shall establish mechanisms to ensure that its Network providers comply with the timely access requirements.
      a) The PHP shall monitor Network providers regularly to determine compliance with the timely access requirements.
      b) The PHP shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
   vi. The PHP shall ensure that Network Providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Members with physical or mental disabilities.
   vii. The PHP shall promote the delivery of services by Network providers in a culturally competent manner to all Medicaid Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
      a) The PHP shall support providers with these requirements including educating providers on the availability of the resource, accessing the resource and creating sufficient interpreter capacity.
   viii. To furnish services to meet Members' accessibility needs, the PHP is encouraged to contract with providers outside of the PHP's Region(s).
      a) An individual Member's accessibility and PHP's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.

e. Essential Providers (SL 2015-245, Section 5)

i. The PHP shall include all Essential Providers located in the PHP's Region(s) in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.
    a) Except for a Veterans Home, a PHP must submit a request for an alternative arrangement relating to any Essential Provider that fails the PHP's Quality Determination process.

ii. At such time the PHP is notified by the Department that a Member is determined eligible for and transferred for treatment to a DMVA-operated Veterans Home, the PHP shall include the Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) in its Network as an Essential Provider and shall reimburse the veterans home at the rates established by the Department until such time as the Member is disenrolled as provided in the Contract.

f. Exceptions to Network Requirements

i. Network adequacy measures, in part, the PHP's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, and all health care services included under the terms of the contract. Recognizing that there are conditions in the field which cannot be remedied by the PHP's alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to network requirements. However, the Department will partner with PHPs which understand the health needs of North Carolina and which find innovative ways to develop or foster provider capacity or otherwise meet the requirements of Medicaid Managed Care. Therefore, the Department will grant exceptions based on the evidence presented by the PHPs and exceptions granted will generally be time-limited.

ii. The PHP may request approval for an alternative arrangement for an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision. An alternative arrangement request must:
    a) Be made for each Essential Provider that the PHP is proposing to not contract with;
    b) Describe efforts to negotiate in good faith;
    c) Include justification for the alternative arrangement with a description of how the alternative arrangement will meet Medicaid Member needs; and
    d) Include the PHP's plan to address Member needs and remedy the need for the alternative arrangement including a suggested time line for implementation.

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

iv. The Department's approval of an exception request to the Network Adequacy Standards or an Essential Provider alternative arrangement will include a specific time frame for the approval. Forty-five (45) calendar days before an exception/alternative arrangement is set

to expire, the PHP shall submit a new request for the exception/alternative arrangement or inform the Department the exception/alternative arrangement is no longer needed.

v. The Department is not required to approve a request for an alternative arrangement with an Essential Provider or exception to meeting the Department's Network Adequacy Standards and may deem a PHP to be out of compliance.

g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)

i. The PHP shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's Network Adequacy Standards (as found *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards)*, state and federal law, and the terms of this Contract.

a) The PHP's Network Access Plan must:

1. Demonstrate compliance, or, for submissions prior to Phase 1 of Medicaid Managed Care, plans for compliance, with all the following:
    i. Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of Members for the Region.
    ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medicaid Members in the Region.
    iii. Include procedures to address the following:
        a) Referrals;
        b) Disclosures and notices to Members of PHP services and features;
        c) Coordination and continuity of care; and
        d) Transition of care that complies with Department requirements set forth in *Section V. C. 4. Transition of Care.*
2. Demonstrate the PHP's efforts to:
    i. Address the needs of all Members, including those with limited English proficiency or illiteracy;
    ii. Ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities; and
    iii. Support and sustain providers, including hospitals, in rural and other traditionally underserved areas.
3. Include the PHP's:
    i. Efforts to establish a network that meets the Department's Network Adequacy Standards.
    ii. Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all Members on an ongoing basis.
    iii. Factors used to build the Network, including a description of the Network and criteria used to select providers, i.e. objective quality standards.
    iv. Process and methodology to understand the distribution of Member health care needs against available providers and provider capacity to serve those needs.
    v. Plan to provide in-network access, compliant with the Department's Network Adequacy Standards, to children to the full range of age-appropriate health care providers, subspecialists and facilities, including:

a) Method for ensuring children's physical and behavioral health needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in pediatrics or in child health and development, and
b) Approach to assure children's access to child psychologists and psychiatrists, pediatric occupational, physical and speech therapists, pediatric neurologists, and pediatric surgeons.

vi. Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.

vii. Geographical location of providers in the Provider Network in relation to where Member's reside.

b) The Network Access Plan must be provided as follows:
1. Thirty (30) days after Contract Award;
2. As specified by the Department;
3. Annually; and
4. Within thirty (30) days of a significant change.

c) The demonstration that the PHP has the capacity to serve the expected enrollment shall be on a regional basis. For a statewide PHP, this means demonstration shall be for each Region 1 through 6.

d) The Department will supply Member eligibility information that includes addresses (with counties) and zip codes for the Medicaid and NC health Choice beneficiaries that are in the mandatory enrollment population as of the date of the report. The information will be provided to the Contractor no later than 30 Calendar Days after Contract Award, at a date to be defined by the Department for purposes of demonstrating compliance with the time and distance standards found in Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards during the Readiness Review, and as other times as needed as part of the network adequacy oversight.

e) The Network Access Plan shall be subject to Department review and approval. The PHP shall amend the Network Access Plan as directed by the Department.

ii. The PHP and its network providers shall comply and cooperate with EQRO network adequacy validations and activities including:
a) Annual validation of PHP's Network adequacy and compliance with state and federal network requirements.; and
b) Telephone surveys of Network providers to verify accuracy of reported data or other aspects of program requirements or performance.

iii. The PHP shall provide the Department with Network data files quarterly and anytime there is significant change that impacts Network adequacy and the ability to provide services. The Department will prescribe the standardized file format. The standardized detailed file layout must include the following data elements:
a) Provider names (first, middle, last);
b) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
c) Street address(as) of service location(s);
d) County(ies) of service location(s);
e) Telephone number(s) at each location;
f) Website URL(s);
g) Provider specialty;

h) Provider NPI or API;
i) NPI type (individual or organization/facility providers);
j) Taxonomy(ies);
k) Whether provider is accepting new Members and the conditions if applicable;
l) Identification as an IHCP
m) Identification as an Essential Provider
n) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
o) Whether provider has completed cultural competency training; and
p) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.

2. Provider Network Management

a. The PHP shall manage its Network to meet availability, accessibility, and quality goals and requirements. In developing its Network, Department expects PHP to negotiate with any willing provider in good faith regardless of provider or PHP affiliation. The PHP shall have a strong monitoring program to ensure providers are meeting Member needs and program requirements.

b. To help recognize the Department's aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency. Until the Department fully implements a PDM/CVO, the Department will engage a Provider Data Contractor, who is certified by the NCQA, to supplement the current enrollment and credentialing process. The period before the PDM/CVO has achieved full Implementation will be considered the Provider Credentialing Transition Period. The information gathered by the Department's vendors will be shared with the PHP who will use that information to make Quality Determinations for network contracting purposes.

c. Provider Contracting
   i. The PHP contracts with Providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses identified in *Attachment G. Required Standard Provisions of PHP and Provider Contracts.*
   ii. The PHP shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) calendar days after the Contract Award.
      a. The PHP may utilize proposed contract templates submitted as part of the Offeror's Proposal and Response prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
      b. Upon approval by the Department, the PHP shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The PHP shall discontinue use of previously submitted contract templates once an amended version is approved.
      c. The PHP shall re-submit contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers when significant changes are proposed. In the context of contract templates, significant change is defined as any

change to the provisions required in Attachment G. Required Standard Provisions for PHP and Provider Contracts.

iii. The PHP shall not include any provider (including ordering, prescribing, or referring only providers) in its Medicaid Managed Care Provider Network that is not enrolled in North Carolina Medicaid.
   a. The PHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract.
   b. This validation should be done monthly thereafter.

iv. The PHP shall not employ or contract with any provider excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).

v. In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the PHP shall not exclude eligible providers from its network except under the following circumstances:
   a. When a provider fails to meet Objective Quality Standards; or
   b. Refuses to accept network rates (which shall not be lower than any applicable rate floors).

vi. The PHP shall not deny a pharmacy the opportunity to participate in its network as required by N.C. Gen. Stat. § 58-51-37(c)(2). Nothing in this subsection shall require the PHP to contract with a pharmacy when the pharmacy fails to meet Objective Quality Standards.

vii. The PHP shall offer to contract with a provider in writing.
   a. All offers shall include the standard provisions for provider contracts found in *Attachment G. Required Standard Provisions of PHP and Provider Contracts*, including the prescribed provisions located therein.
   b. If within thirty (30) calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, the PHP may consider the request for inclusion in the Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the PHP shall not consider the request rejected.
   c. The PHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the PHP for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers, including non-medical service providers (e.g. non-emergency medical transportation drivers), require a provider to participate in the governance of a PLE, or otherwise prohibit a provider from providing services for or contracting with any other PHP.

viii. The PHP shall not require individual practitioners, as a condition of contracting with PHP, to agree to participate or accept other products offered by the PHP nor shall the PHP automatically enroll the provider in any other product offered by PHP. This requirement shall not apply to facility providers.

ix. The PHP shall give written notice to any provider with whom it declines to contract within five (5) business days after the PHPs final decision. The notice shall include the reason for the PHP's decision, the Provider's right to appeal that decision, and how to request an appeal. 42 C.F.R. § 438.12(a)(1).

x. The PHP shall, with regard to payment to any provider or subcontractor that is "related to" the PHP, comply with the requirements in *Section V. A. 4. PHPs and Related Providers* and *Section V. I. 2. Medical Loss Ratio*.

xi. The PHP shall include a provision regarding a Provider's right to file a grievance or appeal (as described in Section V.D.5. Provider Grievances and Appeals) in its contract with providers. The PHP shall include a notice in all provider contracts that the internal appeal process with the PHP must be completed before seeking other legal or administrative remedies under state or federal law.

xii. The PHP shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
   a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
   b. Any information the Member needs to decide among all relevant treatment options.
   c. The risks, benefits, and consequences of treatment or non-treatment.
   d. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 C.F.R. § 438.102(a)(1)(i)-(iv).

xiii. The PHP shall include a provision that requires all in-network primary care providers (PCPs) to perform EPSDT screenings for Members less than twenty-one (21) years of age in accordance with *Section V. C. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*.

xiv. The PHP shall include a provision that requires providers notify the PHP when a Member in a high level clinical setting is being discharged.

xv. The PHP may utilize evergreen contracts, i.e. a contract that automatically renews, with Medicaid Managed Care providers on the condition that the contract also includes the reasons the contract may be terminated or non-renewed.

xvi. The PHP shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.

xvii. In contracting with providers, the PHP shall comply with all applicable Chapter 58 statutes in accordance with *Attachment G. Required Standard Provisions of PHP and Provider Contracts*.

xviii. The PHP shall include in Provider contracts that Participating Providers shall not submit claim or encounter data for services covered by Medicaid Managed Care and PHPs directly to the Department.

xix. In Contract Years 1-3, the PHP shall contract with each LHD in its Region(s) to provide Care Management for At-Risk Children and Care Management for High Risk Pregnant Women, to the extent that each LHD chooses to provide these services.

xx. The PHP shall contract with, and using a Department-developed contract template to be delivered 45 calendar days after award, 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.

d. Provider Preventable Conditions

   i. The PHP shall comply with 42 C.F.R. § 438.3(g) which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§

434.6(a)(12) and 447.26. The PHP shall submit all identified Provider Preventable Conditions in a form or frequency as described in *Attachment J. Reporting Requirements*.

ii. The PHP shall include a provision in all provider contracts that requires the provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the PHP.

e. Indian Health Care Providers

i. The PHP shall use the Medicaid Managed Care Addendum for Indian Health Care Providers when contracting with Indian Health Care Providers as described in *Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers.*

ii. The PHP shall not include any additional special terms and conditions to the Medicaid Managed Care Addendum when contracting directly with IHCPs without mutual consent of both PHP and the IHCP. For any mutually agreed upon additional special terms and conditions, the PHP shall:

a. Within thirty (30) calendar days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.

b. Recognize that the IHCP addendum provisions supersedes any conflicting terms of the contract between PHP and IHCP.

iii. The PHP must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148.

f. Program Integrity

i. The PHP shall develop policies and procedures to perform monitoring and auditing of provider payment. The PHP shall provide those policies and procedures to the Department upon request for review.

ii. The PHP shall require network providers and subcontractors to have compliance plans that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.

iii. The PHP shall require network providers and non-contract providers to have policies and procedures that recognize and accept Medicaid as "the payer of last resort".

iv. The PHP shall prohibit providers and referral providers from billing Members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2).

v. The PHP shall not impose a monetary advantage or penalty that would affect a Member's choice of pharmacy in accordance with N.C. Gen. Stat. § 58-51-37(c)(4) or any other provider.

g. Credentialing and Re-credentialing Process

i. The PHP shall develop a Credentialing and Re-credentialing Policy consistent with the Department requirements and its associated policies and subject to Department approval.

a. The PHP shall develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.

ii. The PHP shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval. PHP is not prohibited from collecting other information from providers necessary for the PHP's

contracting process but that information should not be used for making contracting Quality Determinations.

a. The PHP shall make timely referrals to the Provider Network Participation Committee, as defined in *Attachment M. 6. Uniform Credentialing and Re-credentialing Policy,* of providers who have been identified as potential network providers. The referral shall include all credentialing and verified information pertaining to the provider as provided by the Department.

iii. The PHP shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.D. Providers*.

iv. The PHP is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.

v. Re-credentialing:

a. During the Provider Credentialing Transition Period, the PHP shall apply Objective Quality Standards to contracted providers no less frequently than every five (5) years consistent with the Department policy and procedure.

b. After the Provider Credentialing Transition Period, the PHP shall apply Objective Quality Standards to contracted providers every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.

vi. During the Provider Credentialing Transition Period, the PHP shall apply the Objective Quality Standards most recently approved by the Department, or designated Department vendor, to contracted providers as the provider is re-enrolled in Medicaid.

vii. Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all PHP network providers as Medicaid providers. 42 C.F.R. § 438.602(b)(1).

a. The PHP may execute network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected Members. 42 C.F.R. § 438.602(b)(2).

viii. The PHP shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

h. Network Provider System Requirements

i. The PHP shall accurately and timely load into the PHP's claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.

ii. Unless otherwise written in the contract, the PHP shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:

a. Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;

b. Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;

c. Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
e. Change in existing contract terms within ten (10) business days of the effective date after the change; and
f. Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after the PHP receives updated provider information.

iii. Payment should be made on the next payment cycle following the requirement outlined above.

iv. In no case shall a provider be used as a PCP or loaded into the provider directory during a timeframe in which the provider cannot receive payment on the health plan's current payment cycle.

i. Network Provider Credentialing and Re-credentialing Policy

i. The PHP shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2). The PHP shall develop and maintain a Network Provider Credentialing and Re-credentialing Policy as defined in *Attachment M. 6. Uniform Credentialing and Re-credentialing Policy*

ii. The PHP shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) days after the Contract Award. The Policy must be approved by the Department at least sixty (60) days prior to executing contracts with providers.
   a. The PHP may utilize the draft Policy submitted as part of the Offeror's Proposal and Response prior to approval by the Department with notification to the provider that the Policy is subject to amendment based upon Department review and approval.

iii. PHP shall submit any significant policy changes to Objective Quality Standards to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes.

iv. Provider Network Participation Committee
   a. PHP shall establish and maintain a Provider Network Participation Committee to make Quality Determinations in accordance with PHP's Credentialing and Re-credentialing Policy.
   b. PHP's Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.
   c. PHP shall make Quality Determinations within the following timeframes:
      1. For ninety percent (90%) of providers within thirty (30) calendar days of the Committee's receipt of complete credentialing and verified information for consideration; and
      2. For one hundred percent (100%) of providers within forty-five (45) calendar days of the Committee's receipt of complete credentialing and verified information for consideration. days of the Provider Network Participation Committee's determination.
   d. The PHP shall provide written notice of Quality Determinations to providers within five (5) business days of the Provider Network Participation Committee's determination.

e. The PHP may establish, as part of its Credentialing/Recredentialing Policy, the criteria to define a provider's credentialing files as a "clean file" and a review process for "clean files". The review process must include that a "clean file" is reviewed by the Chief Medical Officer, but review by the Provider Network Participation Committee is not required.

j. Provider Disenrollment and Termination

i. Payment Suspension at Re-Credentialing:

a. The PHP shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.

b. The PHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days of suspension, the Department will terminate the provider from Medicaid.

c. The PHP shall not be liable for interests or penalties for payment suspension at re-credentialing.

d. The PHP shall address payment suspension at re-credentialing in its Network Provider Credentialing and Re-credentialing Policy.

ii. Termination as a Medicaid Provider by the Department:

a. The PHP shall remove any provider from the PHP network, claims payment system, and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) business day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.

b. If the PHP suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the PHP shall release applicable claims and deny payment.

iii. PHP Provider Termination

a. The PHP may terminate a provider from its network with cause. Any decision to terminate must comply with the requirements of the Contract.

b. The PHP shall comply with the Program Integrity Provider Termination Requirements outlined in *Section V. J. 2. Program Integrity*.

c. The PHP must provide written notice to the provider of the decision to terminate to the provider. The notice, at a minimum, must include:

1. The reason for the PHP's decision;
2. The effective date of termination;
3. The Provider's right to appeal the decision; and
4. How to request an appeal.

d. The PHP shall report data to the Department on the number of providers terminated by provider type in a format dictated by the Department for the Network Access Report (Report 4.j.) identified in Section VII. First Restated and Revised Attachment J. Table 1: Reporting Requirements.

k. Member Notice of Provider Disenrollment/Termination

i. The PHP shall notify each Member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the Network. PHP shall:

a. Make a good faith effort to provide written notice within fifteen (15) calendar days after receipt of a notice of termination by the Department or issuance of termination notice to the Provider by the PHP. 42 C.F.R. 438.10(f)(1).
b. Include in the notice information about selecting or being auto-assigned a new AMH/PCP.
c. Describe the PHP's efforts to support transition of care for the Member to the new provider.
d. If the terminated provider was a specialist, assist impacted Members with transition of care.

l. Provider Directory
   i. The PHP shall develop a consumer-facing provider directory of all Network providers including the required information for all contracted providers.
   ii. The directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by Department.
   iii. The PHP shall ensure that the consumer-facing directory:
      a. Be in a format that is machine-readable and readily accessible;
      b. Information is placed in a location on the PHP's website that is prominent and readily accessible by Members;
      c. Includes accurate and updated provider information consistent with Contract requirements;
      d. Information is provided in an electronic form which can be electronically retained and printed; and
      e. Is available in paper form without charge upon Member request and if requested, is provided within five (5) business days.
   iv. In accordance with 42 C.F.R. § 438.10(h)(3):
      a. The PHP shall update the paper directory at least monthly and clearly identify the date of the update.
      b. The PHP shall update the electronic version of the consumer-facing directory no later than ten (10) business days after the PHP receives updated provider information and clearly identify the date of the update.
   v. The PHP shall provide Department with a copy of both the electronic and paper versions of the provider directly as follows:
      a. At the request of the Department during the readiness review;
      b. Annually; and
      c. Any time there has been a significant change in PHP operations that impacts the content of the directory.
   vi. All provider directories must include the following information, at a minimum, as required by 42 C.F.R. § 438.10(h)(1):
      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.

vii. In no case shall a provider be loaded into the provider directory which cannot receive payment on the PHP's current payment cycle.

viii. The PHP shall provide the provider directory to the Enrolment Broker as described in *Section V. K. Technical Specifications.*

3. Provider Relations and Engagement

a. Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to Members. Department seeks a Contractor that will engage and support providers through a call center and online provider portal as well as provide training and education on the Medicaid program and their rights within the program.

b. Provider Relations: Service Line; Provider Portal; Welcome Packet

i. The PHP shall operate a Provider Relations function, that includes a Support Service Line consistent with the applicable standards found in *Section V. G. Program Operations.*

ii. Be staffed with personnel specifically trained on the requirements, policies and procedures of the PHP operating in the North Carolina market and are able to respond to all areas within the provider manual including resolving claims payment inquires, in "one-touch".

iii. The PHP shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web portal may include access to the provider manual.

iv. The PHP shall send a Welcome Packet and enrollment notice to providers within five (5) days of executing a contract with the Provider for participation within its Medicaid Managed Care Network. The Welcome Packet must include orientation information and instructions on how to access the PHP's Provider Manual.

v. The PHP shall develop and maintain a Provider Support Plan as described in *Section V. E. 1. Quality Management and Quality Improvement* and make it available to Department upon request.

c. Provider Education and Training

i. The PHP shall provide education, specific to the Medicaid Managed Care requirements, policies and procedures, training and technical assistance on all PHP-specific administrative

and clinical practices, procedures, policies, programs, and requirements to Network providers.

ii. The PHP shall communicate with Network providers, or include in its training and technical assistance, information as requested by Department.

iii. The PHP shall provide training to Network providers within thirty (30) days of provider joining the Network. Additional training will be provided as determined by the PHP and as requested by Department.

iv. The PHP shall make training materials available on the Provider Online Portal as determined appropriate by the PHP and upon request by Network providers or Department.

v. The PHP shall develop a Provider Training Plan that outlines training topics and dates. The PHP Provider Training Plan shall reference and acknowledge the broader role the PHP has in supporting Department initiatives. Training must include:

a) Annual EPSDT, where EPSDT is relevant to the providers' area of practice:
b) PHP prevention and population health management programs; and
c) Into the Mouth of Babes (IMB) program training (required before being permitted to receive reimbursement for IMB program).

vi. The PHP shall submit the Provider Training Plan to the Department as follows:

a) Upon award of the Contract;
b) When material changes are made to the Training Plan; and
c) Annually.

d. Provider Manual

i. The PHP shall develop, maintain, and distribute a provider manual that offers information and education to providers about the PHP and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:

a) Clinical practice standards and Utilization Management Program;
b) Covered Services, Additional Benefits and Carved-out Services;
c) Provider responsibilities;
d) Primary care provider responsibilities;
e) Network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
f) Telemedicine;
g) Network adequacy and access standards;
h) Billing, claim editing, SNIP editing and clearinghouse requirements;
i) Cultural competency and accessibility requirements;
j) Authorization, utilization review, and care management requirements;
k) Care coordination and discharge planning requirements;
l) Department-required documentation requirements;
m) Provider appeals and grievance process;
n) Complaint or Grievance investigation and resolution procedures;
o) Notification of the availability of the Department's provider ombudsman service where a provider may submit a complaint about a PHP. The manual shall include instructions on how to submit the complaint;
p) Performance improvement procedures including Member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;

q) Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
r) Interest and penalty provisions for late or under-payment by the PHP;
s) North Carolina Medicaid payer of last resort requirements;
t) Member rights and responsibilities;
u) Member cost sharing requirements; and
v) Provider program integrity requirements that address how to report suspected fraud, waste and abuse, and other federal and state requirements.

ii. The PHP shall also include in the Provider Manual providers' obligations to:
a) Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
b) Monitor and report on provider preventable conditions;
c) Retain patient records for the mandated period;
d) Ensure that all documentation regarding services provided is timely, accurate, and complete;
e) Ensure PHP is the payer of last resort; and
f) To report and promptly return overpayments within sixty (60) days of identifying the overpayment.

iii. The PHP shall include standardized language in the Provider Manual as requested by the Department.

iv. The PHP shall submit provider manual to Department for approval thirty (30) days after Contract Award. The PHP shall not use or distribute the Provider Manual prior to approval by Department.

v. The PHP shall regularly review and update the provider manual to reflect changes to applicable federal and state laws, rules and regulations, Department or PHP policies, procedures, bulletins, guidelines or manuals, or PHP business processes as necessary.

vi. The PHP shall submit the provider manual to Department for approval within fifteen (15) days of making substantive updates or revisions.

vii. The PHP shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) days of notification or request by Department. Corrections or revisions to the printed version must be included in the next printing.

viii. The PHP shall make the provider manual available in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

e. Provider Survey

i. The PHP shall conduct ongoing quality assurance of its Provider Relations staff via provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
a) Provider surveys shall be made available after each web, call center or in-person interaction;
b) Surveys and internal audits are intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness.
c) Reports, including the results of provider surveys and 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.

4. Provider Payments

a. Provider payment requirements are established to comply with state law, encourage continued provider participation in the Medicaid program to ensure Member access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of PHP steerage to other providers.

b. The PHP shall assist the Department to comply with all federal laws, state laws, State Plans, Waivers, program integrity or audit requirements, investigations, findings or corrective action plans related to provider payments.

c. The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.

d. Physician and Physician Extender Payments
   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 the Medicaid Fee-for-Service rate for the service or bundle (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.
   ii. The PHP shall reimburse all in-network physicians and physician extenders no less than one hundred percent (100%) of the Medicaid Fee-for-Service rate for obstetrics services, which includes an enhanced rate on all vaginal deliveries (equal to the Medicaid Fee-for-Service rate for caesarian deliveries) unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.
      a) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.
   iii. The PHP shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as outlined below in 9. Additional Directed Payments for Certain Providers.
   iv. The PHP shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with N.C. Gen. Stat. § 58-50-26.

e. Hospital Payments (Excluding Behavioral Health Claims)
   i. The PHP shall reimburse all in-network hospitals no less than the applicable Medicaid Fee-for-Service rate ("rate floor") for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(ii)(A)) and utilize the applicable Fee-for-Service payment methodology, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology.
   ii. The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee-for-Service reimbursement rate using the Medicaid Fee-for-Service case weights and outlier methodology.

iii. The applicable rate floor and methodology for outpatient hospital services, including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.
iv. The hospital rate floors shall apply for the following defined time periods, after which the PHP will have flexibility to negotiate reimbursement arrangements with the hospitals:
    a) The first five (5) contract years for critical access hospitals and hospitals in economically depressed counties as defined by the Department.
    b) The first three (3) contract years for all other hospitals.
v. The PHP shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in the Contract.
vi. The Department shall reimburse hospitals directly for any graduate medical education payments due under the State Plan (as allowed under 42 C.F.R. § 438.60).
vii. The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments.

f. Hospital Payments for Behavioral Health Claims
    i. The PHP shall negotiate inpatient and outpatient hospital rates with hospitals for behavioral health claims to be defined by the Department.

g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments
    i. The PHP shall reimburse FQHCs and RHCs for covered services at negotiated rates that are no less than rates to be defined by the Department and no less than rates paid to other providers for similar services in accordance with 1903(m)(2)(A)(ix) of the Social Security Act.
    ii. The PHP shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by the Department on a schedule to be defined by the Department.

h. Indian Health Care Provider (IHCP) Payments
    i. In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PHP shall reimburse IHCPs as follows:
        a) Those that are not enrolled as an FQHC, regardless of whether they participate in the PHP's network:
            1. The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
            2. The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.
        b) Those that are enrolled as FQHCs, but do not participate in the PHP's network, an amount equal to the amount the PHP would pay a network FQHC that is not an IHCP.
    ii. The PHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

i. Local Health Department (LHD) Payments
    i. The PHP shall reimburse in-network local health departments' enhanced role registered nurses providing EPSDT well child exams, STD exams, low-risk family planning, and obstetrical services according to the enhanced local health department Medicaid fee schedule (as allowed under 42 C.F.R. § 438.6(c)).
    ii. For Contract Years 1-3, the PHP shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.56 PMPM for all

enrolled children ages 0-5). The Department reserves the right to further prescribe the Care Management for At-Risk Children reimbursement amount or methodology or to change the methodology in Contract Years after Contract Year 1.

iii. Reserved.

iv. For Contract Years 1-3, the PHP shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.96 PMPM for all enrolled women, ages 14 to 44). The Department reserves the right to further prescribe the Care Management for High Risk Pregnant Women reimbursement amount or methodology as allowed under 42 C.F.R. § 438.6(c) or to change the methodology in Contract Year 2 or Contract Year 3.

v. The PHP shall negotiate base reimbursement amounts to in-network LHDs that are no lower than rates paid to non-public providers for similar services.

vi. In addition to base reimbursements, the PHP shall make additional, utilization-based, directed payments to in-network LHDs as defined by the Department and as outlined below in *9. Additional Directed Payments for Certain Providers*.

vii. The PHP shall reimburse in-network local health departments providing lab services, as defined by the Department's Laboratory fee schedule, at no less than 100% of the Medicare fee schedule (as allowed under 42 C.F.R. § 438.6(c)), unless the PHP and local health department have mutually agreed to an alternative reimbursement arrangement.

j. Public Ambulance Provider Payments

i. The PHP shall negotiate base reimbursement amounts to in-network public ambulance providers no lower than rates paid to non-public providers for similar services.

ii. In addition to base reimbursements, the PHP shall make additional utilization-based payments to in-network public ambulance providers for Medicaid Members, only, (not NC Health Choice Members) as defined by the Department and as outlined below in *9. Additional Directed Payments for Certain Providers*.

iii. The PHP shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full, for NC Health Choice.

k. State Owned and Operated Facilities Payments

i. The PHP shall reimburse facilities that are state-owned and operated by the Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).

ii. At such time that the PHP is required to cover services provided by Veterans Homes operated by the Department of Military and Veterans Affairs (DMVA), the PHP shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).

l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))

i. The PHP shall make additional directed payments as determined by the Department, to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center.

ii. Additional directed payments will be prescribed by the Department and approved by CMS. Types of payments may include, but may not be limited to payment based on utilization of

certain services multiplied by a Department-defined specific dollar amount or a percentage of the base payment.

iii. The PHP shall include the Department defined additional directed payments in its contracts with applicable providers.

iv. The PHP shall determine a due date for providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.

v. The PHP shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) calendar days of receiving the payment from the State.

vi. The PHP shall submit the data to substantiate additional directed payments to the Department and each applicable provider quarterly in a format to be defined by the Department.

vii. The Department shall reconcile the data to the PHP's encounter submissions. The PHP shall support the reconciliation process upon request from the Department.

viii. The PHP shall adhere to the directed payment service unit encounter requirements as described in *Section V. H. 2. Encounters.*

m. Nursing Facility Payments

i. For a period of time to be defined by the Department, 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 six (6) months prior to the start of the capitation rating year (e.g., January 1 prior to a July 1 rating year), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

n. Hospice Payments

i. The PHP shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:

a) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY).

b) For hospice services provided to Members residing in nursing facilities, the PHP shall reimburse the hospice provider:

1. Hospice rate, and
2. Ninety-five percent (95%) of the Medicaid nursing home Fee-for-Service room and board rate in effect at the time of service.

o. Pharmacy Payments

i. The PHP shall adhere to the pharmacy claims payments requirements as described in *Section V. C. 3 Pharmacy Benefits.*

p. Advanced Medical Home Payments

i. In addition to the payment for services provided, the PHP shall pay AMH practices each of the following components:

a) Medical Home Fee (all Tiers);

b) Care Management Fee (Tiers 3 and 4 only); and

c) Performance Incentive Payments (required only for Tier 3 until such time the Department expands the required payment to other tiers).

ii. The PHP shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the Member is assigned to that AMH practice. Medical Home Fees for AMH Tiers 1 – 3 practices may be prorated for partial months and shall be no less than the following amounts for the first two contract years:

a) $1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee-for-Service program);

b) $2.50 PMPM for Members not in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program); and
c) $5.00 PMPM for Members in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program).

iii. The PHP shall pay Care Management Fees to Tier 3 practices that are negotiated between the PHP and Tier 3 practice and that adequately compensate Tier 3 practices for the additional care management responsibility assumed. The PHP shall not be required to contract with any particular entity as an Advanced Medical Home

iv. In Contract Years 1 and 2, the PHP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:
a) The PHP shall design Tier 3 Performance Incentive Payments to be in addition to Medical Home Fees (i.e., the PHP shall not place all or part of the Medical Home Fees at risk based on performance).
b) The PHP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMH Tier 3.
c) The PHP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set, once finalized.

v. The PHP shall have flexibility to develop its own payments within AMH Tier 4.

q. Payment Limitations
i. The PHP shall not pay more for similar services rendered by any provider or subcontractor that is "related to" the PHP than the PHP pays to providers and subcontractors that are not related to the PHP.
a) For purposes of this subsection, "related to" means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the PHP, an affiliate of the PHP, or the PHP's management company/corporate parent as well as providers or subcontractors that the PHP, an affiliate of the PHP or the PHP's management company/corporate parent has an indirect ownership interest, ownership or controlling interest in.
b) The standards and criteria for determining indirect ownership interest, an ownership interest or a controlling interest are set out at 42 C.F.R. part 455, subpart B.

ii. Upon request by the Department, the PHP shall submit information on payments to related providers and subcontractors and provide a demonstration of how payment levels for related providers and subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are value-based payment arrangements in place.

r. Out of Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)
i. With the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, the PHP shall be prohibited from reimbursing an out of network provider more than ninety (90%) of the Medicaid Fee-for-Service rate if:
a) The PHP has made a good faith effort to contract with a provider but the provider has refused that contract, or
b) The provider was excluded from the PHP's network for failure to meet Objective Quality Standards.

ii. The PHP shall develop Good Faith Provider Contracting Policy that includes a description of how the PHP will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions. The PHP shall submit the policy to the Department for review ninety (90) days after Contract Award.
    a) The PHP shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.
    b) The PHP should provide for a process so a provider may "cure" the issue identified in the Quality Determination. Upon cure, the parties may initiate a new "good faith" contracting effort.

iii. The PHP shall reimburse an out-of-network provider who is providing services to a Member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee-for-Service rate.

iv. The PHP shall reimburse an out-of-network provider who is not excluded for quality reasons or refused a "good faith" contract at one hundred percent (100%) of the Medicaid Fee-for-Service rate if an agreement is not negotiated.

v. The PHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee-for-Service rates specified in State Plan Amendments 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:
    a) Are more reasonably available than can be provided by an enrolled in-state provider; or
    b) The care and services are provided in any one of the following situations:
        1. In response to an Emergency Medical Condition;
        2. The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or
        3. The health of the Member would be endangered if travel were undertaken to return to North Carolina.

vi. In accordance with 42 C.F.R. § 438.206(b)(5), the PHP shall coordinate payment with the out-of-network provider to ensure that the cost to the Member is no greater than it would be if services were provided within the network.

s. Out of Network Emergency Services and Post-Stabilization Services Payments

i. In accordance with 42 C.F.R. § 438.114, the PHP shall be subject to the following requirements:
    a) The PHP shall cover and pay for emergency services without regard to prior authorization or whether the provider that furnishes the service has a contract with the PHP.
    b) The PHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the PHP to seek emergency services.
    c) Likewise, the PHP shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
    d) The PHP shall provide coverage and payment of services until the attending emergency physician, or the provider actually treating the Member, determines that the Member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the Member, of when the Member is sufficiently stabilized for transfer or discharge is binding on the PHP.

ii. In accordance with SSA 1932(b)(2)(D), the PHP shall pay out-of-network providers who provide emergency services or post-stabilization services to a Member no more than the applicable Medicaid Fee-for-Service rates.

iii. The PHP shall reimburse out of state hospitals that are also out of network for emergency and post-stabilization care services according to the applicable Medicaid Fee-for-Service rates.

iv. In accordance with 42 C.F.R. § 422.113(c), the PHP shall be subject to following requirements:

a) The PHP shall be required to reimburse for out of network post-stabilization care services that are pre-approved by a PHP representative.

b) The PHP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain the Member's stabilized condition within one (1) hour of a request to the PHP for pre-approval of further post-stabilization care services.

c) Additionally, the PHP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the Member's stabilized condition in the following instances:

1. If the PHP cannot be contacted;
2. If the PHP does not respond to request for pre-approval within one (1) hour;
3. If the PHP representative and the treating physician cannot reach an agreement concerning the Member's care and a PHP physician is not available for consultation.
4. If the PHP representative and treating physician cannot reach an agreement concerning the Member's care and a PHP physician is not available for consultation, the PHP shall give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with the care of the Member until the PHP physician is reached or one of the other post-stabilization care services criteria is met.

d) The PHP shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:

1. Once a network physician with privileges at the treating hospital assumes responsibility for the Member's care;
2. Once a network physician assumes responsibility for the Member's care through transfer;
3. Once a PHP representative and the treating physician reach an agreement regarding the Member's care; and
4. Once the Member is discharged.

e) The PHP shall limit charges to Members for post-stabilization care services to an amount no greater than what the PHP would charge the Member if he or she obtained the services through the PHP.

t. Payments under Locum Tenens Arrangements

i. The PHP shall recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 45 C.F.R. § 455.410(b).

ii. The PHP shall establish and maintain a Locum Tenens Policy to comply with the requirements of N.C. Gen. Stat. § 58-3-231(b) and (c) and shall submit the Policy to the Department for review ninety (90) days after Contract Award.

u. The PHP shall develop and maintain a Reimbursement Policy consistent with N.C. Gen. Stat. § 58-3-227(a)(5). The PHP shall provide the Policy to the Department upon request, for review.

v. North Carolina State Laboratory of Public Health
For Contract Years 1-3, in instances where a LHD submits a communicable disease test, as defined by the Department, to the North Carolina State Laboratory of Public Health, the PHP shall reimburse the Lab according to applicable Medicaid Fee-For service fee schedule, unless the PHP and North Carolina State Laboratory of Public Health have mutually agreed to an alternative reimbursement arrangement.

5. Provider Grievances and Appeals

a. The PHP shall handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The PHP shall have in place a provider appeals and grievance system, distinct from that offered to Members, that includes a grievance process for providers to bring issues to the PHP, an appeals process for providers to challenge certain PHP decisions, and information regarding access to a state level review through the Office of Administrative hearings. The PHP shall be transparent with providers regarding its appeals and grievance processes and procedures.

b. The PHP shall submit the PHP Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) days after Contract Award. The PHP shall submit any significant policy changes to the Department for review at least sixty (60) calendar days before implementing the changes.

c. The PHP shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends, review existing operational or clinical opportunities to improve the provider experience.

d. Grievances
   i. The PHP shall have a process in place to receive and resolve complaints or disputes with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
   ii. The PHP shall accept and resolve provider grievances regarding the PHP referred from the Department.
   iii. The PHP shall have a method of allowing providers to submit grievances through the PHP provider portal.
   iv. The PHP shall provide information regarding provider grievances to Department as outlined in *Attachment J. Reporting Requirements* and upon request.

e. Appeals
   i. The PHP shall offer providers appeal rights as described in *Attachment I. Provider Appeals*.
   ii. The PHP shall provide written notice of provider's right to appeal with the notice of decision giving rise to the provider's right to appeal.
   iii. The PHP shall have a method of allowing providers to submit appeals through the PHP provider portal.
   iv. The PHP shall accept a written request for an appeal from the provider within thirty (30) calendar days on which:

a) Provider receives written notice from the PHP of the decision giving rise to the right to appeal; or
b) PHP should have taken a required action and failed to take such actions.

v. The PHP shall acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request.

vi. The PHP shall extend the timeframe by thirty (30) calendar days for providers to request an appeal for good-cause shown as determined by the PHP.
a) PHP shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an appeal request.
b) PHP shall include voluminous nature of required evidence/supporting documentation, and appeal of an adverse quality decision as good-cause reasons to extend the timeframe.

vii. The PHP shall provide information regarding provider appeals to Department upon request.

viii. The PHP Grievances and Appeals Policy shall provide that a provider must exhaust the PHP internal appeals process before seeking recourse under any other process permitted by contract or law.

f. Resolution of Appeal

i. The PHP shall establish a committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal. The committee must include an external peer reviewer when the issue on appeal involves whether the provider met Objective Quality Standards.

ii. The PHP shall provide written notice of decision of the appeal within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the PHP. Notice shall include information regarding further appeal rights, if any.

iii. The PHP shall allow providers to be represented by an attorney during the appeals process.

g. Appeals of Suspension or Withhold of Provider Payment

i. The PHP shall limit the issue on appeal in cases of suspension or withhold or provider payment to whether the PHP had good-cause to commence the withhold or suspension of provider payment. PHP shall not address whether the provider has or has not committed fraud or abuse.

ii. The PHP shall notify the Department within ten (10) business days of a suspension or withhold of provider payment.

iii. The PHP shall offer the provider an in person or telephone hearing when provider is appealing whether PHP has good cause to withhold or suspend payment to the provider.

iv. The PHP shall schedule the hearing and issue a written decision regarding whether PHP had good cause to suspend or withhold payment within fifteen (15) business days of receiving the provider's appeal. Upon a finding that PHP did not have good-cause to suspend or withhold payment, PHP shall reinstate any payments that were withheld or suspended within five (5) business days.

v. The PHP shall pay interest and penalties for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

h. Notice to Department

i. The PHP shall provide notice to the Department of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by PHP, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) business days of the appeal.

ii. The PHP shall notify Department if a provider has sued PHP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) business days of being served.

E. Quality and Value

1. Quality Management and Quality Improvement

a. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health.

b. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department.

c. As North Carolina transitions to Medicaid Managed Care, the Department will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes.

d. The PHP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations.

e. The PHP shall have a robust Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan.

   i. The Quality Management and Improvement Program Plan shall include the following elements:

      a) Mechanisms to conduct and assess performance improvement projects (PIPs) specified by the Department;

      b) Mechanisms to assess the quality and appropriateness of care for Members with special health care needs;

      c) Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;

      d) Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, and by key population group (e.g., LTSS);

      e) Mechanisms to incorporate population health programs targeted to improve outcomes measures;

      f) Mechanisms for collection and submission of all quality performance measurement data required by the Department;

g) Mechanisms to detect both underutilization and overutilization of services;
h) Mechanisms for participation in efforts by the Department to prevent, detect, and remediate critical incidents including those required for home and community-based waiver programs;
i) Mechanisms to assess and address health disparities at a statewide and regional level, including findings from the disparity report that PHPs are required to develop;
j) A Provider Support Plan (see additional details below in Section 11); and
k) The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy.

ii. Quality Assessment and Performance Improvement Plan (QAPI) (42 C.F.R. § 438.330)
a) The PHP shall submit an annual QAPI plan, delineating PHP's plans for performance improvement programs and other quality improvement efforts as part of the Quality Management and Improvement Program plan.
b) The PHP shall address any Department concerns regarding performance against quality measures directly through the QAPI plan, and, as applicable, build specific programs to improve quality performance into the QAPI plan.
c) The QAPI plan must include the following elements:
1. Completion of performance improvement projects (PIPs) specified by the Department;
2. Collection and submission of all quality performance measurement data required by the Department;
3. Mechanisms to detect both underutilization and overutilization of services;
4. Mechanisms to assess the quality and appropriateness of care for Members with special health care needs;
5. Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;
6. Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS);
7. Mechanisms to incorporate population health programs targeted to improve outcomes measures;
8. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS services and programs;
9. Mechanisms to assess and address health disparities, including findings from the disparity report that PHPs are required to develop; and
10. The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy.

f. The PHP shall participate in monthly PHP Quality Director Meetings.

g. The PHP shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.

h. The PHP shall modify their proposed process to evaluate the impact and effectiveness of its Quality Assessment and Performance Improvement program as part of each PHP's overall Quality Assessment and Performance Improvement program design as directed by the Department.

i. Quality Measures

i. The PHP shall report, and will be held accountable for performance against, measures aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence.
ii. The PHP shall report a set of quality and administrative measures listed in *Attachment E. Required PHP Quality Metrics* that are meant to provide the Department with a complete picture of the PHP's processes and performance.
    a) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the PHPs prior to launch and annually thereafter.
    b) The PHP shall submit to the Department all data necessary for the Department to calculate the PHP's performance.
iii. The PHP shall incorporate Department identified "Priority Set" into the PHP's QAPI and quality improvement activities. Priority measures are indicated in *Attachment E. Required PHP Quality Metrics.* The "Priority Set" is a subset of the total measure set which will be finalized for PHP by Department prior to go-live. The Department reserves the right to change the priority measure indication.
iv. Beginning in Contract Year 3, the Department may implement withhold measures based on quality measures used to administer a PHP quality withhold/incentive program. A subset of the Priority Set may be included in the Withhold/Incentive Program. Priority measures that may be subject to future withholds are indicated **for reference only** in *Attachment E. Required PHP Quality Metrics*. The Department reserves the right to change priority measures that may be subject to future withholds.
v. The Department shall monitor for CMS development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.

j. Disparities Reporting and Tracking
    i. The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
        a) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the PHP after Contract Award and annually thereafter.
    ii. The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures.
        a) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.

k. Public Health Measure Reporting and Tracking
    i. The PHP shall work with the Department to target areas of collaboration and develop programs as part of Quality Improvement efforts that can:
        a) Remove barriers (e.g., benefit coverage, implementation challenges, Member education);
        b) Align incentives by targeting withholds for measures that will affect public health priorities; and
        c) Require select quality initiatives to be embedded in QAPIs, including PIPs and contributions to health-related resources.

ii. The PHP shall be an active partner in Healthy NC 2020 goals and 2030 https://publichealth.nc.gov/hnc2020/ planning by participating at a minimum as follows:
    a) Joining planning meetings;
    b) Designating a senior level clinical staff person to engage in public health issue discussions; and
    c) Aligning QI activities to support Health NC 2020 and 2030 goals.

l. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)
    i. The PHP shall include no less than three (3) performance improvement projects as part of the annual Quality Assessment and Performance Improvement program. The PHP's PIPs must be approved by the Department annually as part of the PHP's QAPI program.
    ii. The PHP shall develop a Performance Improvement Project (PIP) that is:
        a) Designed to achieve significant improvement in health outcomes as part of the annual PHP Quality Assessment and Performance Improvement program review; and
        b) Includes measurement of performance using quality indicators as part of the annual PHP Quality Assessment and Performance Improvement program review.
    iii. Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
    iv. The PHP shall conduct at least one (1) non-clinical Performance Improvement Project (PIP) on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
    v. The PHP shall be required to develop and execute two (2) clinical performance improvement projects annually that must be related to the following areas:
        a) Pregnancy Intendedness;
        b) Tobacco Cessation;
        c) Diabetes Prevention;
        d) Birth outcomes;
        e) Early childhood health and development;
        f) Hypertension; and
        g) Behavioral Health Integration.
    vi. If the PHP performs below seventy-five percent (75%) for overall CMS 416 rates, the PHP shall submit one Performance Improvement Project on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical Performance Improvement Projects annually.

m. External Quality Review (42 C.F.R. § 438.3(s)(1))
    i. The PHP shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and communicated by the Department.
    ii. The PHP shall participate in the annual the Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS) and Provider Survey conducted by the EQRO.

n. Quality Improvement - Provider Supports
    i. The PHP shall provide support to providers tailored to advance state interventions and ensure providers' ability to achieve the goals outlined in the Quality Strategy.
    The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.

ii. The PHP shall develop and maintain a PHP Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the PHP Provider Support Plan.
iii. The Provider Support Plan shall be developed as a component part of the QAPI and provider support activities should relate to improvement in specific health outcomes.
iv. The PHP Provider Support Plan shall include an overview of which metrics the PHP will use to evaluate its provider engagement progress over time based.
v. The PHP Provider Support Plan shall include:
    a) The list of provider supports;
    b) How the PHP will provide in-person, online, and regional collaborative support opportunities;
    c) A detailed overview of how it will assess which stakeholders will be engaged for participation in Regional Forums (see below);
    d) All planned technical support activities;
    e) An overview of which metrics the PHP will use to evaluate its provider support progress over time; and
    f) Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy.
vi. The PHP shall develop and distribute targeted toolkits to all network providers. The PHP shall be responsible for distributing toolkits related to quality improvement activities, population health management, and specific Department-led transformation initiatives for all network providers.
vii. The PHP shall provide access to online resources to all network providers.
viii. The PHP shall provide quality improvement support to network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
    a) The opioid strategy interventions;
    b) The Healthy Opportunity interventions;
    c) The Advanced Medical Home program;
    d) Behavioral Health integration;
    e) Value-Based Payment;
    f) Pregnancy management/Pregnancy Management Program;
    g) Activities to support at-risk children; and
    h) The CDC 6|18 initiative.
ix. The PHP shall meet with clinical leadership at the regional level at least quarterly to discuss implementation of quality improvement activities aligned with the Quality Strategy (e.g., disease management protocols, maternal and infant health, child health and wellness activities) and implementation of Department-led transformation initiatives (e.g., clinical protocols for high-risk pregnancy management). Clinical leadership should include active network providers (see list below), the PHP CMO and PHP Quality Director. The Department's quality staff and medical leadership should be invited participants.
x. The PHP shall conduct at least one (1) in-person Regional Forum per year. The PHP shall work with the Department to coordinate forums with other PHPs in the Region.
    a) The PHP shall deliver all Regional Forum services and Technical Assistance support activities at a regional level regardless of the number of Regions the PHP offers services in.

xi. The PHP shall provide the space for in person events and all technology necessary to conduct Regional Forums, including conference call and webinar technology.

xii. Invitees shall include:

a) Advanced Medical Homes/Primary Care Physicians;
b) Obstetric/Gynecological Providers;
c) Behavioral Health providers;
d) Local health Departments;
e) School-based health centers;
f) Hospitals;
g) Long-term services and support agencies;
h) Clinical Integrated Networks;
i) Local Department of Social Service (DSS); and
j) Other relevant stakeholders based on the agenda and goals of the Forum.

xiii. The PHP shall also provide an opportunity for providers (in-person, online, routine/ad-hoc) to raise local challenges and exchange best practices related to Quality and Population Health outcomes as outlined in the Quality Strategy and other Department transformation initiatives as part of Regional Forums.

xiv. The PHP shall communicate with the Department-designated primary contact in order to raise regional issues related to Quality and Population Health Outcomes as outlined in the Quality Strategy and as otherwise specified by the Department.

2. Value-Based Payments/Alternative Payment Models

a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value, the Department is encouraging accelerated adoption of value-based payment (VBP) arrangements between PHPs and providers, and requiring that PHPs' Provider Incentive Programs be aligned with the Quality Strategy and related measures. Use of VBP and Provider Incentive Programs will align financial incentives and accountability around the total cost of care and overall health outcomes and ensure that PHPs and providers are recognized and rewarded for quality gains.

b. The Department defines VBP arrangements as payment arrangements between PHPs and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.

c. The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures.

d. PHPs shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward value-based payment, including having systems that can support alternative payment arrangement models which require shared savings and/or risk-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.

e. The PHP shall complete an APM assessment based on the categories developed by HCP-LAN. The Department will provide specifications on the assessment methodology upon Contract Award.

The Department will provide specifications on the assessment methodology upon Contract Award.

i. The Department shall use the APM assessment to demonstrate the "baseline" amount of payment arrangements with providers in HCP-LAN Levels 1 through 4 and compare documented progress to the PHP's final APM Strategy on an annual basis.
ii. The PHP shall report the results of their APM assessment within six (6) months of Contract Award.

f. To ensure the PHP's response aligns with the Department's strategy and goals, the PHP shall provide a description of the PHP's Value Based Purchasing/Alternative Strategy over the initial three (3) year period and its alignment to the Department's short- and long-term goals to shift from a fee-for-service system to VBP. The VBP/APM Strategy must be submitted within six (6) months Contract Award.
   i. The PHP VBP/APM Strategy shall incorporate required incentive programs for AMHs. The PHP may develop additional Physician Incentive Plans provided that any such Physician Incentive Plans are related to the aims and goals set forth in the Department's Quality Strategy and in compliance with the requirements set forth in 42 C.F.R. § 422.208 and 422.210.

g. The Strategy shall also contain the following elements:
   i. The results of the HCP-LAN APM assessment.
   ii. The PHP's goals, strategies and interventions for moving providers through higher levels of the HCP-LAN framework.
   iii. The PHP's strategy to align Medicaid Managed Care payment models with the PHP's other payor contracts.
   iv. The PHP's annual targets for amount of funding in VBP/APM arrangements by year, including a description of the payment model(s), their HCP-LAN classification, and targets across different models and provider types.
   v. The PHP's plan for measurement of outcomes and ROI related to VBP/APM by year.
   vi. Specific program(s) that will be offered to AMH Tier 3 practices, which must align to HCP-LAN Categories 2 through 4 and meet any other criteria specified within AMH program requirements.
   vii. Specific program(s) that will be offered to other AMH providers and/or specialties.
   viii. The PHP's expected percent of total premium flowing to providers through shared savings and other incentive arrangements.
   ix. A description of the PHP's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the PHPs VBP/APM programs. Specific functionalities to address include:
      a) Risk adjustment;
      b) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
      c) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
      d) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
      e) Reporting capabilities; and
      f) Payment functions.

h. The PHP shall submit an updated VBP/APM Strategy to the Department on an annual basis that includes the following updates:

i. Updates to the HCP-LAN APM assessment;
ii. Progress towards the PHPs goals, strategies and interventions for moving providers through higher levels of the LAN framework;
iii. The PHP's progression over time, if applicable, in advancing providers through higher levels of the LAN framework.
iv. Progress toward the PHP's annual targets for amount of funding in VBP/APM arrangements by year;
v. Updates against all Physician Incentive Plans (as applicable); and
vi. Results of the PHP's outcome measurements and analysis of the ROI by year and to-date.
vii. Changes or improvements in the PHP's IT capabilities necessary for the successful implementation of the targeted VBP/APM arrangements.

i. Additionally, the PHP shall participate in any VBP/APM stakeholder meeting process initiated by the Department. The PHP will be responsible for meeting any requirements outlined by a Departmental VBP/APM stakeholder group for future contract years.

j. Starting in Contract Year 3, the Department may use PHP-submitted HCP-LAN assessments to implement withholds associated with VBP penetration.

k. Physician Incentive Plans
i. The PHP is permitted to develop Physician Incentive Plans outside of the VBP and Pregnancy Management Program requirements and put forth by the Department, provided that any such physician incentive plans are related to the aims and goals set forth in the Quality Strategy.
ii. The PHP shall submit all Physician Incentive Plans as part of the PHP VBP/APM Strategy to the Department for review and approval prior to PHP implementation of such incentives.
iii. Any Physician Incentive Plans developed by PHPs shall be in compliance with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, in which references to 'MA organization', 'CMS', and 'Medicare beneficiaries' must be read as references to 'PHP', 'the Department', and 'Medicaid beneficiaries', respectively.
iv. The PHP shall submit to the Department annual reports as part of the annual update to the VBP/APM strategy containing a detailed overview of any implemented (and previously approved) Physician Incentive Plans, or, if no such arrangement is in place, attest to that fact. Annual Physician Incentive Plan reports must provide assurance satisfactory to the Department that the requirements of 42 C.F.R. § 422.208 are met.
v. The PHP shall provide the following information to any Medicaid Member who requests it:
a) Whether the PHP uses a Physician Incentive Plan that affects the use of referral services;
b) The type of incentive arrangement; and
c) Whether stop-loss protection is provided.

F. Stakeholder Engagement

1. Engagement with Federally Recognized Tribes

a. The PHP must have a strong understanding of and capability to meet the needs of federally recognized tribal members, including North Carolina's federally recognized tribe – the Eastern Band of Cherokee Indians (EBCI).

b. As specified in Section 4. (5)e. of Session Law 2015-245, as amended by Session Law 2016-121, members of federally recognized tribes are exempt from mandatory enrollment in Medicaid

Managed Care enabling them to choose enrollment in the Medicaid Fee-for-Service or Medicaid Managed Care at any time.

c. The Department is collaborating with the EBCI to develop a Tribal Option that considers and addresses the unique cultural, behavioral health and medical needs of federally recognized tribal members.

d. The PHP shall establish an ongoing partnership with the EBCI and other tribal populations that supports Members who are tribal members.

e. For federally recognized tribal members that enroll in a PHP, the PHP will implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health care for the individual, family, or community members of federally recognized tribes. The Strategy should adapt individual engagement interventions, programs, and policies, demonstrate cultural humility, cultural awareness, respect and honor and fit the historical and cultural context of the individual, family, or community members of federally recognized tribes.

f. The Tribal Engagement Strategy shall include:
   i. A proposal of an administrative, clinical and operating model intended to meet the needs of federally recognized tribes and specifically in western NC;
   ii. Culturally appropriate, proactive, innovative methods for engaging and communicating with EBCI tribal members and EBCI leadership;
   iii. A proposal and strategy to improve communication through the utilization of a health information exchange in order to improve coordination of care and health outcomes for tribal members;
   iv. A description of how the PHP's care management and quality strategies take into consideration the needs of tribal members;
   v. Seamless integration with the ECBI, its local Public Health and Human Services (PHHS) staff, members of other federally recognized tribes residing in NC and other tribal populations native to North Carolina;
   vi. Medicaid Managed Care education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may create barriers to health care, provider access and service delivery; and
   vii. Approaches the PHP will take to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities.

g. The Tribal Engagement Strategy shall be submitted to the Department for review and approval within ninety (90) days of Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.

h. The PHP shall consult with the Indian Tribes and Tribal Organizations quarterly regarding Medicaid Managed Care initiatives impacting tribal populations.

i. The PHP shall collaborate with the EBCI to facilitate, at least semi-annually, meetings and forums with the EBCI and IHCPs that serve tribal members.

j. When requested, the PHP shall make member education and training material available to licensed and unlicensed physical and behavioral health personnel who work with federally recognized tribal members or their families.

k. The PHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

i. The PHP shall provide and maintain a point of contact for IHCP billing issues to the Department.

l. The PHP shall ensure its staff, materials, and resources adhere to the requirements described in *Section V. B. 3. Member Engagement*.

m. Annually, the PHP shall train their staff regarding the PHP's Tribal Engagement Strategy and in providing cultural sensitive and consumer-specific supports to the tribal population as referenced in *Section V. G. 2. Staff Training*.

2. Engagement with Community and County Organizations

a. The PHP must have a strong understanding of and capability to meet the needs of North Carolina's local communities, including County Agencies (e.g., local health departments, local Department of Social Services, Area Agency on Aging, Local Education Agencies, housing authorities, county commissioners, county managers, etc.) and County and Community Based Organizations (e.g. faith-based organizations, food pantries) that deliver services to Members and their families.

b. The PHP shall engage with County Agencies and County and Community Based Organizations (CBOs) to understand the potentially unique resources and needs of each community and to integrate its model of care with the local community it serves.

c. The PHP shall establish an ongoing partnership with North Carolina County Agencies and CBOs that support North Carolina Medicaid and NC Health Choice Members, in the Region(s) that the PHP is contracted to cover.

d. The PHP shall develop and implement a Local Community Collaboration Strategy that supports continued engagement with county and community organizations and build partnerships at the local level to improve health of their Members.

e. The Local Community Collaboration Strategy shall address how the PHP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, Member engagement, and local continuums of care.
   i. The strategy shall include:
      a) Approach to understand the unique needs of the counties and communities the PHP is serving;
      b) Methods of collaborative outreach with county agencies, CBOs, community partners;
      c) Measures of successful engagement and collaboration; and
      d) Reporting of outcomes to county agencies, CBOs, and community partners.

f. The Local Community Collaboration Strategy shall be submitted to the Department for review and approval within ninety (90) days of Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.

g. The PHP shall consult with the county agencies, county executives and/or the county commissioners' association quarterly regarding Medicaid Managed Care initiatives impacting counties and community organizations.

h. The PHP shall collaborate with the county agencies, county executives and/or the county associations to facilitate, at least semi-annually, meetings and forums with the county agencies, county executives and/or the county associations.

3. Integration with Other Department Partners

a. The Department seeks a PHP with the ability to seamlessly integrate with key Medicaid Managed Care partners, including the Enrollment Broker, Ombudsman Program and local county DSS offices to support beneficiaries through the transition to and on-going implementation of Medicaid Managed Care. To achieve this goal, the PHP shall be required to do the following:
   i. Engage in joint community based education events and activities with the staff of the Enrollment Broker and Ombudsman Program as requested by the Department, including but not limited to health fairs and community events.
   ii. Provide information to the Enrollment Broker such that those interested in enrolling have adequate, written descriptions of the PHP's rules, procedures, benefits, services, and other information necessary for Members to make an informed decision about enrollment.
   iii. Provide educational materials described in *Section V. B. 3. Member Engagement* in hard copy and electronic format for distribution to local DSS offices and to Members that may utilize the Ombudsman Program for assistance.
   iv. Collaborate with the Ombudsman Program to facilitate issue resolution for Members navigating the Medicaid Managed Care delivery system.
   v. Coordinate efforts with the Department, the Enrollment Broker and the Ombudsman Program to improve the Member experience by incorporating Member feedback into the PHP education campaign strategy by modifying, updating, removing, changing, or adding materials, call center scripts, website content, education materials, presentations, or other administrative or operational processes.
   vi. Collaborate with county DSS offices, PHHS offices, community based and advocacy organizations and the Ombudsman Program to understand and incorporate the needs of Member into the PHP's Member education strategy.

G. Program Operations

1. Service Lines

a. All service lines shall be staffed with personnel specifically trained on the requirements, policies and procedures of the North Carolina market and can resolve an inquiry or issue in "one-touch".

b. The PHP shall establish the following service lines as part of its call center:
   i. **Member Service Line**: To enable Members to conveniently access information about benefits or claims, referral assistance and access to treatment or services.
   ii. **Provider Support Service Line**: To assist providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries and complaints
   iii. **Pharmacy Service Line**: To assist pharmacies and prescribers with point of sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.
   iv. **Nurse Line**: To provide Members with around-the-clock access to medical information and advice on where to access care.
   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 is confidential, toll free number 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.

c. The PHP shall adhere to the Department's hours of operations, location, and staffing and Member ID requirements for each service line:

Section V.G. Table 1: Member and Provider Support Call Center Operations			
Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card
i. Member Service Line	1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch) 2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week 3. Open all State holidays	Yes	Yes
ii. Provider Support Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Open all State holidays	Yes	Yes
iii. Pharmacy Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Prescriber prior authorization services available to meet 24-hour review requirements as defined in *Section V. C. 3. Pharmacy Benefits* 3. Open all State holidays	Yes	Yes
iv. Nurse Line	1. Twenty-four (24) hours per day / seven (7) days per week / 365 days per year	No	Yes
v. Behavioral Health Crisis Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	Yes	Yes

d. The PHP service lines shall be accessible via a toll-free telephone line.

e. The PHP services lines shall have capacity to handle:
   i. All inbound and outbound telephone calls during the hours of operation as defined in this Section;
   ii. Calls from Members and providers, with Limited English Proficiency, as well as Members and providers with communications impairments, including individuals with hearing and/or speech disabilities;
   iii. Technology needed to receive calls from deaf, hard of hearing and Deaf-Blind callers to include TTY, Captioned phones and amplified phones;
   iv. After-hours calls, including:
      a) Accepting, recording or providing instruction in response to incoming calls during non-business hours;
      b) Allowing option to leave a message and request for call back;
      c) If a request for a call back is made, the return phone call shall be made the following business day during normal hours of operations; and
      d) Department approval of the after-hours message.

v. An Automated Voice Response System (AVRS) which:
    a) Interacts with the Member through voice and/or numeric prompts and allows Members to perform self-service activities and resolve simple inquiries without the need to interact with a live person;
    b) May prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the Member prior to the call being distributed to a call center representative;
        1. The AVRs must have the capability of allowing non-enrolled Members and providers to access service line staff.
    c) Offers user-friendly options that are easily understood by Medicaid beneficiaries and authorized representatives (including a decision tree illustrating AVRS system);
    d) Works in conjunction with an Automated Call Distributor (ACD) which intelligently routes and effectively manages all calls to appropriate and available staff:
        1. When a Member desires to speak with a live person; and
        2. Based on unique Member needs i.e. caller language needs.

vi. Ensure adequate staffing and capacity to meet the service line performance standards defined in the Contract.

f. The PHP shall be permitted to use overflow or secondary call centers to meet capacity requirements as defined in this Section. All call centers shall be held to the same service line performance standards as defined within the Contract.

g. The PHP shall be permitted to provide educational messages or other messages which improve the customer experience (e.g., announcement of new program changes or reminders) while callers are on hold, as directed or approved by the Department.

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

i. All PHP services lines shall be able to transfer calls via warm transfer to all other PHP service lines, when appropriate.

j. The PHP shall digitally record and store one hundred percent (100%) of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months.

k. The PHP shall allow the Department real time remote access via secure internet connection to all call recordings, including video and audio, with the Department having ownership and control of these recordings.

l. The PHP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge on North Carolina Medicaid and NC Health Choice as defined within this Contract.

m. The PHP shall acquire the necessary phone number(s) to support the requirements of this Section within sixty (60) calendar days of the Contract Award.
    i. The PHP shall relinquish ownership of the toll-free number(s) upon contract termination or expiration, at which time the Department shall take title of these telephone numbers.

ii. All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the PHP and shall be paid prior to the Department taking title.

n. The PHP shall develop service line scripts for use by PHP staff when talking with Members, authorized representatives, and providers.
   i. All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies and procedures of the North Carolina market.
   ii. The PHP shall submit to the Department for approval a listing of topics which scripts will address, and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
      a) Member Medicaid Managed Care resources, education and assistance to understand Medicaid and NC Health Choice benefits;
      b) Provider contracting;
      c) AMH certification;
      d) Provider claim submission and adjudication issues;
      e) Service prior authorization process and status;
      f) Member pharmacy lock-in program;
      g) Information to contact the Enrollment broker;
      h) Member grievance and appeal process, including information on Member supports available; and
      i) Other topics as identified by the Department.
   iii. All service line scripts shall be made available to the Department upon request, and all Member Service Line, Nurse Line, and Behavioral Health Crisis Line scripts shall be approved by the Department prior to use or when significant changes are made.

o. The PHP shall track all call center interactions with Members, authorized representative and providers. The record of contact must include:
   i. Member/potential Member's name;
   ii. Medicaid or NC Health Choice identification number (preferred);
   iii. Channel of interaction;
   iv. Demographics, including, but not limited to
      a) Phone number and
      b) Emergency or alternative number if needed;
   v. Notes summary of Member/potential Member interaction (e.g. summary of issue, if issue was resolved or addressed, what information was provided by the PHP's representative);
   vi. Record of the time and date of interaction;
   vii. Contact agent;
   viii. Resolution and/or if additional follow-up is or was required; and
   ix. Interpreter requests and the language requested;

p. The PHP shall develop and maintain a Call Center and Service Line Policy that defines how the PHP will meet and maintain the requirements of the Contract. The Policy shall be made available to the Department, upon request.
   i. The Policy shall include at a minimum:
      a) Service line process flows and call-tree routing options;
      b) Service line script topics;
      c) Staffing and licensure requirements;
      d) Quality assurance and monitoring approach;
      e) Provider and Member issue tracking and resolution process; and

f) Incorporation of provider and Member issues into broader PHP quality improvement.

q. Member Service Line:
   i. Emergency Member issues shall be defined as a Member having an Emergency Medical Condition or in need of emergency services.
   ii. The Member services line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined in *Section V. B. 3. Member Engagement*.
   iii. The PHP Member Service Line must be able to connect to the PHP Behavioral Health Crisis Line via a warm transfer twenty-four (24) hours per day, seven (7) days per week.

r. The Nurse Line shall integrate with the PHP's overall care management program.
   i. Within forty-eight (48) hours of a Member call, the Nurse Line shall follow up with the Member's care manager to share relevant clinical and follow up information.

s. Pharmacy Service line:
   i. The Service Line Policy shall include standards to meet twenty-four (24) hour prior authorization requirement as defined in *Section V. C. 3. Pharmacy Benefits*.

t. Behavioral Health Crisis Line:
   i. The PHP Behavioral Health Crisis Line must be staffed with licensed BH professionals.
   ii. The PHP Behavioral Health Crisis Line must immediately connect to the crisis response systems.
   iii. The PHP Behavioral Health Crisis Line must have patch capabilities to 911 emergency services.
   iv. The PHP Behavioral Health Crisis Line must not:
      a) Allow Members to receive a busy signal in order to meet the minimum performance requirements;
      b) Allow Member calls to be answered by an automated response;
      c) Allow Members to leave messages and receive a call back;
      d) Shift calls to an overflow system during high volume call times; or
      e) Allow Maximum call duration limits.

2. Staff Training

a. The PHP shall meet the Department's goals and objectives of providing support and services to meet Member and provider needs by training and educating PHP staff members and contractors on the requirements, policies and procedures of Medicaid Managed Care and the unique needs of Medicaid Managed Care Members.

b. The PHP shall ensure that staff and contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under this contract. Staff members having contact with Members or providers, or with the Department or the county Departments of Social Services staff shall receive training regarding the appropriate identification and handling of questions and concerns.

c. The PHP shall train new staff to the North Carolina Medicaid Program within seven (7) calendar days of their start date.

d. The training program shall include distinct training for:
   i. Member services staff and contractors;
   ii. Provider relations staff and contractors;

iii. Staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators; and
iv. Staff and contractors whose work integrates with the Department.

e. The PHP shall be responsible for ensuring training directed toward Member Services staff and contractors include, but are not limited to:
   i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
   ii. Services which the PHP is required to make available to all Members;
   iii. Awareness of all supports and services that enhance the Member experience;
   iv. Awareness of stakeholders who may interact with Members;
   v. Member rights and responsibilities;
   vi. Member grievance and appeals process, including State Fair Hearing Process;
   vii. The PHP's provider networks;
   viii. Overcoming barriers to accessing medical care;
   ix. Understanding the role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to Members' health and health care needs;
   x. Awareness of other Medicaid Managed Care and Medicaid Fee-for-Service programs and services for distinct populations, including individuals with military service or who are pregnant;
   xi. Linking Members to other state and local programs or assistance, including but not limited to social services, state-funding behavioral health services, law enforcement and the criminal justice system.
   xii. Fraud, waste, and abuse detection, investigation, and prevention;
   xiii. Process for offering suggestions to improve the Member or provider experience;
   xiv. Awareness of and sensitivity to low-income families, individuals with disabilities, people who do not fluently speak or read English, or individuals with varying levels of reading comprehension or illiteracy;
   xv. Ability to communicate appropriately with bilingual individuals or those with special needs. Use of bilingual interpreters, sign language interpreters both in person and through video remote interpreting, Relay Video Conference Captioning, video relay service, 711 relay services, TTY machines, or assistive communication devices;
   xvi. Awareness of benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI;
   xvii. Sensitivity to different cultures and beliefs;
   xviii. Understanding of generational, experiential and other preferences to receiving information;
   xix. Unique needs, experiences of members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:
      a) The significance of extended families including an understanding that the definition of extended families is different than non-native families;
      b) The different service eligibility for non-enrolled family members of enrolled members in EBCI or other federally recognized tribes;
      c) Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish); Respect for traditions where gender and age may play an important role:
         1. Elders have a highly respected status due to their life experiences;

2. Elders tend to be non-verbal;
3. Pregnant individuals; and
4. Veterans.

d) The different service types and benefit plans available through the Tribal Option; and

xx. HIPAA and the Department's Privacy and Security requirements.

f. The PHP shall be responsible for ensuring training directed towards Provider relations staff and contractors include, but are not limited to:
   i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
   ii. Awareness of all supports and services that enhance the provider experience;
   iii. Awareness of stakeholders who may interact with providers;
   iv. Awareness of other Medicaid Managed Care and Medicaid Fee-for-Service services for distinct populations;
   v. Covered services, including EPSDT;
   vi. Provider rights and responsibilities;
   vii. Fraud, waste, and abuse detection, investigation, and prevention;
   viii. Use of bilingual interpreters, sign language interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, or assistive communication devices;
   ix. Sensitivity to different cultures and beliefs;
   x. Understanding of generational, experiential and other preferences to receiving information;
   xi. Unique needs and requirements of Indian Health Care Providers; and
   xii. HIPAA and the Department's Privacy and Security requirements.

g. The PHP shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators include, but are not limited to:
   i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, cost sharing, key initiatives and priorities, and program goals;
   ii. Awareness of all supports and services that enhance the Member experience;
   iii. Member rights and responsibilities;
   iv. Member grievance and appeals process;
   v. Awareness of other Medicaid Managed Care and Medicaid Fee-for-Service services for distinct populations;
   vi. Fraud, waste, and abuse detection, investigation, and prevention; and
   vii. HIPAA and the Department's Privacy and Security requirements.

h. The PHP shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the Department includes topics identified for all other training programs.

i. Submission and Approval
   i. No later than fifteen (15) calendar days after Contract Award, the PHP shall submit a training and evaluation program to the Department.
      a) The training program shall comply with all state and federal provisions, and should utilize Department resources where available.
      b) Each training program shall be approved by the Department before use with PHP staff and contractors.

c) The PHP shall initiate training within five (5) calendar of approval by the Department.

ii. Training materials include, but are not limited to:
   a) Training Policies and Procedures;
   b) Training Plan;
   c) Training Curriculum; and
   d) Evaluation Methodology.

iii. The PHP shall update the training materials and conduct training of its staff and contractors annually, as changes are made to Medicaid Managed Care, in response to improving the Member experience, improving the provider experience, improving staff and contractor performance, or as requested by the Department.
   a) The PHP shall submit all updates and changes to the Department for review and approval before use with PHP staff and contractors.

j. The PHP must collaborate with the Department on providing training to Department, county DSS staff, the EBCI, the Ombudsman program and Enrollment Broker.
   i. Training must:
      a) Be completed at least sixty (60) calendar days prior to the Managed Care Phase 1 open enrollment period;
      b) Be hosted at multiple locations as defined by the Department;
      c) Contain information on the role of the PHP;
      d) Describe the relationship and integration of the PHP with the Department, Enrollment Broker, county DSS staff, the EBCI PHHS, and the Ombudsman program; and
      e) Describe how to navigate the public facing websites.
   ii. Materials for the training must be provided to the Department no later than thirty (30) days prior to scheduled events for review, if necessary.

3. Reporting

a. The PHP shall comply with all the reporting requirements established by the Contract.

b. The Department shall provide the PHP with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in *Attachment J. Reporting Requirements*.

c. The Department may, at its discretion, change the content, format or frequency of reports or require the PHP to submit additional reports both ad hoc and recurring.
   i. If the Department requests any revisions to the reports already submitted, the PHP shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.

d. The PHP shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.

e. The PHP shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.

f. Except as otherwise specified, all reports shall be specific to each Region covered by this Contract.

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

h. Upon request, the PHP shall provide the Department with all underlying data required to produce reports required under the Contract.

4. PHP Policies

a. The PHP shall develop policy documents outlining key business process, procedures and staffing requirements as required in this Contract.

b. The policy document shall include:
   i. Outline processes and procedures;
   ii. Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
   iii. Define required PHP and Department systems; and
   iv. Describe PHP's continuous improvement approach to update policies.

c. All required PHP policies are outlined in the Contract. The PHP shall submit policy documents to the Department for review and approval as defined in the Contract.

d. After initial approval, the PHP shall submit any material modifications, additions, or deletions of all policies to the Department at least thirty (30) calendar days prior to implementation.

5. Business Continuity

a. The PHP shall develop and maintain a Business Continuity Plan this is acceptable to the Department, and demonstrate the adequacy of the Plan at the Department's request. The PHP shall adhere to all applicable published Department Privacy and Security policies, (located at https://it.nc.gov/documents/statewide-information-security-manual and https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/) and all other requirements set forth in the Contract.

b. Within thirty (30) calendar days of the Contract Award, the PHP shall submit a detailed description of its Business Continuity Plan for all requirements specified in the Contract. See *Attachment N. Business Continuity Management Program.* The PHP shall demonstrate how it will restore call center operations and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) calendar days following a natural or manmade disaster. The Plan shall meet recognized industry standards for security and disaster recovery requirements. The Plan shall identify disaster situations (e.g., fire, flood, terrorist event, hurricanes/tornadoes), which could result in a major failure. For each identified situation, the PHP shall explain in detail:
   i. The preventive measures that would be instituted to minimize the likelihood of its occurrence;
   ii. The back-up, off-site storage, and other pre-disaster safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
      a) Descriptions of the controls for back-up processing, including how frequently back-ups occur;
      b) Documented back-up procedures;
      c) The location of data that has been backed up (off-site and on-site, as applicable);
      d) Identification and description of what is being backed up as part of the back-up plan;
      e) Any change in back-up procedures in relation to the PHP's technology changes;
      f) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and

g) The same safety and data security measures need to be in place as for normal operations.

iii. Identify and review all federal or state disaster declarations made in North Carolina or affecting North Carolina in the last five (5) years as part of the PHP's business continuity planning;

iv. The tasks that would be involved, and identify by job description or title the PHP's staff and the Department's staff involvement;

v. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans;

vi. The time-frame required to accomplish full recovery from the point of interruption;

vii. The procedures for coordinating with the Department in the event of a disaster; and

viii. The procedures for notifying the Department, Enrollment Broker, Members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.

c. As part of the Business Continuity Plan, the PHP shall submit Business Continuity Plan(s) for any/all call center(s) for the Department's review and approval within thirty (30) calendar days of the Contract Award and be updated at least every six (6) months thereafter.

d. The PHP shall notify the Department each time the Business Continuity Plan is activated within two (2) hours of an event.

e. The Plan shall, at a minimum, include an overflow telephone system to operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.

i. The overflow system must interface with the call tracking and recording standards and technology required in the Contract.

ii. All quality and performance standards required in this Contract shall apply to the overflow call center.

H. Claims and Encounter Management

1. Claims

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.

b. Incorrect claim payment or inappropriate claim denial result in increased administrative costs to both the provider and the PHP and by extension, increase the program costs of Medicaid Managed Care. Therefore, the PHP shall develop, maintain and operate a claims payment, review and program integrity process which minimizes incorrect claim payments and inappropriate claim denials.

c. Claims Processing and Reprocessing Standards

i. The PHP shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when the Department decisions are made that would warrant reprocessing (i.e. Member retrospective eligibility determinations or plan enrollment changes).

ii. In addition to processing claims for all Medicaid Managed Care covered services, the PHP shall have the operational and administrative capability to process ILOS, Value-Added services, and qualifying EPSDT services which may be otherwise non-covered.

iii. The PHP shall process and reimburse providers in accordance with the Department's prompt payment standards, regardless of Provider contracting status.

a) Prior to paying a claim, the PHP shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of Provider contracting status.

b) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid and NC Health Choice programs, are subject to an out of state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.

iv. The PHP shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:

a) The PHP shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.

b) The PHP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes.

c) The PHP shall capture and retain the IP address/location and the user login/user name for all claims submitted via an on-line portal.

v. In instances where a provider submits an adjustment to a previously adjudicated claim, the PHP shall adjudicate the adjusted claim within the same timeframes as required for the initial Clean Claim.

vi. The PHP shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.

d. Prompt Payment Standards

i. The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.

a) Medical Claims

1. The PHP 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 timely process the claim.
2. The PHP 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.

b) Pharmacy Claims

1. The PHP shall within fourteen (14) calendar days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely 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.

c) If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within ninety (90) calendar days of the notice requesting the required

additional information, the PHP may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).

ii. The PHP shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).

iii. Pursuant to N.C. Gen. Stat. § 58-3-225(f), the PHP may require that claims be submitted within one hundred eighty (180) calendar days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) calendar days after the date of the Member's discharge from the facility. However, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

iv. Interest and Penalties

a) The PHP shall pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.

b) In addition to the interest on late payments required by this Section, the PHP shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.

c) The PHP shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).

v. The PHP shall maintain written or electronic records of its activities under this Section in accordance with N.C. Gen. Stat. § 58-3-225(i).

vi. For purposes of actions which must be taken by a PHP as found in Section V.H.1.d., Prompt Pay Standards, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

e. The PHP shall comply with the Department's Tribal Payment Policy, to be provided by the Department upon Contract Award.

f. Overpayment or Underpayment Recovery

i. The PHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the PHP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. 42 C.F.R. § 438.608(a)(2).

ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with N.C. Gen. Stat. § 58-3-225(h).

iii. The PHP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.

g. System Standards

i. The PHP shall have a Claims Processing and Management Information System (MIS) capable of meeting Medicaid Managed Care requirements and maintaining compliance throughout the term of the Contract.

ii. The PHP shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a Member.

h. Mass Adjustment
   i. The PHP shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
   ii. The PHP shall comply with the Department's policies and procedures on mass adjustment.

2. Encounters

a. The Department collects and uses medical, behavioral health, and pharmacy service encounter data for many purposes including, but not limited to, Federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.

b. The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with Medicaid Managed Care.

c. Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, penalties paid or recovered, incentive payments paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated services, third party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the PHP, its delegees or subcontractors.

d. Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPPA rejection and not a denied claim or claim line.

e. Submission Standards and Frequency
   i. The PHP shall ensure that all HIPAA transactions adhere to the Department Encounter Submission Companion Guide and Encounter Data Manual developed by the Department or its vendor(s) to be provided at Contract Award.
   ii. The PHP shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
   iii. The PHP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Submission Companion Guide and Encounter Data Manual.
   iv. Encounter data submissions must contain adjustments made by PHP due to payment errors and/or provider adjusted claims.
   v. The PHP shall submit a monthly certification from the PHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
   vi. The PHP is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
   vii. Specifications

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

viii. The PHP shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the PHP submitted an encounter data file.

ix. Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
    a) Timeliness
        1. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) calendar days from the claim adjudication date.
        2. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) calendar days from the claim adjudication date.
    b) Completeness
        1. The PHP shall submit all claims processed as encounters, as defined in this Section.
        2. The PHP encounter data submissions shall meet or exceed a monthly data acceptance rate of ninety-eight percent (98%) as compared to the PHP's monthly certification.
        3. Encounter data completeness shall be measured as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
        4. If the PHP encounter submission rate is less than one-hundred percent (100%), the PHP shall submit one-hundred percent (100%) of omitted encounters from the initial encounter submission date.
    c) Accuracy

1. PHP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
2. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.

x. Initial Encounter Data at Medicaid Managed Care Launch
   a) The PHP shall include encounter data for medical claims which have a date of service on or after the Medicaid Managed Care Launch date on which the PHP becomes responsible for the administration of services.
   b) The PHP shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the PHP becomes responsible for the administration of services.

xi. To support the Department achieving efficient encounter data processing, the PHP shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.

xii. In the event the PHP enters into a sub-capitated or other Value Based Payment reimbursement arrangement with a provider, the PHP shall be responsible for submitting all encounters to the Department, containing all the required data fields.

xiii. The PHP shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.

f. Encounter Data Resubmission Standards

i. Following the Department's validation and processing of encounter data submissions, the PHP shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.

ii. The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial Date of Service.
   a) The PHP shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
   b) The Department will work with a PHP for any retroactive encounter denial longer than three (3) years after the initial Date of Service.

iii. Timeliness
   a) The PHP will receive notification of medical encounter data errors requiring correction and resubmission within thirty (30) calendar days of the PHP's initial medical encounter data submission date.
      1. PHP shall, where the PHP submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) business days following the date that the negative 999 response is generated.
      2. PHP shall, where PHP submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) business days following the date that the negative 999 response is generated.

b) Within thirty (30) days after a pharmacy encounter fails NCPDP edits, X12 (EDI) edits or NC MMIS system edits, the PHP or its subcontractor shall correct and resubmit each pharmacy encounter for which errors can be remedied.

iv. Completeness and Accuracy. Unless otherwise directed by the Department, the PHP shall correct and successfully resubmit:
   a) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) calendar days from the date the 277 was generated;
   b) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) calendar days from the date the 277 was generated;
   c) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) calendar days from the date the 277 was generated.

v. The PHP or its subcontractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP pharmacy encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

f. Data Validation and Processing

i. The PHP shall have the capability to access sufficient enrollment information to perform Member and service provider matching on all claim and/or encounter transactions, if necessary.

ii. The Department shall utilize data validation protocols on encounter data files to assess PHP encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).

iii. The PHP shall perform testing with the Department prior to system changes when medical or pharmacy clinical policy changes that may impact operational transactions (i.e. encounter submissions) are identified by PHP or by Department. The PHP shall not implement any system changes until testing is approved by the Department.

iv. The PHP shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.

v. The PHP shall, in instances where the PHP is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) days prior to the date the modified file will be submitted to the Department production environment.

vi. The PHP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.

vii. At the discretion of the Department, the PHP may be prohibited from submitted a specific encounter type to the Department's Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the PHP. In addition, if the PHP's access to the Production Encounter Processing System is revoked, the PHP must actively test with the Department until such time that the

compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) calendar days. Any penalties incurred by the PHP because of the loss of production access are the responsibility of the PHP.

g. Denied Claims Submitted as Encounters
    i. The PHP shall submit denied claims as encounters to support denial trend analysis.
    ii. PHP submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
    iii. On denied claims submitted as encounters, the PHP shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
    iv. Denied claims submitted as encounters must also include the same data content, including provider, Member and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
    v. The PHP shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction or the Department designated pharmacy encounter format.

h. Communication and Oversight
    i. If the PHP experiences a technical issue preventing encounter data submission, the PHP shall notify the Department via the approved communication method within the predefined timeline.
    ii. The PHP shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the PHP's system(s) or process(es) that prevents the PHP from submitting encounter data files as scheduled.
    iii. The PHP shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
    iv. The PHP shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.

i. Testing
    i. The PHP will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the PHP to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The PHP shall pass the testing phase for all encounter claim type submissions at a time specified by the Department
    ii. The PHP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Submission Companion Guide and Encounter Data Manual.

j. In the event of Contract Termination or Non-renewal, the PHP shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) calendar days following the Contract Termination Effective Date for adjudicated claims with the Date of Service (DOS) on or before the Contract Termination or Non-renewal effective date.

k. In instances where the Contract has been terminated for greater than ninety (90) calendar days from the contract termination effective date, the PHP shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

I. Financial Requirements

1. Capitation Payments

a. Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of PHPs. Capitation payments include risk-adjusted Monthly Per Member Per Month payments, maternity event payments and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFP. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Draft Rate Book.

b. The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates. More information on both rate setting and risk adjustment can be found in *Section IX. Draft Rate Book*. Further details will be provided after Contract Award.

c. The Department shall set PHP capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.

d. The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.

e. The PHP shall supply, certify, and validate data to support rate setting, risk adjustment, and qualified directed payments based on schedules to be provided by the Department after Contract Award.

f. The Department shall update the PHP risk adjustment factors applied to capitation rates based on changes in monthly enrollment for Contract Year 1. In subsequent years, the Department shall update the PHP risk adjustment factors on a frequency no more than monthly and no less than every six (6) months.

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 live birth, to the Department. The required documentation and process for submission will be finalized prior to Contract Year 1effective date, and annually thereafter, and included in an Amendment.

h. The Department will reimburse PHP for additional directed payments to providers as required under *Section V. D. 4. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The PHP is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The PHP shall provide the necessary data to support this process in a format and frequency to be defined by the Department.

i. The Department will make capitation payments in accordance in with the Payment and Reimbursement term in *Section III. D. 32. PAYMENT AND REIMBURSEMENT*.

2. Medical Loss Ratio

a. The Medical Loss Ratio standards are to ensure the PHP is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.

b. The PHP shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two bases as follows:
   i. The PHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8.
   ii. The numerator of the PHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the PHP's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
   iii. The denominator of the PHP's CMS-defined MLR for a MLR reporting year shall equal the PHP's adjusted premium revenue. The adjusted premium revenue shall be defined as the PHP's premium revenue minus the PHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
   iv. The PHP shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.
      a) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:
         1. The PHP is permitted to include expenditures made for voluntary contributions to health-related resources that align with the Department's Quality Strategy and meet the following conditions:
            i. Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas.
            ii. Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.
         2. The PHP is prohibited from including in the MLR numerator any of the following expenditures:
            i. Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.
            ii. Payments to related providers that violate the Payment Limitations as required in the Contract.
         3. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:
            i. Payments from the Department to reimburse for required additional directed payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
   i. The PHP's classification of activities that improve health care quality shall be subject to Department review and approval.

ii. The PHP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
    a) Interest or penalty payments to providers for failure to meet prompt payment standards;
    b) Rebates paid to the Department if the PHP exceeds the minimum MLR threshold for a prior year;
    c) Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the PHP exceeds the minimum MLR threshold for a prior year; and
    d) The PHP shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), PBM fees and spread pricing, marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as HCQI including corporate allocations.

iii. The PHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.

iv. The PHP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 Member months in a MLR reporting year.

v. Payments related to the Enhanced Case Management Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.

vi. The PHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.

d. If the PHP's Department-defined MLR is less than the minimum MLR threshold, the PHP shall do one of the following:
    i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
    ii. Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V. C. 8. Opportunities for Health*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
    iii. Allocate a portion of the total obligation to contributions to health-related resources and the remaining portion to a rebate to the Department, with amounts for each at the discretion of the PHP.

e. The minimum MLR threshold in aggregate across all contracted PHPs shall be exactly eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49. To recognize MLR variability across rate cells, the minimum MLR threshold for the PHP shall be calculated based on the capitation revenue mix of the PHP, by taking the revenue weighted average of each of the Department-calculated factors based on the total capitation payments made for the rating year for each payment category.

f. The PHP must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports. 42 C.F.R. § 438.8(n).

g. The PHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PHP within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the

PHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. 42 C.F.R. § 438.8(k)(3).

h. In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the PHP shall:

   i. Re-calculate the MLR for all MLR reporting years affected by the change, and
   ii. Submit a new MLR report meeting the applicable requirements. 42 C.F.R. § 438.8(m).

3. Financial Management

a. The Department's financial management requirements were developed to monitor and promote program sustainability. The Department expects, and will rely upon, the PHP to be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve Member health. The Department will pay the PHP a capitation payment that is set in an actuarially sound manner. The PHP is expected to manage PHP expenditures within the capitation payments and have access to sufficient capital to cover any losses the PHP experiences.

b. The PHP shall closely track and report their expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor PHP expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.

c. Managing and Monitoring Cost Growth
   i. The PHP shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
   ii. Pursuant to Section 5.(6)a. of Session Law 2015-245, risk-adjusted cost growth for the PHP's Members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."
   iii. The Department shall monitor annual cost growth of PHP expenditures by region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
   iv. The PHP shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.

d. Pharmacy Savings
   i. Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, requires that PHP spending for prescribed drugs, net of rebates, ensures the Department realizes a net savings for the spending on prescription drugs. To ensure net savings, the Department shall monitor PHP compliance with the Department's Preferred Drug List and compliance with pharmacy claims encounter reporting.
   ii. The PHP shall provide reports as requested, and in a format prescribed, by the Department to demonstrate net pharmacy savings.

e. Reinsurance
   i. The PHP shall have and maintain at all times an adequate plan for protection against insolvency pursuant to N.C. Gen. Stat. § 58-93-70. Any arrangement proposed by the PHP is subject to review and approval by NC DOI. The PHP shall provide the Department with

the most currently approved plan, including amendments, upon request. The PHP shall inform the Department when a previously approved plan is revised.

ii. The PHP shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify PHP of any required changes to the proposed reinsurance arrangement or alternative mechanism. The PHP shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.

iii. The PHP shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. This requirement may be met by providing copies of documentation submitted to the Commissioner of Insurance pursuant to N.C. Gen. Stat. §§ 58-93-70 and 58-93-75. The Department may require additional protections and documentation at any time.

iv. The Department reserves the right to revisit reinsurance requirements annually and to modify the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that such a change in the threshold is deemed warranted by the Department.

v. The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a PHP or its reinsurer within forty-five (45) calendar days of the request by the PHP.

vi. The PHP shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the PHP or the reinsurance carrier, the PHP shall be fully responsible for all pending and unpaid claims.

vii. Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include Medicaid Managed Care Members as a covered class.

viii. The PHP shall notify the Department when the PHP incurs a claim against the reinsurance policy.

f. Financial Viability

i. The PHP shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. (Current assets include any short-term investments that can be converted to cash within five (5) business days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%).

ii. The PHP shall maintain a Defensive Interval Ratio above thirty (30) calendar days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as Cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period measured in days.

iii. The PHP shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.

iv. The Department reserves the right to impose enrollment caps on the PHP based on the PHP's financial position.

J. Compliance

1. Compliance Program

a. The PHP shall implement a comprehensive Compliance Program focused on ensuring the PHP is in compliance with all applicable federal and state laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.

b. The PHP's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include:

i. Written policies, procedures, and standards of conduct that articulate the PHP's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:

a) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Medicaid Managed Care program, including termination of the provider agreement with the PHP. 42 C.F.R. § 438.608(a)(4)

b) Retention policies for the treatment of recoveries of all overpayments from the PHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i).

c) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the PHP is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii).

d) Reporting to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. 42 C.F.R. § 438.608(c)(3).

e) Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5).

f) Process for providers to report and promptly return overpayments within sixty (60) days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2).

ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors.

iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the PHP's Compliance Program and its compliance with the requirements under the Contract.

iv. A system for training and education for the Compliance Officer, the PHP's senior management, and the PHP's employees on the federal and state standards and requirements under the Contract.

v. Effective lines of communication between the Compliance Officer and the PHP's employees.

vi. Enforcement of standards through well-publicized disciplinary guidelines.

vii. Identification of potential and actual compliance risks.

viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as

identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

c. The PHP shall develop a Compliance Plan which defines the PHP's Compliance Program.
   i. The PHP shall provide the Compliance Plan to the Department:
      a) As part of the Implementation Plan, during Readiness Review;
      b) Annually thereafter; and
      c) Upon request by the Department.
   ii. The PHP shall revise the PHP's Compliance Plan as requested by the Department.
   iii. The PHP shall submit any requested document within five (5) calendar days of the Department's request to review the PHP's Compliance Plan, and any other policy or procedures governing the PHP's compliance activities.
   iv. Annually, the PHP shall develop monitoring and auditing work plan(s) for the upcoming year.
      a) The PHP shall submit a Compliance Program report describing the workplans for the upcoming year.
      b) In Contract Year 1, the report shall be submitted ninety (90) days prior to Phase 1 of Medicaid Managed Care.
      c) Following Contract Year 1, the Compliance Program report shall include proposed workplan(s) for the upcoming year and summarize of the status of the previous year's work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.

2. Program Integrity

a. To ensure the effective use and management of public resources in the delivery of services to Medicaid Managed Care Members, the PHP shall also increase awareness within its organization and across its provider network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the PHP shall comply with all applicable federal and state laws and regulations including, but not limited to Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.

b. To promote Program Integrity, the PHP shall adhere to the following program standards, at a minimum:
   i. Validation of Exclusion List Status
      a) The PHP shall, prior to contracting, check the exclusion status of all contracted providers against the following lists (collectively, these lists are referred to as the "Exclusion Lists") to ensure that the PHP does not pay federal funds to excluded persons or entities:
         1. State Exclusion List;
         2. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
         3. The System of Award Management (SAM);
         4. The Social Security Administration Death Master File (SSADMF);
         5. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
         6. Office of Foreign Assets Control (OFAC).

b) The PHP shall disclose to the Department within thirty (30) calendar days of PHP's knowledge any disciplinary actions that have been imposed on any licensed physician, physician assistant, nurse practitioner or psychologist or their governing body related to fraud, waste, or abuse as defined within the Contract.

c) The PHP shall check, at least every month, the exclusion status of persons with an ownership or controlling interest in the PHP, agents and managing employees of the PHP, network providers, delegated entities, and subcontractors against the Exclusion Lists to ensure that the PHP does not pay federal funds to excluded persons or entities. The PHP shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).

d) The PHP shall take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.

e) The PHP shall report to the Department within two (2) business days of identification of an Excluded Person the following information:
   1. The name(s) of the Excluded Person(s);
   2. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
   3. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.

ii. Prohibited Relationships

a) In accordance with 42 C.F.R. § 438.610, the PHP shall not knowingly have a relationship with any of the following:
   1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
   2. An individual or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person.
   3. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
   4. For the purposes of this Section, a "relationship" means any of the following:
      i. A director, officer, or partner of the PHP;
      ii. A subcontractor of the PHP, as governed by 42 C.F.R. § 438.230;
      iii. A person with beneficial ownership of five percent (5%) or more of the PHP's equity; or
      iv. A network provider or person with an employment, consulting or other arrangement with the PHP for the provision of items and services that are significant and material to the PHP's obligations under this Contract.

b) If the Department learns that the PHP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the PHP has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the PHP unless

the Secretary of HHS directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the PHP unless the Secretary of HHS provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

iii. Deficit Reduction Act Reporting
   a) The PHP shall have a policy and procedure which complies with the requirements of the Deficit Reduction Act (DRA) of 2005, which requires entities that make or receive annual Medicaid payments of five million ($5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
   b) The PHP shall submit annually to the Department, in the format prescribed by the Department, policies and procedures in accordance with the Deficit Reduction Act.
   c) Providers and Subcontractors
      1. The PHP shall require network providers and subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the Deficit Reduction Act of 2005 requirements.
      2. The PHP shall provide its network providers and subcontractors with training materials regarding fraud, waste, and abuse prevention.
      3. The PHP shall annually certify that no payments are made for services or items provided to a provider, subcontractor, or financial institution located outside of the United States.
      4. In accordance with federal regulations, the PHP shall require network providers and non-contract providers to have and implement a policy recognizing Medicaid as the payer of last resort.

iv. Suspensions and Withholds for Payments to Providers for Program Integrity
   a) The PHP shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold.
   b) The PHP shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold.
   c) When the Department notifies the PHP that payments to a provider have been suspended or are being withheld, the PHP shall suspend payments to or withhold payments from the provider in accordance with the Department's instructions within one (1) business day of receipt of the notice or as otherwise instructed. The PHP shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
   d) The PHP shall commence a payment suspension or withhold in accordance with the Department's instructions and such suspension or withhold shall continue until the PHP receives notice from the Department to lift the suspension or withhold.
   e) The PHP shall lift the suspension or withhold within three (3) business days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
   f) The PHP shall obtain the Department's written approval of the suspension prior to suspending payments to any provider due to suspected fraud or abuse. The PHP

shall initiate such suspension within two (2) business days of receipt of the approval if the Department approve the suspension of payment.

g) The PHP shall provide the following information to the Department to request a suspension or withhold of payment to a network provider or non-contract provider:
   1. Name of the network provider or non-contract provider and NPI;
   2. The nature of the suspected fraud;
   3. Basis for the suspension/withhold;
   4. Desired date for the suspension/withhold to begin;
   5. Proposed length of the suspension/withhold;
   6. Proposed percentage of the withhold, if applicable; and
   7. If applicable, the good cause rationale for imposing a partial payment suspension.

h) The PHP shall be permitted to immediately stop payment to providers in the case of credible fraud, waste, or abuse.

v. Prohibited Payments

a) The PHP shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
   1. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
   2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
   3. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
   4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
   5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.

vi. The PHP shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services (U.S. DHHS), the Inspector General of the US DHHS, the Comptroller General, and Members a description of transactions between the PHP and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:

a) Any sale or exchange, or leasing of any property between the PHP and such a party;
b) Any furnishing for consideration of goods, services (including management services), or facilities between the PHP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
c) Any lending of money or other extension of credit between the PHP and such a party. Section 1903(m)(4)(A) of the Social Security Act.

c. Coordination of Provider Monitoring and Auditing
    i. The PHP may conduct an audit of a provider or accept a self-disclosure from a provider even when the Department or MID conducted an audit of the same provider or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period with prior permission from the Department.
    ii. The PHP shall comply with any Department directive not to conduct an audit of a provider.

3. Fraud, Waste, and Abuse Prevention

a. To promote integrity in all PHP activities and combat fraud, waste, and abuse, the PHP shall:
    i. Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (Members, providers, subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid Managed Care;
    ii. Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits;
    iii. Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
    iv. Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
    v. Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
    vi. Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;
    vii. Refer all credible allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department;
    viii. Define the quality and data integrity standards maintained by the PHP to produce accurate clinical quality metrics and reporting to the Department; and
    ix. Have an identified individual(s) testify to the potential financial loss due to fraud, waste, and abuse upon request by the Department.

b. Fraud, Waste, and Abuse Investigation Staffing
    i. The PHP shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the PHP in preventing and detecting fraud and abuse.
    ii. The PHP shall establish a Special Investigations Unit (SIU) sixty (60) calendar days prior to Phase 1 of Medicaid Managed Care, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan. The PHP shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.
        a) The SIU will consist of at least one (1) dedicated staff member who is located in North Carolina.
        b) The PHP's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
        c) The PHP shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics,

government/public administration, auditing, security management or pre-law, or have at least three (3) years of relevant experience.

d) The PHP shall require that the members of its SIU, as well as its Chief Compliance Officer, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training.

c. Investigation Coordination

i. The PHP shall refer credible allegations of fraud, including instances involving the PHP's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) days of making the credibility determination.

ii. Once a credible allegation of fraud has been referred to the Department, until further written notice by the Department, the PHP shall not take any further action including the following:

a) Contacting the subject of the investigation about any matters related to the investigation;

b) Continuing the investigation into the matter;

c) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or

d) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

iii. The PHP shall cooperate with all appropriate state and federal agencies, including MID and/or federal OIG, in investigating fraud and abuse.

iv. The PHP shall provide data or information requested by the Department or MID in the standardized forma within five (5) calendar days of receiving the request.

v. The PHP shall cooperate with the Department and MID to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.

vi. If the PHP is directed to complete the investigation into potential instances of fraud, then the PHP shall report to Department and MID, in a specified format, its finding within ten (10) calendar days of the conclusion of the investigation.

vii. The PHP shall report new information related to a previously referred potential instance of fraud where PI and MID did not intervene in the investigation to the Department. The PHP shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) days of receiving or identifying the new information.

viii. The PHP cannot take action, such as termination or suspension, or withhold of payment, related to potential findings of fraud, waste or abuse without approval of the Department and/or MID. Any such action taken after PHP has received approval by the Department must be reported to the Department within five (5) days of taking the action.

ix. Action by the PHP shall not preclude the Department or MID from conducting an audit or accepting a self-disclosure from a provider even if the PHP has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.

x. The PHP must participate in:

a) Monthly calls with the Department regarding fraud, waste, and abuse;

b) Quarterly in person meetings with the Department and MID regarding fraud and abuse; and

c) Ad hoc calls or meetings as requested by the Department and MID.

d. Whistleblower Protections
    i. The PHP shall develop and maintain a Whistleblower Policy related to whistleblower protections and submit to the Department for review ninety (90) days after Contract Award.
    ii. The PHP shall include fraud, waste, and abuse policies and procedure information in the PHP's employee handbook with reference to and description of the applicable federal and state fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the PHP's compliance policies and how to access those policies.

e. Fraud Prevention Plan
    i. The PHP shall develop and maintain a Fraud Prevention Plan subject to Department review and approval. The PHP shall submit the Plan to the Department:
        a) Ninety (90) days after Contract Award;
        b) Annually thereafter; and
        c) Upon request by the Department.
    ii. The PHP shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the PHP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the PHP's Fraud Prevention Plan.
    iii. The Fraud Prevention Plan shall include the following:
        a) The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2;
        b) Name of the Chief Compliance Officer;
            1. The Chief Compliance Officer shall be responsible for making the decisions on which fraud, waste, or abuse cases to refer to the Department.
        c) Description of the Special Investigations Unit (SIU), the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care;
        d) Description of other staff assigned to fraud, waste, and abuse functions;
        e) Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
        f) Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
        g) Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
        h) Processes and procedures for in-network provider and PHP staff terminations related to suspected or confirmed fraud and abuse;
        i) Processes and procedures by which the PHP avoids fraud, waste and abuse engaged in by out-of-network providers;
        j) Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by Members;
        k) Training procedures for directors, officers, employee, delegated entities, and subcontractor education on federal and state laws, as well as PHP practices for detection, identification, reporting and prevention of fraud, waste and abuse;
        l) Processes and procedures for ensuring in and out of network providers and Members know and understand fraud, waste and abuse obligations;
        m) Processes and procedures for putting a provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating

whether prepayment review continues to be appropriate. The Policy shall be included in the PHP's provider manual;

n) Description of the PHP's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
   1. A list of automated pre-payment claims edits;
   2. A list of automated post-payment claims edits;
   3. A list of desk audits on post-processing review of claims planned;
   4. A list of reports on network provider and non-contract provider profiling used to aid program and payment integrity review;
   5. The methods the PHP will use to identify high-risk claims and the PHP's definition of "high-risk claims";
   6. Visit verification procedures and practices, including sample sizes and targeted providers types or locations;
   7. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
   8. Policies and procedures used by the PHP designed to prevent, detect, and report known or suspected fraud, waste and abuse;
   9. A list of references in provider and Member material regarding fraud and abuse referrals (e.g. on Member EOB);
   10. Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly; and
   11. The process by which the Special Investigations Unit (SIU) shall monitor the PHP's marketing representative activities to ensure that the PHP does not engage in inappropriate activities, such as provision of inducements.

o) Assurance that the identities of individuals reporting violations by the PHP are protected and that there is no retaliation against such persons;

p) Description of criminal background and exclusion screening processes for its owners, agents, delegated entities, employees, network providers and subcontractors; and

q) Process and procedures for working and coordinating with the Department, including its state and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.

4. Third Party Liability (TPL)

a. The PHP shall be responsible for actively seeking and identifying third party resources for the purposes of the following:
   i. Cost avoidance;
   ii. Credit balance;
   iii. Commercial health insurance;
   iv. Medicare disallowance;
   v. Casualty insurance; and
   vi. Liability insurance.

b. Cost Avoidance
   i. The PHP shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
      a) Policy number;
      b) Policyholder's name;

c) Group Policy number;
d) Group Policy name;
e) Identification of whether the policyholder is the non-custodial parent;
f) Member Medicaid/NC Health Choice ID;
g) Member relationship to policy holder;
h) The begin date of insurance coverage; and
i) The end date of insurance coverage.

c. The PHP shall engage in third party resource recovery and cost avoidance for all other types of recovery.

d. The PHP shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP.

e. The PHP shall report cost recovery and cost adjustments through the encounter process, including denials.

f. The PHP shall make every reasonable effort to determine the liability of third parties to pay for services rendered to Members and to cost avoid and/or cost recover such liability from the third party.

g. The PHP shall treat all funds recovered by the PHP from third party resources as income to the PHP.

h. TPL Recovery
   i. The PHP shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
   ii. The PHP shall open a new case upon receipt of a Third-Party Liability Accident Information Report form from the Member's attorney or other reliable leads that indicate third party recovery might be possible.
   iii. The PHP shall be responsible for attorneys retained for tort action, through contact with the Members, participating providers, and the Department for seeking and identifying third party resources.
   iv. The Department shall review the effectiveness of the PHP's TPL recovery programs annually and may revoke TPL activities from an PHP if the PHP's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the PHP's TPL Recovery programs may include:
      a) A comparison to annual Fee-for-Service recovery averages to PHP recovery averages per beneficiary.
      b) The percentage of recoveries over total spend.
      c) The percentage of cost avoidance over total spend.
      d) The average turnaround time from the remittance to recovery.
      e) The average number of policy adds in comparison to historical Fee-for-Service Policy adds on a monthly basis.
      f) Quarterly audits on PHP encounter data.
   v. The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.

i. Identification of Other Forms of Insurance
   i. The PHP shall notify the Department within five (5) calendar days if it has identified that a Member has another form of insurance.

ii. The PHP shall load and submit to the Department updates and additions on other forms of insurance into its system within thirty (30) calendar days of matching and verification.
iii. The PHP shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been updated in the PHP's system or submitted by the PHP to the Department for Medicaid Managed Care Members.
iv. The PHP shall ensure that the information on other forms of insurance accurately tracked and maintained within the Member record. The PHP must correct all errors made in its submission of other forms of insurance to the Department within five (5) business days of notification by the Department and must provide proof of such corrections upon request from the Department.
v. The PHP shall review paid claims to determine which paid claims should have been paid by the Member's other forms of insurance instead of by the PHP.
vi. The PHP shall notify the Department of overpayments paid to the PHP from an insurance carrier for recovery claims billed by the PHP for Members with other forms of coverage.
vii. The PHP shall bill the applicable insurance carriers for Medicaid Managed Care Members' major medical, prescription drug and dental claims within thirty (30) calendar days of matching the claims to TPL segments pertaining to Members' active insurance policies for commercial insurance direct billing.
    a) The PHP shall adhere to the billing requirements of each commercial insurance carrier.
    b) In instances where the carrier will not accept the claim without supporting medical records, the PHP shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) calendar days of becoming aware of the need for medical records for commercial insurance direct billing.
viii. Within ten (10) business days after receipt of a direct claim billing denial or other types of denials, the PHP shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the PHP's IT system; and resubmit the claim to the appropriate insurance carrier.

j. Subrogation Cases
i. Pursuant to 42 C.F.R. § 438.608, the PHP agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
ii. The PHP lien in each subrogation case shall be equal to the payments made by the PHP.
iii. The PHP shall identify the PHP paid medical claims amounts for each subrogation case using data from the paid claims file.
iv. Relevant information in the subrogation case at the time of closure shall include:
    a) Settlement sheet listing all providers with medical subrogation rights.
    b) Original lien amount of each entity with subrogation right.
    c) The PHP recovered amount.
    d) The amount disbursed to each entity involved.
v. The PHP shall review the diagnosis code and Member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
vi. A subrogation case shall be closed with recovery after the PHP lien has been satisfied to the statutory limits, as referenced in N.C. Gen. Stat. § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery only after the PHP provides relevant and adequate documentation

supporting the reason for case closure without recovery. The PHP shall obtain and record all relevant information in the subrogation case at the time of closure.

vii. In accordance with N.C. Gen. Stat. § 108A-57(a1), the PHP shall collect the amount of the PHP lien or up to one-third (1/3) of the amount of the Member's gross recovery in the personal injury or wrongful death case, whichever is less.

viii. The PHP shall coordinate collection of the settlement amount with the Member or the Member's attorney.

ix. The PHP shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the PHP's claim to any part of the proceeds of any settlement.

x. The PHP shall not compromise, waive or reduce the PHP's lien without written authorization from the Department or its designated legal counsel.

xi. The PHP shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.

xii. The PHP shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.

k. The PHP shall develop and maintain a TPL Policy for review and approval by the Department.

i. The TPL Policy shall include the following:

a) Cost avoidance activities;

b) Payment recovery activities;

c) Identification of other forms of insurance processes and procedures; and

d) Subrogation, including:

1. The analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify beneficiaries with a legal liable third party; and

2. Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'

ii. The PHP shall submit the TPL Policy:

1. Ninety (90) days after Contract Award;

2. Annually thereafter; and

3. Upon request by the Department.

5. Recipient Explanation of Medical Benefit (REOMB)

a. The PHP shall create the REOMB using the previous month's claims for North Carolina Medicaid and the previous month's paid claims (i.e. February claims comprise March REOMB sample).

b. The PHP shall include the following in the REOMB:

i. List of services provided and billed to the PHP;

ii. The name of the provider administering the service;

iii. The date on which the service was administered;

iv. The paid and unpaid services; and

v. The reason a service was not paid.

c. The PHP shall exclude those claims that include sensitive procedure information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB as defined by the Department. Sensitive procedure information shall be defined as any procedures for allergies,

newborn treatment and care, and any treatment for a Member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, and sterilization.

d. The PHP shall exclude sensitive procedure information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with NC Chapter 48A.

e. The PHP shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month, whichever is less. (Excluded claims include those in referenced in this Section).

f. The PHP shall send the REOMB via US mail to randomly selected Members that have been approved by the Department. The PHP shall collect responses from the REOMB mailing.

g. The PHP shall use a Department approved sampling method to determine population for the REOMB and include it in the PHP's annual Fraud Prevention Plan.

h. The PHP shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.

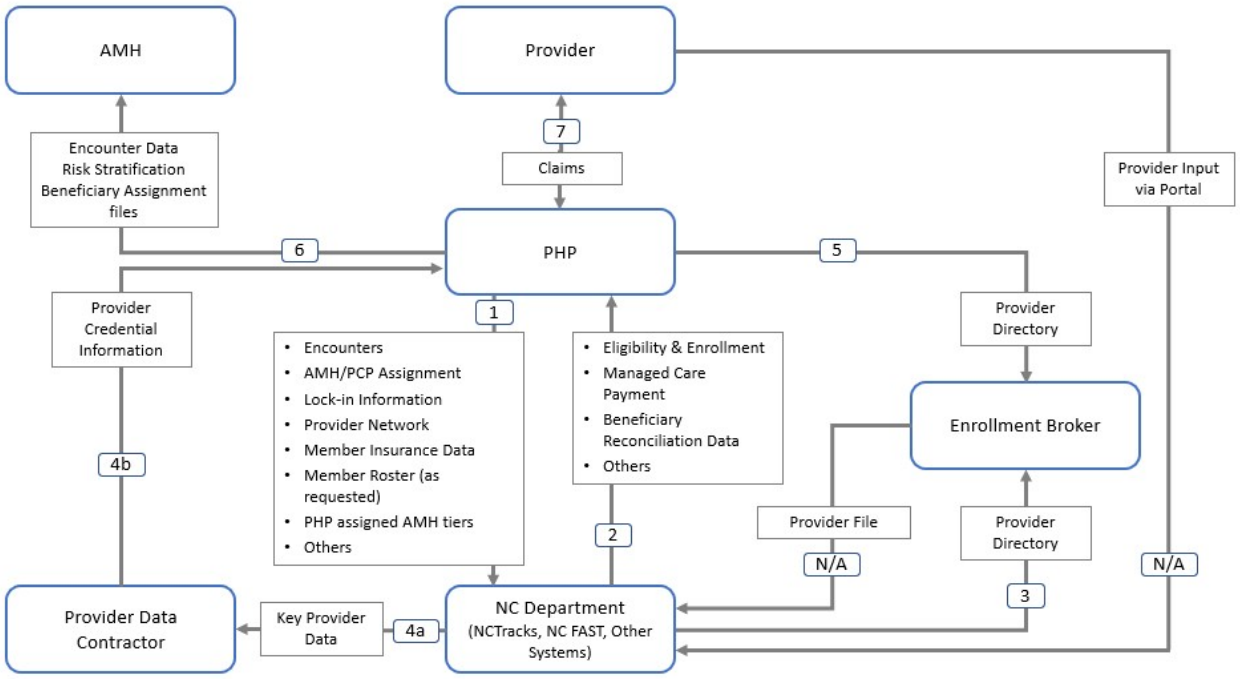
i. The PHP shall provide ad hoc REOMB to a Member upon request.

K. Technical Specifications

1. Data Exchange Model

a. The following diagram and accompanying matrix provides a point in time, high-level view of the primary data exchanges associated with the PHP, the Department, and Department Vendors. As the program evolves and technical designs are finalized the data exchanges depicted below will change. The PHP will be responsible for implementing the data exchanges as defined by the Department.

b. The Department anticipates changes to its Information Technology Systems. The PHP will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file). The Department will provide test environments to allow adequate testing time.



No.	Data Exchange Description – For Informational Purposes
1.	The PHP will send the Department or its Vendors the following data: a) Encounter Data – Medical and pharmacy encounter data b) AMH/PCP Assignment – The PHP will submit to the Department the Member's assigned AMH/PCP c) Lock-in Data – Member lock-in data (including pharmacy and prescriber) d) Provider Network Data e) Member Insurance Data f) Member Enrollment – On request the PHP will send the Department its current, complete roster of Medicaid Managed Care Members g) PHP Assigned AMH Tiers – The Provider and updated AMH Tier assignment anytime the PHP changes the Provider Attested AMH tier including the reason for the change.
2.	The Department will send the PHP the following data: a) Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records b) Managed Care Payments c) Member Reconciliation Date – The Department will send weekly 834 files to be used by the PHP for reconciliation purposes
3.	The Department will send the Enrollment Broker the following data: a) Fee for Service Providers – The Department will send the Enrollment Broker its Fee-for-Service provider roster for inclusion in the Consolidated Provider Directory.

No.	Data Exchange Description – For Informational Purposes
4a.	The Department will send to its Provider Data Contractor (PDC) its roster of Managed Care Medicaid Providers on a daily basis. This will be a full file.
4b.	The PDC will add supplementary data to the Departments Provider data and make available to the PHP via a secure FTP site. This data is the Department's Provider data to be used by the PHP for contracting and Provider reconciliation. This will be a full file.
5.	The PHP will send the Enrollment Broker the following data: a) All Contracted Medicaid Managed Care Providers – The PHP will send to the Enrollment Broker its directory of Medicaid Managed Care providers for inclusion in the Consolidated Provider Directory
6.	The PHP will send the following data to the AMH's: a) Member Assignments b) Encounter / Claims Data c) Member Risk Stratification Data
7.	The PHP and the Provider will exchange the following data: a) Claims Data – the contracted Providers will send claims data for payment to the PHP. b) Payment Data – The PHP will send payments to the provider.

2. Electronic Data Submission

a. Electronic Data Interchange (EDI) and Other Integrations

i. Integrations between the PHP, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.

ii. The PHP shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 C.F.R. § 142.308(d).

iii. If the PHP stores, transmits, or maintains data or information in an encrypted format, the PHP will, at the Department's request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.

iv. The PHP will work with the Department or its designated Vendor to establish and manage all integration.

v. Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the PHP's ability to deliver Member services, it must be reported immediately. The PHP will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at

its discretion will track issues reported by the PHP and may require a more comprehensive corrective action plan if the Department identifies trends in the PHPs performance.

b. Retransmissions
   i. If the PHP receives an unintelligible transmission from the Department or Department vendor, the PHP will immediately notify the Department and the Department shall retransmit as soon as the errors are remediated.
   ii. If the PHP is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the PHP shall retransmit as soon as the errors are remediated.
   iii. For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.

c. Test Data Transmission
   i. The PHP will be required to test **all** data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for Member enrollment prior to Open Enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the PHP, or between the PHP and other Department vendors such as the Enrollment Broker or Provider Data Contractor. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.

3. Enrollment and Reconciliation

a. Member Enrollment and Reconciliation
   i. Enrollment:
      a) The PHP shall accept an 834 eligibility file daily from the Department with new, modified, and terminated Member records.
      b) The PHP shall add, modify, or terminate Members daily based on 834 eligibility file.
      c) The PHP shall send a daily Pharmacy lock-in file to the Department, or entity designated by the Department.
   ii. Reconciliation:
      a) The Department will provide to the PHP a weekly 834 eligibility file, including all Members that were added, modified, and terminated for the period.
      b) The PHP at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
      c) At the Department's request, the PHP shall provide a full roster of Members currently enrolled in their PHP in the Department's preferred format within seventy-two (72) hours.
      d) The PHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
      e) The Department shall determine if corrections are needed to the enrollment data to address PHP discrepancies identified during reconciliation.
      f) The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the PHP.

g) The PHP shall add, modify, or terminate Members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
h) The PHP shall reconcile the monthly 820 payment file with the weekly 834 eligibility file.
i) The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
j) In addition to the reconciliation process defined above, the PHP shall be able to identify duplicate Members and report those findings to the Department in a format defined by the Department.

b. Advanced Medical Home/Primary Care Physician Assignment and Reconciliation
   i. All AMH/PCP choices made by the Member at application will be transmitted to the PHP by the Department via an 834 transaction.
   ii. If no choice is made by the Member, the PHP shall assign an AMH/PCP and transmit to the Department on a daily basis.
      a) The file format and layout will be defined by the Department. It is anticipated this will be a daily batch transaction.
   iii. The PHP shall reconcile AMH/PCP data with the Department at least monthly using the monthly 834 file described above.
   iv. The PHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
   v. The Department shall determine if corrections are needed to the AMH/PCP data to address PHP discrepancies identified during reconciliation.
   vi. The PHP will provide to the Department any AMHs that the PHP moves to a Tier other than that attested to by the Provider and sent to the PHP by the Department.

c. Provider Enrollment and Credentialing
   i. The Department or a designated vendor will provide to the PHP a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment and credentialing information.
      a) During the Provider Credentialing Transition Period, the information will be provided on a daily basis, in a format and transmission protocol to be defined by the Department.
      b) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the PHP a notice of change to the frequency and format not less than one-hundred and twenty (120) days prior to implementation.
   ii. The PHP shall reconcile provider data with the Department, or designated vendor, at least monthly.
   iii. The PHP is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
   iv. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address PHP discrepancies identified during reconciliation.

4. Provider Identification Numbers (NPIs, APIs)

a. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the PHP must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the PHP.

b. The Department produces a daily provider file that includes all active and terminated Medicaid Providers. The PHP is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.

5. Provider Directory

a. The PHP shall develop a Provider Directory in accordance with *Section D. 2 Provider Network Management* and integrate provider directory information into the Enrollment Broker's Consolidated Provider Directory to support PHP choice counseling and selection.
   i. The PHP should use the National Provider Identifier (NPI) issued by NPPES as the unique provider identifier. For those providers who do not qualify for NPI's, the Atypical Provider ID issued by NC DHHS' NCTracks system should be used.

b. Consolidated Provider Directory Data Transmissions
   i. The Department has included within the scope of its Enrollment Broker the creation of a Consolidated Provider Directory which will include all Managed Care and Medicaid Fee for Service providers.
   ii. The PHP will, at a frequency defined by the Department, create a full provider file including data (as defined in the Contract) on all contracted providers in their network. The PHP will deliver the file based on the Enrollment Brokers defined technical process.
   iii. The final file format will be determined by the Enrolment Broker; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).
   iv. The transport will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).
   v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the selected Enrollment Broker.
   vi. The PHP shall be provided with policies and process flows developed by the Enrollment Broker that defines the overall process.
   vii. The Department has recommended that the Enrollment Broker leverage the open source tools developed by healthcare.gov in developing the Consolidated Provider Directory. The PHP should review this information as well as it will be the basis of the interface between the PHP and the Enrollment Broker. The documentation is available at https://www.healthcare.gov/developers/.

6. Technology Documents

a. The PHP shall provide the following documents to the Department for review and approval thirty (30) calendar days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.

b. Security Compliance Plan: The PHP shall provide a plan that details how the PHP will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the Plan shall be updated annually and resubmitted to the Department for review. The plan must include at a minimum:

i. Approach to customer and Member data protection including internal programs and policies;
ii. Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
iii. Approach to complying with HITECH and HIPAA;
iv. Approach to risk analysis and assessment associate with NIST;
v. Processes for monitoring for monitoring for security vulnerabilities including the use of external organization such as US CERT;
vi. Processes and plans for vulnerability and breach management including response processes; and
vii. Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).

c. Encounter Implementation Approach. The PHP shall provide a plan that shows how the PHP will implement their encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
i. Approach to meeting performance, accuracy, and timeliness requirements;
ii. Operating model including staffing and technology to process and submit encounters;
iii. Reference data management process including how the State's reference data (if applicable) will be integrated into the encounter management process;
iv. Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
v. QA and Process improvement processes including how errors detected by the State's Encounter Processing System are addressed by the Offeror, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Offeror's processes; and
vi. The plan should include distinctions for medical and pharmacy encounter management.

d. System Interface Design. The PHP shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
i. Detailed design by interface showing the Offeror's approach to meeting the requirements defined by the State;
ii. Approach to managing EDI transactions including technology;
iii. Technical integration architecture including the Offerors technical approach to integrating multiple internal systems with external partners;
iv. Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
v. Software and platform testing processes for new interfaces including the data management approach.

7. PHP Data Management and Health Information Systems

a. The following Section contains high-level information on Health Information System and Member Data that will be established, maintained, analyzed, and reported by the PHP. Specific details on the data, analysis, and reporting will be provided upon Contract Award.

i. The PHP shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the PHP's operations as well as satisfying the reporting requirements detailed in this RFP which may include but are not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

ii. The PHP shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act.

iii. The PHP shall collect and maintain data on Member and Provider characteristics and interactions as specified by the state and on all services furnished to Members through a claims processing system or other methods as specified by the state.

iv. All data, reports, and information submitted by the PHP on behalf of the Providers (including Providers within or outside of its networks) shall be validated by the PHP as accurate and complete prior to submission.

v. The PHP shall collect data from Providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.

vi. The PHP shall make all collected data available to the Department and upon request to CMS.

Revised and Restated RFP 30-190029-DHB
Section VI. Contract Performance and
Section VII. Attachments A-N.

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VI. Contract Performance

A. Contract Violations and Noncompliance

a. The Contractor shall comply with all terms, conditions, requirements, performance standards, and applicable laws as set forth in the Contract or any amendments thereto including any rules, policies, or procedures incorporated pursuant to the Contract.

b. The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity including but not limited to, remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the Contractor has violated any provision of the Contract, or if the Contractor does not comply with any other applicable North Carolina or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract, which shall include, but may not be limited to the following:
   i. Fails substantially to provide medically necessary covered services;
   ii. Imposes on Members premiums or cost share that are in excess of the premiums or cost share permitted by the Department;
   iii. Acts to discriminate among Members on the basis of their health status or need for health care services;[1]
   iv. Misrepresents or falsifies information that it furnishes to CMS or to the State;
   v. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider;
   vi. Fails to comply with the requirements for physician incentive plans as required by 42 C.F.R. §§ 422.208 and 422.210;
   vii. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information; or
   viii. Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.

c. Risk Level Assignment
   i. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or any other noncompliance by the Contractor, the Department shall assign the violation into one of four risk levels:
      a) **Level 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or jeopardize the integrity of Medicaid Managed Care.
      b) **Level 2:** Action(s) or inaction(s) that jeopardize the integrity of Medicaid Managed Care, but does not necessarily jeopardize Member(s) health, safety, and welfare or reduces access to care.
      c) **Level 3:** Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid Managed Care.

[1] This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3).

d) **Level 4:** Action(s) or inaction(s) that inhibit the efficient operation of Medicaid Managed Care.

ii. The Department's decision to impose specific remedial action(s), intermediate sanction(s) and/or liquidated damages against the Contractor will include consideration of some or all of the following factors:
   a) Risk Level assignment;
   b) The nature, severity, and duration of the violation;
   c) The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, program integrity);
   d) Whether the violation (or one that is substantially similar) has previously occurred;
   e) The timeliness in which the Contractor self-reports a violation;
   f) The Contractor's history of compliance;
   g) The good faith exercised by the Contractor in attempting to stay in compliance (including self-reporting by the Contractor); or
   h) Any other factor the Department deems relevant based on the nature of the violation.
   i) The Department may impose additional remedial actions, intermediate sanctions, or liquidated damages and/or elevate the violation to a higher Risk Level if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.

iii. Additional detail on risk level assignment is included in *Attachment K. Risk Level Matrix*.

d. Notice of Deficiency
   i. Except for the appointment of temporary management imposed pursuant to the Contract, prior to the imposition of any remedial action, intermediate sanction, or liquidated damages against the Contractor or termination of the Contract for cause, the Department shall provide the Contractor with written notice detailing the nature of the violation or noncompliance, the risk level assigned to the violation, any actions the Department seeks to impose against the Contractor, and, if applicable, the method and timeframes by which the Contractor may dispute the claim of noncompliance and the imposed actions.
   ii. Within three (3) business days of full remediation of the identified violation(s) in the Notice of Deficiency, or within another timeframe as requested by the Department, the Contractor shall provide the Department with written notice confirming the date that the noncompliant behavior was resolved and the actions the PHP took to remediate the noncompliance.

e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages
   i. Remedial Actions
      a) Prior to the imposition of intermediate sanctions or liquidated damages or contemporaneously with, if the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may require the Contractor to take or to engage in the following actions to address identified violation(s) or other noncompliance:
         1. Immediate remediation of the non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the violation or noncompliance;
         2. Submission and implementation of a Corrective Action Plan; or
         3. Participation in additional education or training.
   ii. Corrective Action Plans (CAPs)
      a) CAPs developed by the PHP

1. Following notification of the original violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the violation until an approved CAP is implemented.
2. Any CAP required to be submitted by the Contractor shall, at a minimum, identify the following:
    i. The finding resulting in a request for corrective action by the Department;
    ii. A description of how the finding resulting in a request for corrective action will be remediated;
    iii. The timeline for the implementation and completion of the corrective action(s); and
    iv. The name of the responsible person who will lead all corrective action activities.
3. Any CAP submitted by the Contractor shall be subject to approval by the Department.
4. The Contractor shall submit the CAP within fifteen (15) calendar days, or within a time determined by the Department depending on the nature of the violation, from the date on the written notice requesting the CAP.
5. Upon receipt, the Department may accept the plan as submitted, accept the plan with specified modifications, or reject the plan.
6. If the Department requests modifications or rejects the CAP, the Contractor shall revise or submit a new plan within ten (10) calendar days, or within a time determined by the Department depending on the nature of the violation, that addresses the identified concerns identified.
7. The Contractor shall complete the corrective action(s) contained in the plan within the time period determined and approved by the Department.
8. The Contractor shall provide updates to the Department on the remediation of all findings resulting in a request for corrective action at the interval requested by the Department.

b) CAPs defined by the Department

1. The Contractor shall accept and implement a Department defined CAP.

iii. Effective Date of Remedial Actions

a) The notice effective date for any requirement imposed by the Department for the Contractor to engage in a remedial action is the date on the written Notice of Deficiency. Any time frames regarding Contractor action will be calculated from the date on the written notice.

b) A remedial action is not contestable under the Dispute Resolution process described in this Section, and the Contractor shall be required to complete the remedial action within the timeframe provided in the Notice of Deficiency, except for a requirement to submit and implement a CAP that shall be completed in accordance with Contract requirements.

iv. Intermediate Sanctions

a) If the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may impose the following intermediate sanctions against the Contractor:

1. Civil monetary penalties in accordance with 42 C.F.R. § 438.704;

2. Appointment of temporary management of the Contractor in accordance with 42 C.F.R. § 438.706(a);[2]
3. Notification to Members of their right to terminate their enrollment with the Contractor without cause;
4. Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction;
5. Suspension, recoupment, or withholding of payment;
6. Suspension of all or part of marketing activities;
7. Suspension of part of the Contract;
8. Exclusion from participation in the Medicaid Managed Care; or
9. Any other additional sanctions allowed under North Carolina or federal law or regulation.

b) Effective Date of Intermediate Sanctions
1. If the Contractor elects not to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day following the expiration of the period to appeal included in the written Notice of Deficiency, or on the effective date provided by the Department in the written notice based on the nature of the violation and the sanction imposed.
2. If the Contractor elects to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day of the date on the written final decision issued by the Department.
3. The Department shall not be required to delay the appointment of temporary management to provide the Contractor the opportunity to dispute the imposition of the sanction before imposing temporary management. The Department shall not terminate temporary management until it determines that the Contractor can ensure that the noncompliant behavior resulting in the temporary management will not reoccur.

v. Liquidated Damages
a) If the Contractor is determined to be in violation with the terms, conditions, requirements, and/or performance standards of the Contract, it is presumed by the Contractor that the Department will be harmed, and the Department shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.
b) The actual damage sustained by the Department as a result of the Contractor's failure to meet the requirements of this Contract will be extremely difficult or impossible to ascertain with precise accuracy. Therefore, the Department and the Contractor agree that if the Contractor is in violation of the terms, conditions, requirements and/or performance standards of the Contract, the Department may assess liquidated damages against the Contractor in accordance with the Contract.
c) Following receipt of a Notice of Deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract until such time as the Department, in its sole discretion, determines the violation(s) has been cured.

[2] If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. Part 438, the Department will notify affected Members of their right to terminate enrollment in the Contractor without cause.

d) The Department, in its sole discretion, reserves the right to assess a general liquidated damage of two hundred and fifty dollars ($250) per day, per occurrence, as applicable, for any violation not specifically listed in this Section.
e) Liquidated damages assessed by the Department do not affect the PHP's rights or obligations with respect to any third party including beneficiaries or providers.

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
Administration and Management		
1.	Failure to meet plan readiness review deadlines as set by the Department.	$5,000 per calendar day
2.	Failure to comply with conflict of interest requirements described in *Attachment O.8. Disclosure of Conflicts of Interest.*	$10,000 per occurrence
3.	Failure to timely provide conflict of interest or criminal conviction disclosures as required by At*tachment O.7. Disclosure of Litigation and Criminal Conviction.*	$1,000 per calendar day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Attachment O.9. Disclosure of Ownership Interest*.	$2,500 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
Members		
5.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section V.B.4. Marketing*	$5,000 per occurrence
6.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section V.B.2. Medicaid Managed Care Enrolment and Disenrollment.*	$500 per occurrence per Member
7.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section V.B.3. Member Engagement.*	$250 per occurrence per Member

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
8.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.6. Member Grievances and Appeals.*	$500 per occurrence
9.	Failure to report to the Department a denial of an expedited appeal request and the reasoning for the denial within twenty-four (24) hours of the issuance of the Notice of Resolution as described in *Section V.B.6. Member Grievances and Appeals.*	$500 per calendar day
10.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$5,000 per occurrence
11.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND $500 per calendar day for each day the PHP fails to provide continuation or restoration as required by the Department.
12.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.6. Member Grievances and Appeals.*	$1,000 for each mediation or hearing that the PHP fails to attend as required
Benefits and Care Management		
13.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	$5,000 per occurrence per Member
14.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$5,000 per standard authorization request $7,500 per expedited authorization request
15.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified Section *V.D.1. Provider Network.*	$1,000 per occurrence

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
16.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$2,500 per occurrence
17.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.C.3. Pharmacy Benefits.*	$2,500 per calendar day per occurrence
18.	Failure to comply with Transition of Care requirements as specified *Section V.C.4. Transition of Care.*	$100 per calendar day, per Member AND The value of the services the PHP failed to cover during the applicable transition of care period, as determined by the Department.
19.	Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified *Section V.C.5. Non-Emergency Transportation*.	$500 per occurrence per Member
20.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	$1,500 per occurrence per driver
21.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	$250 per occurrence per Member
22.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	$1,500 per calendar day per vehicle
23.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	$250 per calendar day
24.	Failure to develop a Care Plan for a Member that includes all required elements as described in the *Section V.C.6. Care Management* (including a failure by a designated care management subcontractor to comply).	$500 per deficient/missing plan
25.	Failure to complete a Comprehensive Assessment, including reassessments, within the timeframes specified in *Section V.C.6. Care Management.*	$100 per calendar day per Member
		$500 per calendar day per High-Risk Pregnant woman
		$500 per calendar day per At-Risk child
26.	Failure to develop a Care Plan for each Member with LTSS needs in accordance with *Section V.C.6. Care Management*.	$1,000 per occurrence per Member

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
27.	Failure to comply with minimum Transitional Care Management requirements as described in *Section V.C.6. Care Management.*	$250 per occurrence per Member
28.	Failure to timely notify the Department that the PHP lowered a provider's AMH Tier status.	$500 per calendar day per occurrence
29.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with a LHD.	$500 per calendar day
30.	Failure to implement and maintain an Opioid Misuse Prevention Program and Member Lock-In Program as described in *Section V.C.7. Prevention and Population Health Management Program.*	$2,000 per calendar day for each day the Department determines the PHP is not in compliance
Providers		
31.	Failure to update online and printed provider directory as required by *Section V.D.2. Provider Network Management*.	$1,000 per occurrence
32.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by *Section V.D.2. Provider Network Management.*	$100 per calendar day per Member for failure to timely notify the affected Member
33.	Failure to follow the Quality Determination process established by the PHP's Credentialing and Re-Credentialing Policy.	$2,000 per occurrence per provider
34.	Failure to complete a provider Quality Determination within forty-five (45) calendar days of receipt of all verified information by the Provider Network Participation Committee.	$50 per calendar day per provider
35.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in *Section V.D.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$2,500 per month for failure to meet any of the listed standards, either individually or in combination
36.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	$250 per calendar day

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
37.	Failure to maintain accurate provider directory information as required by *Section V.D.2. Provider Network Management.*	$100 per confirmed incident
38.	Failure to timely provide notice to the Department of capacity to serve the PHP's expected enrollment as described in *Section V.D.1. Provider Network.*	$2,500 per calendar day
Quality and Value		
39.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.E.1. Quality Management and Quality Improvement.*	$5,000 per calendar day
40.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per calendar day
41.	Failure to timely submit QAPI to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per calendar day
42.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.3. National Committee for Quality Assurance (NCQA) Association.*	$100,000 per month for every month beyond the month NCQA accreditation must be obtained
Claims and Encounter Management		
43.	Failure to timely submit monthly encounter data set certification.	$1,000 per calendar day
Financial Requirements		
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Attachment J: Reporting Requirements.*	$2,000 per calendar day
45.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section V.I.2 Medical Loss Ratio* and *Attachment and Attachment J. Reporting Requirements.*	$2,000 per calendar day

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
46.	Failure to timely and accurately submit monthly financial reports in accordance with *Attachment J: Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per calendar day
47. **Compliance**		
48.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.J.3. Fraud, Waste and Abuse Prevention.*	$5,000 per calendar day that the Department determines the PHP is not in compliance
49.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.J.1. Compliance Program* and *Attachment J: Reporting Requirements.*	$1,000 per calendar day
50.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.J.4. Third Party Liability* and *Attachment J: Reporting Requirements*	$250 per calendar day
51.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$2,500 per incident for failure to fully cooperate during an investigation
52.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	$250 per calendar day
53.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.J.3. Fraud, Waste and Abuse Prevention* and *Attachment J: Reporting Requirements.*	$2,000 per calendar day

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
Technical Specifications		
54.	Failure by the PHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$500 per Member per occurrence per AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PHP's failure to comply with the terms of this Contract, the PHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
55.	Failure by the PHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$500 per Member per occurrence
56.	Failure by the PHP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500 per Member per occurrence, not to exceed $10,000,000
Directives and Deliverables		
57.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$500 per calendar day that the Department determines the PHP is not in compliance
58.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$1,000 per occurrence per committee that the Department determines the PHP is not in compliance
59.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$500 per calendar day the unapproved agreement or materials are in use

Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
60.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$1,500 per occurrence per plan/program that the Department determines the PHP is not in compliance
61.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	$500 per calendar day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action

vi. Payment of Liquidated Damages and other Monetary Sanctions

a) If the Contractor elects not to appeal the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within ten (10) calendar days of the date on the written notice assessing the liquidated damages or other monetary sanctions.

b) If the Contractor elects to dispute the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages or other monetary sanctions shall be due and payable within ten (10) calendar days of the date on the written notice of final decision issued by the Department upholding its original decision to impose the liquidated damages or other monetary sanctions (including a final decision modifying the amount owed).

c) If the Contractor fails to pay liquidated damages or other monetary sanctions by the applicable due date, the Contractor shall be subject to interest and a late payment penalty in accordance with N.C. Gen. Stat. § 147-86.23 until the past due amount is paid.

d) The Department shall reserve the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount (including interest and late payment penalties) from future capitation payments owed to the Contractor. Actions taken by the Department to withhold a portion of a capitation payment for assessed liquidated damages or other monetary sanctions shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a). The Department shall provide written notice to the Contractor prior to withholding a portion of the capitation payment for assessed liquidated damages or other monetary sanctions.

vii. Dispute Resolution

a) The Contractor shall exhaust the dispute resolution process as provided in the Contract to contest the imposition of intermediate sanctions, the assessment of liquidated damages, and/or for cause termination of the Contract pursuant to 42 C.F.R. § 438.708 by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.

b) Dispute Resolution

1. The Contractor shall have the right to contest disputes arising under this Contract including the imposition of intermediate sanctions, liquidated damages, or a withhold through the dispute resolution process, except that the Contractor shall

not have the right to contest a requirement imposed by the Department to perform a remedial action.

2. To raise a dispute, the Contractor shall submit a written request for dispute resolution within fifteen (15) calendar days of the date on the written notice imposing the Department's intended action. The Department may extend the Contractor's deadline to request dispute resolution for good cause if the Contractor requests an extension within ten (10) calendar days of the date on the written notice.
3. The Contractor shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
4. The Contractor waives any dispute not raised within fifteen (15) calendar days of the date on the written notice imposing any proposed action by the Department (unless the Department grants an extension).
5. The Contractor also waives any arguments it fails to raise in writing within fifteen (15) calendar days (unless the Department grants an extension) of the date on the written notice imposing the proposed action, and waives the right to use any materials, data, and information not contained in or accompanying the Contractor's written request for dispute resolution in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
6. The Department shall review the dispute resolution request and submitted evidence and information and issue a written final decision within sixty-five (65) calendar days of the Contractor's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the Contractor of any extension and the reason for such extension.
7. The final decision issued by the Department following dispute resolution shall not be subject to further appeal within the Department.

c) Hearing Prior to Termination of Contract with Cause

1. The Contractor shall only be entitled to a hearing prior to the Department seeking to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the Termination for Cause Section of the Contract.
2. At least fifteen (15) calendar days prior to the hearing, the Contractor shall receive written notice of the hearing that includes the date, time, place and nature of the hearing. The hearing may be held in-person or by telephone.
3. The hearing may be conducted if the Contractor fails to appear at the hearing after receiving proper notice.
4. At the hearing, the burden shall be on the Contractor to demonstrate that the Department's decision to terminate the Contract with cause pursuant to 42 C.F.R. § 438.708 should be reversed.
5. Following the hearing, the Contractor shall receive a written final decision within sixty-five (65) calendar days of the date of the scheduled hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, the Contractor shall be notified of the extension and the reason for such extension.

6. For a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to the Contractor, and give the Contractor's Members notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services after the contract is terminated.

d) The Department and the Contractor may be represented by legal counsel throughout the dispute resolution process.

e) For any adverse action taken by NCDOI against the Contractor related to the licensure or solvency of the Contractor, the Contractor shall follow DOI's appeals process, as described in the Prepaid Health Plan Licensing Act, Article 93 of Chapter 58 of the General Statutes[3], to dispute the adverse action. The Department, in its sole discretion, may take separate, additional action, in accordance with *Section VI.A. Contract Violations and Noncompliance*, against the Contractor based on any adverse action taken by DOI.

viii. Notice to External Agencies

a) The Department shall provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) calendar days after the Department imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.

b) The Department may provide written notice to DOI after the Department imposes or lifts any intermediate sanction(s), liquidated damages, or withholds against the Contractor.

c) The Department shall provide notice as required by law to any other state or federal agency for violations of the terms, conditions, or requirements of this Contract or for any other violation of applicable laws or regulations by the Contractor.

ix. Publication of Remedial Actions, Intermediate Sanctions, and Liquidated Damages

a) The Department may publish on its website on a quarterly basis a list of Contractors that were subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the risk level assigned to violation(s), the type of actions imposed on the Contractor, and the basis for the actions taken by the Department.

b) The Department shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by the Department.

x. The Department, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a PHP for any good cause as determined by the Department, which includes the right of the Department to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the PHP works to resolve the underlying issue that resulted in the action taken by the Department.

B. Service Level Agreements

1. The Contractor shall meet the performance standards specified in this Section.
2. If the Contractor fails to meet the performance standards, the Department may assess liquidated damages as provided in *Section VI.A. Contract Violations and Noncompliance*, and any other remedial action or intermediate sanction, in accordance with *Section VI.C. Withholds* for the period in which the deficiency occurs and until the Department, in its sole discretion, determines the deficiency has been cured.

[3] See Section 1 of Session Law 2018-49.

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
Enrollment and Disenrollment					
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Daily	$1,000 per occurrence
Member Grievances and Appeals					
2.	Member Appeals Resolution - Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
	Member Appeals Resolution - Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$5,000 per month
Pharmacy Benefits					
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
Service Lines					
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
7.	Call Response Time/Call Answer Timeliness - Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
8.	Call Wait/Hold Times - Member Services line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
9.	Call Abandonment Rate – Member Services line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
10.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-eight percent (98%) of all incoming calls.	The time after the initial answer to an incoming call and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$15,000 per month
12.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
13.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$10,000 per month
14.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
16.	Call Response Time/Call Answer Timeliness - Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$5,000 per month
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
19.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
20.	Call Wait/Hold Times -Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
21.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
Encounters					
22.	Encounter Data Timeliness/ Completeness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) calendar days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per claim per calendar day

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
23.	Encounter Data Timeliness/ Completeness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) calendar days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	$100 per claim per calendar day
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$50,0000 per week
26.	Encounter Data Reconciliation	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$10,000 per month

Section VI.A. Table 2: PHP Service Level Agreement					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
Website Functionality					
27.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	$2,500 per occurrence
28.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month
29.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence (each communication outside of the standard for the month)

C. Withholds

1. The PHP shall participate in the Department's withhold program.
2. The withhold program will conform to 42 C.F.R. § 438.6.
3. The withhold program will be effective eighteen (18) months following the effective date of Phase 1 of Medicaid Managed Care, or at a later date as determined by the Department.

VII. Attachments A - N

Attachment A. PHP Organization Roles and Positions

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

Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff	These individuals will carry out the implementation and readiness review terms of the contract.	• N/A
2. Full-Time Member Services Staff	These individuals will coordinate communication with Members.	• Must reside in North Carolina
3. Member Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates Member complaints, grievances and appeals in a timely manner.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program
4. Full-Time Member Complaint, Grievance, and Appeal Staff	These individuals will work to resolve Member complaints, grievances and appeals in accordance with state and federal laws and this Contract.	• Must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals for
5. Full-Time Utilization Management Staff	These individuals will conduct utilization management activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Shall be NC-licensed nurses and/or licensed behavioral health professionals in good standing
6. PBM Liaison	If the PHP partners with a third-party PBM, this individual will serve as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	• N/A
7. Care Management Supervisor	This individual shall be responsible for all staff and activities related to the care management program, and shall be responsible for ensuring the functioning of care management activities across the continuum of care.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program • Care Manager for behavioral health services is NC-licensed LCSW in good standing

Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		• Care Manager for medical services is a NC-licensed registered nurse in good-standing
8. Full-Time Care Managers	This individual shall be responsible for conducting all functions and activities of the care management program and serve as the lead for each care management teams.	• Must reside in North Carolina • Must be licensed practitioners • Must be supervised by an RN, LCSW, or psychologist with trauma-based experience and training
9. Care Management Staff	As part of the care management team, these individuals shall be responsible for conducting all functions and activities of the care management program.	• Must reside in North Carolina • Care management staff may include social workers, community health workers and peers
10. Behavioral Health (BH) Managers and Full-Time BH Staff	These individuals shall be responsible for integrating into the clinical and care management teams to ensure Member's behavioral health needs are fully integrated into the service delivery system.	• Must reside in North Carolina • Experience working in behavioral health managed care and clinical setting • Licensed behavioral health professional practicing within their scope
11. Full-Time Care Management Housing Specialist	This individual(s) will assist Members who are homeless in securing housing.	• Must reside in North Carolina
12. Full-Time Care Management Transition Staff	These individuals will assist Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.	• Must reside in North Carolina
13. Provider Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program

Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
14. Provider Relations and Call Center Staff	These individuals will coordinate communications between the PHP and providers.	• Must reside in North Carolina
15. Pharmacy Director for the Pharmacy Service Line	This individual will oversee all Pharmacy Service Line staff management and ensure the team meets the requirements of the Contract.	• NC registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
16. Pharmacy Technician Supervisor for the Pharmacy Service Line	This individual will ensure Pharmacy Service Line staff are trained on and compliant with pharmacy clinical coverage policies, prior authorization (PA) requirements, and drug formularies/preferred drug lists.	• Certified Pharmacy Technician registered with the NC Board of Pharmacy • Minimum of three (3) years of pharmacy benefits call center experience
17. Liaison between the Department and the North Carolina Attorney General's Medicaid Investigation Division	This individual will serve as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must reside in North Carolina
18. Special Investigations Unit (SIU) Lead	This individual shall lead the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate the Department and OCPI, as well as ensure timely resolution of investigation.	• Fully dedicated to the North Carolina Medicaid Managed Care Program Funded from the North Carolina Medicaid budget
19. Special Investigations Unit (SIU)	These individuals will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Associate's or bachelor's degree in criminal justice or related field, or have at least 3 years of relevant experience

Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
20. Tribal Provider Contracting Specialists	These individuals shall be trained in IHCP requirements and accountable to developing necessary tribal networks.	• Must reside in North Carolina
21. Liaison to the Division of Social Services	This individual will serve as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serve as a primary contact to triage and escalate Member specific or PHP questions.	• Must reside in North Carolina

Attachment B. Clinical Coverage Policy List

The *Section VII. Attachment B. Table 1: Clinical Coverage Policy List* below documents the complete list of Clinical Coverage Policies the Department maintains currently for its Fee-for-Service program. Full detail on the policies is available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
Allergies	1N-1: Allergy Testing 1N-2: Allergy Immunotherapy
Ambulance Services	15: Ambulance Services
Anesthesia	1L-1: Anesthesia Services 1L-2: Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Burn Treatment and Skin Substitutes	1G-1: Burn Treatment 1G-2: Skin Substitutes
Chiropractic Services	1F: Chiropractic Services
Cardiac	1R-1: Phase II Outpatient Cardiac Rehabilitation Programs 1R-4: Electrocardiography, Echocardiography, and Intravascular Ultrasound
Community Based Services	3A: Home Health Services 3D: Hospice Services 3G-1: Private Duty Nursing for Beneficiaries Age 21 and Older 3G-2: Private Duty Nursing for Beneficiaries Under 21 years of Age 3H-1: Home Infusion Therapy 3L: State Plan Personal Care Services (PCS)
Dietary Evaluation and Counseling and Medical Lactation Services	1-I: Dietary Evaluation and Counseling and Medical Lactation Services
Facility Services	2A-1: Acute Inpatient Hospital Services 2A-2: Long Term Care Hospital Services 2A-3: Out-of-State Services 2B-2: Geropsychiatric Units in Nursing Facilities
Hearing Aid Services	7: Hearing Aid Services

Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
Laboratory Services	1S-1: Genotyping and Phenotyping for HIV Drug Resistance Testing 1S-2: HIV Tropism Assay 1S-3: Laboratory Services 1S-4: Genetic Testing 1S-8: Drug Testing for Opioid Treatment and Controlled Substance Monitoring
Maternal Support Services (Baby Love)	1M-2: Childbirth Education 1M-3: Health and Behavior Intervention 1M-4: Home Visit for Newborn Care and Assessment 1M:5, Home Visit for Postnatal Assessment and Follow-up Care 1M-6: Maternal Care Skilled Nurse Home Visit
Medical Equipment	5A-1: Physical Rehabilitation Equipment and Supplies 5A-2: Respiratory Equipment and Supplies 5A-3: Nursing Equipment and Supplies 5B: Orthotics & Prosthetics
Obstetrics and Gynecology	1E-1: Hysterectomy 1E-2: Therapeutic and Non-Therapeutic Abortions 1E-3: Sterilization Procedures 1E-4: Fetal Surveillance 1E-5: Obstetrics 1E-6: Pregnancy Medical Home
Ophthalmological Services	1T-1: General Ophthalmological Services 1T-2: Special Ophthalmological Services
Physician	1A-2: Preventive Medicine Annual Health Assessment 1A-3: Noninvasive Pulse Oximetry 1A-6: Invasive Electrical Bone Growth Stimulation 1A-7: Neonatal and Pediatric Critical and Intensive Care Services 1A-8: Hyperbaric Oxygenation Therapy 1A-9: Blepharoplasty/Blepharoptosis (Eyelid Repair) 1A-11: Extracorporeal Shock Wave Lithotripsy 1A-12: Breast Surgeries 1A-13: Ocular Photodynamic Therapy 1A-14: Surgery for Ambiguous Genitalia 1A-15: Surgery for Clinically Severe or Morbid Obesity

Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
	1A-16: Surgery of the Lingual Frenulum 1A-17: Stereotactic Pallidotomy 1A-19: Transcranial Doppler Studies 1A-20: Sleep Studies and Polysomnography Services 1A-21: Endovascular Repair of Aortic Aneurysm 1A-22: Medically Necessary Circumcision 1A-24: Diabetes Outpatient Self-Management Education 1A-25: Spinal Cord Stimulation 1A-26: Deep Brain Stimulation 1A-27: Electrodiagnostic Studies 1A-28: Visual Evoked Potential (VEP) 1A-30: Spinal Surgeries 1A-31: Wireless Capsule Endoscopy 1A-32: Tympanometry and Acoustic Reflex Testing 1A-33: Vagus Nerve Stimulation for the Treatment of Seizures 1A-34: End Stage Renal Disease (ESRD) Services 1A-38: Special Services: After Hours 1A-40: Fecal Microbiota Transplantation 1A-41: Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone 1A-42: Balloon Osital Dilation
Podiatry	1C-1: Podiatry Services 1C-2: Medically Necessary Routine Foot Care
Radiology	1K-1: Breast Imaging 1K-2: Bone Mass Measurement 1K-6: Radiation Oncology 1K-7: Prior Approval for Imaging Services
Reconstructive Surgery	1-O-1: Reconstructive and Cosmetic Surgery 1-O-2: Craniofacial Surgery 1-O-3: Keloid Excision and Scar Revision 1-O-5: Rhinoplasty and/or Septorhinoplasty
Rural Health Clinics, FQHCs and Health Departments	1D-1: Refugee Health Assessments Provided in Health Departments 1D-2: Sexually Transmitted Disease Treatment Provided in Health Departments 1D-3: Tuberculosis Control and Treatment Provided in Health Departments 1D-4: Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics

Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
Solid Organ Transplants	11B-1: Lung Transplantation 11B-2: Heart Transplantation 11B-3: Islet Cell Transplantation 11B-4: Kidney (Renal) Transplantation 11B-5: Liver Transplantation 11B-6: Heart/Lung Transplantation 11B-7: Pancreas Transplant 11B-8: Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Specialized Therapies	10A: Outpatient Specialized Therapies 10B: Independent Practitioners (IP) 10D: Independent Practitioners Respiratory Therapy Services
Stem Cell or Bone Marrow Transplants	11A-1: Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) 11A-2: Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia) 11A-3: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia 11A-5: Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias 11A-6: Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors 11A-7: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma 11A-8: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Multiple Myeloma and Primary Amyloidosis 11A-9: Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms 11A-10: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma 11A-11: Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma 11A-14: Placental and Umbilical Cord Blood as a Source of Stem Cells 11A-15: Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
	11A-16: Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
Telemedicine and Telepsychiatry	1-H: Telemedicine and Telepsychiatry
Ventricular Assist Device	11C: Ventricular Assist Device
Vision Services	6A: Routine Eye Exam and Visual Aids for Recipients Under Age 21

Attachment C. Approved Behavioral Health In Lieu of Services

The *Section VII. Attachment C. Table 1: Department-Approved Behavioral Health In Lieu of Services* below is a list of all Behavioral Health In Lieu of Services (ILOS) that have been approved by the Department as described in *Section V.C. Benefits and Care Management*. Per this contract, Offeror may use the Behavioral Health ILOS services or settings that are a medically appropriate, cost-effective alternative to a State Plan covered service. (This is not intended to provide any guidance on which behavioral health services are covered by Standard Plans.)

Section VII. Attachment C. Table 1: Department-Approved Behavioral Health In lieu of Services
Behavioral Health Urgent Care
Institute for Mental Disease for acute psychiatric care
Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)
Rapid Care Services

Attachment D. Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, Deliverables, and implementation of services based on Phase 1 of Medicaid Managed Care beginning on November 1, 2019. This list is not comprehensive, and the Department may make adjustments after Contract Award.

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates

Milestone Reference Number	Key Milestone	Description	Tentative Date
1.	Contract Award	The date the Department will award the Managed Care Contract for Standard Plans	2/4/2019
2.	Contract Effective Date	Anticipated approval of PHP Contract by CMS	Contract Award + ninety (90) days
3.	Commencement of PHP Implementation Planning	The date the PHP Implementation Team must be ready to commence Implementation Planning activities	2/4/2019
4.	Draft Implementation Plan	The date the PHP's Implementation Plan Draft must be submitted to the Department	Contract Award + fourteen (14) days
5.	Draft PHP marketing materials	The date the PHP's marketing materials must be submitted to the Department	Commencement of PHP marketing – ninety (90) days
6.	Identification of additional resources for Implementation Team	The date the PHP must identify any additional resources needed to support the implementation activities	Contract Award + twenty (20) days
7.	Submission of PHP Operating Plan	The date the PHP's PHP Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
8.	Submission of Business Continuity Plan	The date the PHP's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
9.	Submission of key technology Deliverables	The date the PHP submits to the Department: • Security Compliance Plan • Encounter Implementation Approach • System Interface Design	Contract Award + thirty (30) days
10.	Submission of key provider materials	The date the PHP submits to the Department: • Network Access Plan • Provider Contract templates • Credentialing and Re-credentialing Policy	Contract Award + thirty (30) days

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
11.	Acquisition of service line phone numbers	The date the PHP must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days
12.	PHP license obtained	Anticipated deadline for PHP to obtain PHP license issued by the NCDOI	Phase 1 Open enrollment – ninety (90) days
13.	Submission of key Member materials	The date the PHP submits to the Department: • Enrollment and Disenrollment Policy • Member ID Card • Welcome Packet • Tribal engagement strategy • Local Community Collaboration Strategy	Contract Award + ninety (90) days
14.	Submission of key clinical and care management materials	The date the PHP submits to the Department • Transition of Care Policies • Care Management Policy • UM Program Policy	Contract Award + ninety (90) days
15.	Submission of training program	The date the PHP's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
16.	Establishment of PHP Office and Call Center(s) in NC	The date the PHP must establish all call center(s) and staff in North Carolina	Contract Award + ninety (90) days
17.	Submission of APM assessment and Three-Year. VBP Strategy	The date the PHP's APM assessment must be submitted to the Department	Contract Award + six (6) months
18.	Commencement of Readiness Review Activities	The date DHHS will begin readiness review activities with the PHP	No later than ninety (90) days prior to Phase 1 Managed Care Launch
19.	Commencement of Marketing Activities	The date the PHP is allowed to begin marketing activities	Phase 1: Phase 1 open enrollment period – eight (8) weeks Phase 2: Phase 2 open enrollment period – eight (8) weeks
20.	Phase 1 open enrollment period	The timeframe that Medicaid Managed Care eligible beneficiaries who reside in Phase 1 selected Regions are able to enroll in a PHP	At least one-hundred and five (105) days prior to November 1, 2019

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
21.	Phase 1 Managed Care Launch	The date the PHP must begin delivering health care services to its enrolled Phase 1 beneficiaries	November 1, 2019
22.	Phase 2, cross-over open enrollment period	The timeframe that Medicaid Managed Care eligible beneficiaries who reside in Phase 2 selected Regions are able to enroll in a PHP	At least one-hundred and five (105) days prior to February 1, 2020
23.	Phase 2 Managed Care Launch	The date the PHP must begin delivering health care services to its enrolled beneficiaries	February 1, 2020

Attachment E. Required PHP Quality Metrics

The Section VII. Attachment E. Table 1: Survey Measures and General Measures list the Department's quality and administrative measures that are meant to provide the Department with a complete picture of PHP's processes and performance as described in Section V.E. Quality and Value. These Measures include a select set of Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

PHP shall track all measures listed below. Priority measures are indicated in the column labeled "Priority Measure." The Department reserves the right to add additional quality metrics, including metrics required under the North Carolina Section 1115 Demonstration Waiver, and change the priority measure indication.

Section VII. Attachment E. Table 1. Survey and General Measures

Reference #	*NQF #*	*Measure Name*	*Priority Measure*	*AMH Measure*	*Interim Measure*	*Gap Measure*
1.	1879	Adherence to Antipsychotic Medications for Individuals With Schizophrenia			x	X
2.	0023	Adult Body Mass Index (BMI) Assessment	x			X
3.	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)	x			
		Total BMI Percentile Documentation				
		Total Counseling for Nutrition				
		Total Counseling for Physical Activity				
4.	1388	Annual Dental Visits (Total Rate)				X
5.	2508	Dental Sealants for 6-9 Year Old Children at Elevated Carries Risk				X
6.	1334	Percentage of Eligibles Who Received Preventive Dental Services	x			X
7.	0105	Antidepressant Medication Management (Both Rates)			X	x

		Acute Phase Treatment				
		Continuation Phase Treatment				
8.	0002	Appropriate Testing for Children With Pharyngitis			x	
9.	0069	Appropriate Treatment for Children With Upper Respiratory Infection			x	
10.	1799	Medication Management for People With Asthma (Medication Compliance 75% Rate only)			x	
		Age 5 -11: 75% of treatment period				
		Age 12-18: 75% of treatment period				
		Age 19-50: 75% of treatment period				
		Age 51-64: 75% of treatment period				
		Total Rate: 75% of treatment period				
11.	1800	Asthma Medication Ratio (Total Rate)	x	x	x	x
12.	0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			x	
13.	2372	Breast Cancer Screening				x
14.	0032	Cervical Cancer Screening	x	x		x
15.	0038	Childhood Immunization Status (Combination 10)	x	x		x
16.	0033	Chlamydia Screening in Women (Total Rate)				x
17.	0061; 0575; 0055	Comprehensive Diabetes Care (BP Control [<140/90], HbA1c Control [<8.0%], Eye Exam)				x
		Hemoglobin A1c (HbA1c) Testing (HA1C)			X (12 month rolling average)	
		Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			x	
		Eye (Retinal) Exam				

18.	0059	Comprehensive Diabetes Care: HbA1c poor control (>9.0%).	x		X (12 month rolling average)	x
19.	0547	Statin Therapy for Patients With Diabetes (Both Rates)				x
		Received Statin Therapy			X (12 month rolling average)	
		Statin Adherence 80%				
20.	0731	Comprehensive Diabetes Care (CDC)			X (12 month rolling average)	
21.	0018	Controlling High Blood Pressure	x	x	x	x
22.	1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				x
23.	0543(adherence)	Statin Therapy for Patients With Cardiovascular Disease (Both Rates)				x
		Received Statin Therapy Total			x	
		Statin Adherence 80% Total			X (12 month rolling average)	
24.	2371	Annual Monitoring for Patients on Persistent Medications				x
		ACE/ARB				
		Digoxin				
		Diuretics				
		Total Combined Rate				
25.	0039	Flu Vaccinations for Adults Ages 18-64				x
26.	0576	Follow-Up After Hospitalization for Mental Illness	x	x	x	

		7- Day Follow-up				
		30-Day Follow-up				
27.	0108	Follow-Up for Children Prescribed ADHD Medication (Both Rates)				x
		Initiation Phase				
		Continuation and Maintenance (C&M) Phase				
28.	1391	Frequency of Prenatal Care (≥81 percent of expected visits only)				
29.	1517	Prenatal and Postpartum Care (Both Rates)	x			
		Timeliness of Prenatal Care				
		Postpartum Care				x
30.	2902	Contraceptive Care: Postpartum	x			
31.	2903	Contraceptive Care: Most & Moderately Effective Methods	x			
32.	1407	Immunizations for Adolescents (Combination 2)	x	x		x
33.	N/A	Adolescent Well-Care Visit				x
34.	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)	x			
		Age 13-17 yrs: Initiation of AOD Treatment				
		Age 13-17 yrs: Engagement of AOD Treatment				x
		Age 18+ years: Initiation of AOD Treatment				
		Age 18+ years: Engagement of AOD Treatment				x
		Total Rate: Initiation of AOD Treatment				
		Total Rate: Engagement of AOD Treatment				x

35.	0027	Medical Assistance With Smoking and Tobacco Use Cessation	x	x		x
36.	2856	Pharmacotherapy Management of COPD Exacerbation (Both Rates)				x
		Systemic Corticosteroid				
		Bronchodilator				
37.	1392	Well-Child Visits in the First 15 Months of Life				
		0 Visits				
		1 Visit				
		2 Visits				
		3 Visits				
		4 Visits				
		5 Visits				
		6 or More Visits				
38.	1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	x	x		x
39.	N/A	Children and Adolescents' Access to Primary Care Practitioners				
		12 - 24 months of age				
		25 months - 6 years old				
		7- 11 years old				
		12- 19 years old				
40.	N/A	Percentage of Low Birthweight Births	x			x
41.	N/A	Percentage of Pregnant Smokers Receiving Appropriate Screening/Treatment for Smoking	x			
42.	2940	Use of Opioids at High Dosage in Persons Without Cancer				x
43.	N/A	Current use of Prescription Opioids and Benzodiazepines	x			
44.	2605	Follow-up After ED Visit for Mental Illness or Alcohol or Other Drug Abuse				

45.	2607	Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)				
46.	2950	Use of Opioids from Multiple Providers in Persons Without Cancer				
47.	3175	Continuity of Pharmacotherapy for Opioid Use Disorder				
48.	1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge				
49.	0006	Getting Care Quickly	x			
50.	0006	Getting Needed Care	x			
51.	0009	Coordination of Care	x			
52.	0006	Customer Service	x			
53.	0006	Rating of Health Plan				
54.	0006	Rating of All Health Care	x			
55.	0006	Rating of Personal Doctor	x			
56.	0006	Rating of Specialist Seen Most Often				
57.	N/A	Overall Provider Satisfaction with PHP	x			
58.	N/A	Screening for Social Determinants of Health				
59.	N/A	Screening for Pregnancy Risk				
60.	0052	Use of Imaging Studies for Low Back Pain				
61.	N/A	Total Cost of Care	x	x		
62.	N/A	Ambulatory Care (AMB)				
63.	1598	Inpatient Utilization- General Hospital/Acute Care (IPU)	x			

64.	1768	Plan All-Cause Readmissions	x	x		
65.	N/A	Measures of Avoidable Utilization	x	x		
		Avoidable Emergency Department Utilization				
		Avoidable Inpatient Utilization (Adults)				
		Avoidable Pediatric Utilization				
66.	N/A	Select Public Health measures Tobacco Use Decrease the percentage of adults who are current smokers Decrease the percentage of high school students using tobacco Decrease the percentage of women who smoke during pregnancy Decrease exposure to second hand smoke in the workplace Diet/Exercise Increase fruit and vegetable consumption among adults Increase percentage of adults who get recommended amount of physical activity Substance Abuse Unintentional Poisoning Mortality Rate				

Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards

At a minimum, Offeror's network shall consist of hospitals, physicians, advanced practice nurses, substance use disorder and behavioral health treatment providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section V.D.1. Provider Network.*

For the purposes of this attachment and the Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

More information is available at: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

In order to ensure that all Members have timely access to all covered health care services, Offeror shall ensure its network meets the following time and distance standards as measured from the Member's residence for adult and pediatric providers separately through geo-access mapping at least annually, at a minimum:

Section VII. Attachment F. Table 1: PHP Time and Distance Standards

Reference Number	Service Type	Urban Standard	Rural Standard
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
3	Hospitals	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members
4	Pharmacies	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members

Section VII. Attachment F. Table 1: PHP Time and Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
5	OB/GYN[4]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
6	Occupational, Physical, or Speech Therapists	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
7	Outpatient Behavioral Health Services	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members
8	Location-Based Services (Behavioral Health)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
9	Crisis Services (Behavioral Health)	≥ 1 provider of each crisis service within each PHP Region	
10	Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP Region	
11	Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of Members
12	Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	≥ 2 providers of clinically managed low-intensity residential treatment services within each PHP Region.	

[4] Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Attachment F. Table 1: PHP Time and Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
13	All State Plan LTSS (except nursing facilities)	PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
14	Nursing Facilities	PHP must have at least 1 nursing facility accepting new patients in every county.	PHP must have at least 1 nursing facility accepting new patients in every county.

The PHP is required to use the definitions of service categories for Behavioral Health time and distance standards found in *Distance Standards* for behavioral health service types in *Section VII. Attachment F. Table 1: PHP Time and Distance Standards* and *Section VII. Attachment F. Table 2: Definition of Service Category for Behavioral Health Time*.

Section VII. F. Table 2: Definition of Service Category for Behavioral Health Time and Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children)
2.	Location-Based Services (Behavioral Health)	• Psychosocial rehabilitation (adult) • SA Comprehensive Outpatient (adult) • SA Intensive Outpatient Program (adults and children) • Opioid treatment (adult)
3.	Crisis Services (Behavioral Health)	• Adult facility-based crisis • Child facility-based crisis • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)

Section VII. F. Table 2: Definition of Service Category for Behavioral Health Time and Distance Standards		
Reference Number	**Service Type**	**Definition**
		• Clinically managed residential withdrawal management
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)
6.	Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	• Clinically managed low-intensity residential treatment services

Offeror is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:

Section VII. F. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) Calendar days for Member less than six (6) months of age Within thirty (30) Calendar days for Members six (6) months or age and older.
2	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar days
4	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. F. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar days
Specialty Care			
6	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar days
8	After-Hours Access – Emergent and Urgent Instructions	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Behavioral Health Care			
9	Mobile Crisis Management Services	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within thirty (30) minutes
10	Urgent Care Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours

Section VII. F. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
11	Urgent Care Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
13	Routine Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
14	Emergency Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
15	Emergency Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

The PHP is required to use the following provider types as "specialty care" providers for purposes of *Section VII. Attachment F. Table 1: PHP Time and Distance Standards* and *Section VII. Attachment F. Table 3: PHP Appointment Wait Time Standards* as found in this attachment:

Section VII. F. Table 4: Specialty Care Providers	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Infectious Disease

Section VII. F. Table 4: Specialty Care Providers	
Reference Number	**Service Type**
10.	Hematology
11.	Nephrology
12.	Neurology
13.	Oncology
14.	Ophthalmology
15.	Optometry
16.	Orthopedic Surgery
17.	Pain Management (Board Certified)
18.	Psychiatry
19.	Pulmonology
20.	Radiology
21.	Rheumatology
22.	Urology

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).

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 requests the interest or the penalty.*

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 IHCIA Section 601, 25 U.S.C. § 1661.

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

   (f) "Tribal health program" has the meaning given in the IHCIA 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 IHCIA, 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 in within this Contract.

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 IHCIA, 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 IHCIA, 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:* _____

(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) IHCIA, 25 U.S.C. § 1601 et seq.

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

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

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

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

Attachment I. Provider Appeals

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

Section VII. Attachment I. Table 1: Provider Appeals	
Reference Number	**Appeal Criteria**
For Network Providers	
1	A network provider has the right to appeal certain actions taken by the PHP. Appeals to the PHP shall be available to a network provider for the following reasons:
a)	Program Integrity related findings or activities;
b)	Finding of fraud, waste, or abuse by the PHP;
c)	Finding of or recovery of an overpayment by the PHP;
d)	Withhold or suspension of a payment related to fraud, waste, or abuse concerns;
e)	Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in the PHP's Objective Quality Standards as described in *Section V.D. Providers* of the RFP*,* as provided under Section 5.(6)d. of Session Law 2015-245, as amended;
f)	Termination of, or determination not to renew, an existing contract for LHD care/case management services;
g)	Determination to lower an AMH provider's Tier Status; and
h)	Violation of terms between the PHP and provider.
For Out-of-network Providers	
2	An out-of-network provider may appeal certain actions taken by the PHP. Appeals to the PHP shall be available to an out-of-network provider for the following reasons:
a)	A determination to not initially credential and contract with a provider based on objective quality reasons outlined in the PHP's Objective Quality Standards as described in *Section V.D. Provider,* and as provided under Section 5.(6)d. of Session Law 2015-245, as amended;
b)	An out-of-network payment arrangement;
c)	Finding of waste or abuse by the PHP; and
d)	Finding of or recovery of an overpayment by the PHP.

Attachment J. Reporting Requirements

The following table details the Medicaid Managed Care Program reports that the PHP must submit to the Department. The Department will provide additional details on report format, fields and frequency after Contract Award.

1. Although the State has indicated the reports that are required, the PHP may suggest additional reports.
2. As part of Readiness Activities, the PHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. The Department reserves the right to require additional reports beyond what is included in this document. The PHP shall submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
1. ***Administration and Management***	
a. PHP Operating Report	Annual report of each entity identified under the PHP Operating Report, providing evidence of PHP oversight activities and entity performance (i.e. metrics, CAPs, sanctions)
2. ***Members***	
a. PHP Enrollment Summary and Detail Reports	Weekly detail report and monthly summary report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
b. Member Services Quality Assurance Report	Quarterly report of survey results which measures member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
c. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.
d. Planned Marketing Procedures, Activities, and Methods	Annual report of planned marketing activities including number/types of events, locations, description of materials distributed, and number of Members reached.
e. Medicaid Clearinghouse Uploads	Detailed reporting of each Notice of Adverse Benefit Determination issued by the PHP to a Member and each grievance received by PHP from members.
f. Member Incentive Programs Report	Quarterly report of member outreach, utilization, and metrics for all Member Incentive Programs

3. ***Benefits and Care Management***	
a. Out-of-Network (OON) Services Request Reports	Quarterly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning.
b. Institute of Mental Disease Report	Weekly summary of members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.
b. Benefit Determination/Prior Authorization Report	Quarterly report that provides information on prior approval requests by individual Member, service type, determination date, and approval status
c. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides information on prior approval requests by individual Member, service type, determination date, and approval status.
d. Clinical Strategies Implemented to promote clinical integration of Behavioral and physical health services	Quarterly reports of Behavioral Health Integration efforts
e. Incurred Cost-Sharing	Quarterly report on the number of families whose cost-sharing liabilities exceed the 5% of total income requirement, the average cost sharing liability for a family, and cost sharing totals by service.
f. Antipsychotic Safety Monitoring Report for Members Through Age 17	Monthly report highlighting the safety monitoring activities related to psychotropic drug use in members through age 17.
g. Pharmacy DUR Program Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.
h. Pharmacy Financial Arrangements Assentation	Annual pharmacy financial arrangements attestation
i. EPSDT Reports	Quarterly and monthly EPSDT reporting including volume of approvals and denials, types of services required, and total paid claims.
j. Care Management Dataset	Monthly financial, utilization, and outcome data at the provider and beneficiary level for all care management programs.
k. Pregnancy Management Program Incentive Report	Quarterly pregnancy management incentive programs report
l. Care Management Return on Investment (ROI) Report	Annual Report of ROI for Care Management
m. Prevention and Population Health Report	Quarterly report of all members outreached to and served, and key program metrics
n. Tobacco Cessation Program Report	Quarterly report of tobacco cessation line utilization and outcomes
o. Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs
p. Enhanced Care Management Pilot Report	Quarterly report of members served, services used, total costs related to Enhanced Care Management pilots
q. Psychotropic Medications for Youth Report	Report to identify trends/usage of psychotropic medications in children 17 years of age and younger

4.	***Providers***	
	a. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.
	b. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how members needs are being met, the PHPs work to alleviate the inadequacy.
	c. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods.
	b. Network Data Details Report	Quarterly report containing demographic information on network providers.
	c. Provider Network Geographical Mapping Report	Periodic report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
	d. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
	e. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
	f. Network Access Report	Quarterly report with various data relating to network access including accounting for new and terminated providers, patient access under transitions of care, PCP selection/ assignment related data, and provider outreach efforts during the reporting period.
	g. Provider-Preventable Conditions Log	Quarterly report of the log of Provider Preventable Conditions
	h. Gap Analysis/Service Needs Assessment	Annual report to demonstrate continuing need for a network adequacy exception request or an essential provider alternate arrangement request.
	i. Ad Hoc Rate Ceiling Necessity Report	Ad hoc report to identify provider types for which the PHP recommends an establishment of a rate ceiling, to include information supporting the recommendation.
	j. Provider Grievances and Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
	k. Litigated Provider Appeals Report	Monthly report on litigated provider of appeals, including number/type of appeal and appeal outcomes.
	l. Additional Directed Payments for Certain Providers Reports	Quarterly reports to support additional directed payments to certain providers, including local health departments, public ambulance providers, FQHC/RHCs, certain hospitals and certain faculty physicians.

m. Provider Quality Assurance	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
5. ***Quality and Value***	
a. Quality Measures Dataset	Annual quality calculated measure percentages, and numerators/denominators sets, quarterly interim calculated measures on select measures
b. QAPI, Provider Support and PIP Reports	Quarterly QAPI/PIP/Provider support program activities and metrics.
c. NCQA Accreditation Report	Annual Accreditation update, including accreditation status; accreditation level; accreditation survey type, if applicable; accreditation results (corrective action plans, summaries of findings), if applicable; and accreditation expiration date.
d. PHP VBP Report	Annual reports detailing types/dollar amounts of VBP arrangement, VBP outcomes, progress towards VBP goals, and VBP projections for following year.
6. ***Stakeholder engagement***	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.
b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. ***Program Administration***	
a. Service Line Report	Quarterly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
d. Load Reports	Report to confirm files are accepted and properly loaded into the PHP's system (example: PDL update). Report required for each set of data/information sent to the PHP.
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Dual-Eligibility Report	Monthly report of Members whose claims should have been presented to Medicare before submission to the PHP

c. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
d. Fraud, Waste and Abuse Report: Providers and Members	Quarterly summary of potential and actual fraud, waste and abuse by provider/member. Including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Pharmacy Fraud, Waste and Abuse: Prescribers, Pharmacies, Members	Quarterly summary of potential and actual pharmacy fraud, waste and abuse by provider/member. Including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
f. Fraud Prevention Report	Annual update on Fraud Prevention Plan, including a list of activities planned but not performed under the approved Fraud Prevention Plan and reason(s) for non-performance, results of the activities performed pursuant to the approved Fraud Prevention Plan and any additional similar activities performed which were not included in the Fraud Prevention Plan, and a summary of each audit, on-site review or other activity performed.
g. Overpayment recoveries	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7)
h. Program Integrity Termination Report	Monthly report on staff terminations related to suspected and confirmed fraud, including
i. Other Provider, and Member Complaints Report	Detailed cumulative listing of provider and member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
9. ***Financial Requirements***	
a. Monthly Financial Schedule	Monthly financial report providing the Department with details on PHP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to encounter submissions to identify discrepancies.
b. Quarterly Financial Schedule	Quarterly financial report providing the Department with details on PHP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, utilization statistics, payments made under alternative payment models, recoupments, and timely provider payment statistics and other items.
b. Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.
c. Unaudited Financial Schedule	Annual submission of the unaudited financial schedule that includes restated monthly and quarterly financials, as well as a preliminary MLR.

d.	Audited Financial Statements	Annual submission of the audited financial statements. 42 C.F.R. § 438.3(m).
e.	Annual PHP Medical Loss Ratio (MLR) Report	Annual Medical Loss Ratio report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).
f.	NAIC Filings	Regulatory filings will be provided upon request by the Department.
g.	Claim payment summary by category of service and provider (NPI)	This report will include claims payment history by category of service for certain providers (NPI) as requested by the Department.
h.	Total Cost of Care (TCOC) and Cost Growth Report	As required in Section 5.(6)a. of Session Law 2015-245, annual report to monitor cost growth. Report will also provide a summary of cost drivers and steps the PHP is taking to address the cost drivers and mitigate future cost growth.
i.	Pharmacy Saving Report	As required in Section 5.(6)b. of Session Law 2015-245, as amending by 2016-121, ad hoc report to support Department monitoring of net pharmacy savings.

Attachment K. Risk Level Matrix

The PHP agrees and acknowledges that the Risk Level Matrix is intended to be an illustrative, non-exhaustive list of the types of acts, failures to act, behaviors, and/or practices that may be assigned to a specific level by the Department upon consideration of some or all of the factors described in the Contract.

If the PHP is found to be non-compliant with the terms, conditions, or requirements of the Contract or of any other violation by the Department, the PHP agrees and acknowledges that the Risk Level Matrix, as provided in the Contract, is for demonstrative purposes only, and the Department retains the sole discretion to assign an appropriate level to each type of noncompliance or violation by the PHP based on the nature of the noncompliance or violation as described in the Contract.

The PHP further agrees and acknowledges that the content included in the examples of noncompliant behavior and/or practices in the Risk Level Matrix are not the full scope of violations subject to a Risk Level assignment by the Department and that if a specific example of noncompliant behavior or practice identified in the Matrix occurs, the Department is not obligated to assign the noncompliant behavior or practice in accordance with the level provided in this Matrix.

Section VII. Attachment K. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or the integrity of Medicaid Managed Care	Failure to substantially provide medically necessary covered services Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract Imposing on Members premiums or cost-sharing that are in excess of that permitted by the Department Failure to substantially meet minimum care management and care coordination requirements Failure to substantially meet minimum Transition of Care Policy requirements Failure to substantially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception) Denying coverage for out-of-network care when no reasonable access to an in-network provider is available Continuing failure to resolve Member and provider appeals and grievances within specified timeframes

Section VII. Attachment K. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to maintain PHP license in good standing with DOI Failure to timely submit accurate and/or complete encounter data in the required file format Misrepresenting or falsifying information that it furnishes to CMS or to the Department Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation Failure to substantially comply with the claims processing requirements and standards Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) Failure to substantially comply with the Preferred Drug List requirements Failure to timely fulfil commitment to participate as a Qualified Health Plan (QHP) on the Federally Facilitated Marketplace in the individual health insurance market in North Carolina in QHP Plan Year 2021 as defined in *Attachment O: Offeror's Proposal and Response*. Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation One or more Level 2 violations within a Contract year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize Member(s) health, safety, and welfare or access to care	Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract Failure to comply with established rate floors and fee schedules as required under the Contract Failure to make additional directed payments to certain providers as required under the Contract Failure to make quality determinations for provider contracting within required timeframes EQRO or other program audit reports with substantial findings

Section VII. Attachment K. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to comply with Member services requirements (including hours of operation, call center, and online portal) Failure to maintain the privacy and/or security of data containing protected health information (PII) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PII Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation Two or more Level 3 violations within a Contract year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program	Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) Failure to notify the Department and Members of terminated network providers within required timeframes Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) Using unapproved Member notices, educational materials, and handbooks and marketing materials Engaging in prohibited marketing activities and practices Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation Three or more Level 4 violations within a Contract year

Section VII. Attachment K. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation the managed care program	Submission of a late, incorrect, or incomplete report or Deliverable (excludes encounter data and other financial reports) Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation Failure to comply with time frames for distributing (or providing access to) Member handbooks, identification cards, provider directories, and educational materials to Members (or potential Members) Failure to meet minimum requirements requiring coordination and cooperation with external entities EQRO or other program audit reports with non-substantia findings Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements) Failure to timely furnish a policy, handbook, directory, or manual upon request by a Member or potential Member as required under the Contract

Attachment L. Managed Care Terminology Provided to the PHP for Use with Members Pursuant to 42 C.F.R. § 438.10

1. Appeal: A review by the Plan of an adverse benefit determination.
2. Co-Payment: Also known as a "Copay" is a fixed amount paid by the Member for certain covered health care services. The copay amount may vary by service or provider. Example: A member cost of $1.00 for a generic prescription.
3. Durable Medical Equipment: Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is appropriate for home use and is not useful to a person without illness or injury. For devices classified as DME after January 1, 2012, has an expected life of three (3) years.
4. Emergency Medical Condition: A medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.
5. Emergency Medical Transportation: Medically necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.
6. Emergency Room Care: Care given for a medical emergency, in a part of the hospital where emergency diagnosis and treatment of illness or injury is provided, when it is believed that one's health is in danger and every second counts.
7. Emergency Services: Inpatient and outpatient services by a qualified provider needed to evaluate or stabilize an emergency medical condition.
8. Excluded Services: Services that are not covered by the PHP.
9. Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes the Member's right to dispute an extension of time proposed by the PHP to make an authorization decision.
10. Habilitation Services and Devices: Health care services that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings.
11. Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.
12. Home Health Care: Certain medically necessary services provided to Members in any setting in which normal life activities take place other than a hospital, nursing facility, or intermediate care facility. Services include skilled nursing, physical therapy, speech-language pathology, and occupational therapy, home health aide services, and medical supplies.

13. Hospice Services: Special services for patients and their families during the final stages of illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.
14. Hospitalization: Care in a hospital that requires admission as an inpatient for a duration lasting more than twenty-four (24) hours. An overnight stay for observation could be outpatient care.
15. Hospital Outpatient Care: Care for a Member in a hospital, or distinct part of a hospital, for professional services of a duration less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.
16. Medically Necessary: Those covered services that are within generally accepted standards of medical care in the community and not experimental.
17. Network: A group of doctors, hospitals, pharmacies, and other health care experts contracted by the PHP to provide health care services.
18. Non-participating provider: Non-Par or non-participating providers are physicians or other health care providers that have not entered into an agreement with the PHP and are not part of the Network, unlike participating providers. They may also be called out-of-network providers.
19. Participating Provider: Par or participating providers are physicians or other health care providers that have an agreement with the PHP and are part of its Network. These agreements outline the terms and conditions of participation for both the payer and the provider.
20. Physician Services: Health care services a licensed medical physician, or physician extender such as a nurse practitioner or physician assistant, provides, orders, or coordinates.
21. Plan (or Health Plan): The company providing you with health insurance.
22. Preauthorization: The approval needed from your plan before you can get certain health care services or medicines.
23. Premium: The amount paid for health insurance monthly. In addition to a premium, other costs for health care, including a deductible, copayments, and coinsurance may also be required.
24. Prescription Drug Coverage: Refers to how the PHP helps pay for its Members' prescription drugs and medications.
25. Prescription Drugs: Also known as prescription medication or prescription medicine, is a pharmaceutical drug that legally requires a medical prescription to be dispensed.
26. Primary Care Physician: A licensed medical doctor (MD) or doctor of osteopathy (DO) that provides and coordinate's patient needs and initiates and monitors referrals for specialized services when required. See Primary Care Provider.
27. Primary Care Provider (PCP): The participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.
28. Provider: A health care professional or a facility that delivers health care services, like a doctor, hospital, or pharmacy.

29. Rehabilitation Services and Devices: Health care services and equipment that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to sickness, injury, or disablement. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.
30. Skilled Nursing Care: Care that requires the skill of a licensed nurse.
31. Specialist: A provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
32. Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get Urgent Care in a walk-in clinic for a non-life-threatening injury (like the flu or sprained ankle).

Attachment M. POLICIES

1. North Carolina Medicaid Managed Care Enrollment Policy

a) Background

The Department will ensure that Medicaid[5] and NC Health Choice beneficiaries, their families and caregivers are supported in the transition to Medicaid Managed Care throughout the enrollment process, including selecting a Prepaid Health Plan (PHP) and an advanced medical home (AMH) and/or primary care provider (PCP). The Department will ensure beneficiaries and their families have the tools and resources to access care and experience a smooth transition from Medicaid Fee-For-Service to Medicaid Managed Care, and throughout Medicaid Managed Care implementation.

The Department is planning to implement Medicaid Managed Care in two (2) phases based on Regions, with distinct open enrollment periods for each phase, for the initial transition of beneficiaries from Medicaid Fee-for-Service to Medicaid Managed Care to ensure successful implementation.

b) Scope

The North Carolina Medicaid Managed Care Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the PHPs in the enrollment of beneficiaries into Medicaid Managed Care. The intent of this Policy is not to replace any existing enrollment processes related to Medicaid Fee-For-Service and/or Local Management Entities/Managed Care Organizations (LME/MCOs).

c) Populations Eligible for Medicaid Managed Care

The Department is responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt, or mandatory at any point in time. The PHP must adhere to Medicaid Managed Care eligibility determinations made by the Department and enroll or disenroll beneficiaries in accordance with those determinations and this Policy. Populations to be excluded, exempt or mandatory in Medicaid Managed Care are defined in the Contract.

d) Medicaid Managed Care Eligibility Determinations

The Department is responsible for performing, managing and maintaining all Medicaid Managed Care enrollment and cost sharing eligibility determinations. It is the responsibility of the Enrollment Broker, the PHP and other partners of the Department operating within Medicaid Managed Care to adhere to the determinations made by the Department.

e) Prepaid Health Plan Enrollment

i. Consistent with 42 C.F.R. § 438.810, the Department will contract with an Enrollment Broker to provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives, who want to select a PHP and an AMH/PCP or have questions about Medicaid Managed Care.

ii. Crossover populations

1. Open enrollment
   a. To support beneficiary choice, the Department will offer the crossover population a sixty (60) calendar day open enrollment period to select a PHP prior to the scheduled transition date from Medicaid Fee-for-Service to Medicaid Managed Care.
   b. During the open enrollment period, the Enrollment Broker will engage in proactive outreach that explains the Enrollment Broker's services, provides managed care education, and supports PHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care.

[5] "Medicaid" includes both Medicaid and NC Health Choice programs within this Policy unless noted otherwise.

c. If a beneficiary selects a PHP during the open enrollment period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.
d. If a beneficiary does not select a PHP during the open enrollment period, the Department will auto-assign the beneficiary to a PHP based on the Department's defined auto-assignment algorithm. The Department will transmit PHP assignment to the PHP through an 834 eligibility file.
e. For a beneficiary in a crossover population who selects a PHP, or who is auto-assigned into a PHP, coverage by the PHP begins on the first day of the scheduled transition date to Medicaid Managed Care for the specific crossover population. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.

2. Choice period
a. After coverage by a PHP begins, the Member will have ninety (90) calendar days to change his or her PHP without cause.
b. During the choice period, the Enrollment Broker will continue to provide choice counseling and support the Member with PHP and AMH/PCP selection.
c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the member selected the PHP.
d. If a Member does not select a different PHP during the choice period, the Member will remain in his or her PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

iii. Ongoing enrollment (post Medicaid Managed Care implementation)

1. New Medicaid applicants eligible for Medicaid Managed Care
a. New Medicaid applicants will have an opportunity to select a PHP and AMH/PCP as part of the eligibility application process.
b. If an applicant selects a PHP during the eligibility application process, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.
c. If an applicant does not select a PHP as part of the eligibility application process, the applicant will be auto-assigned to a PHP based on the Department-defined auto-assignment algorithm described in Section 6.f.vi. The Department will transmit the auto-assignment to the assigned PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.
d. For applicants determined Medicaid Managed Care eligible who select a PHP or who are auto-assigned into a PHP, coverage by the PHP begins on the first day of the month in which Medicaid eligibility is determined. However, the new Medicaid beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
e. Choice period
i. After coverage by the PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.
iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the

new PHP will begin on the first day of the next month in which the Member selected the PHP.

iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her previously selected or auto-assigned PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

2. New beneficiaries eligible for Medicaid Managed Care
   a. For a beneficiary determined eligible for Medicaid Managed Care after implementation, the beneficiary will be auto-assigned into a PHP based on the Department-defined auto-assignment algorithm.
   b. The Department will transmit the auto-assignment to the assigned PHP through an 834 eligibility file. Coverage by the assigned PHP will begin on the first day of the month in which the beneficiary is determined eligible for Medicaid Managed Care. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
   c. Choice period
      i. After coverage by a PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
      ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.
      iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
      iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her auto-assigned PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section f.

iv. Medicaid eligibility redetermination
   1. Upon receiving a notice from the Department of the Member's upcoming annual redetermination, the Member may contact the Enrollment Broker prior to the redetermination decision to select a different PHP for his or her upcoming eligibility year.
   2. If a Member is redetermined eligible for Medicaid and has not selected a different PHP prior to the redetermination decision, the Department will auto-assign the Member into the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care. However, the Member will have an additional opportunity to select a different PHP during his or her annual choice period.
   3. Annual choice period
      a. If a Member is redetermined eligible for Medicaid, the Member will receive a notice from the Department and will be offered ninety (90) calendar days to select a different PHP.
      b. During the choice period, the Enrollment Broker will provide choice counseling and support the Member in PHP and AMH/PCP selection.
      c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
      d. If a Member is redetermined eligible and has not selected a different PHP during the choice period, the Member will remain in the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care.

e. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, the Member will receive his or her choice period, plus additional time added to the choice period equal to the number of calendar days the redetermination decision was delayed.

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

v. Special cases

1. Exempt populations

a. The Enrollment Broker will provide choice counseling to exempt populations and support PHP/Medicaid Fee-For-Service/Tribal Option (as applicable) and AMH/PCP selection throughout the beneficiary's eligibility year.

b. If a beneficiary in an exempt population selects a PHP, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.

c. If a beneficiary in an exempt population selects a different PHP, or delivery system (such as Medicaid Fee-For-Service or Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by the new PHP or delivery system begins on the first day of the next month in which the beneficiary selected the new PHP or delivery system.[6]

2. Deemed newborns

a. If a Member is known to be pregnant, the PHP shall validate that the Member selects an AMH/PCP for the child prior to the birth.

b. Upon delivery, a deemed newborn will be assigned to the mother's PHP, and the PHP will begin providing coverage to the newborn immediately. The PHP is responsible for the provision and payment of services for the deemed newborn in the hospital or birthing center, even if the deemed newborn has not appeared on the PHP's roster.

c. If the PHP receives notification of birth prior to discharge, the PHP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.

d. The PHP shall report the deemed newborn's birth to the Department within five (5) calendar days upon learning of the birth and, at a minimum, provide the Department with the mother's name, social security number, NC FAST case number, Member identification number, residing county, and the newborn's name, sex, and date of birth.

e. If the PHP has not received confirmation of a deemed newborn's enrollment in the PHP through an 834 eligibility file following the deemed newborn's birth, the PHP shall notify the Department and the Enrollment Broker and send notification of the birth within sixty (60) calendar days from the date of delivery.

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

vi. PHP auto-assignment

1. In accordance with 42 C.F.R. § 438.54, the Department developed auto-assignment algorithms for every beneficiary determined Medicaid Managed Care eligible who does not select a PHP during their open enrollment period (for crossover populations only) or during the Medicaid eligibility application process. The Department may use the auto-assignment algorithm in other instances

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

deemed appropriate by the Department and as required by North Carolina or federal law or regulation.

2. In its sole discretion, the Department may change the auto-assignment algorithm.
3. For the crossover population and for a new beneficiary enrolled into Medicaid Managed Care, the auto-assignment algorithm is defined according to the following components in this order:
   a. Beneficiary's geographic location;
   b. Whether the beneficiary is a member of a special population (e.g. member of a federally recognized tribe, or BH I/DD Tailored Plan eligible).
   c. PHP/AMH selection upon application and PCP/AMH historic relationship.
   d. Plan assignments for other family members.
   e. Previous PHP enrollment during previous twelve (12) months (for those who have "churned" on/off Medicaid managed care).
   f. Equitable plan distribution with enrollment subject to:
      i. PHP enrollment ceilings and floors, per PHP, to be used as guides.
      ii. Increases in a PHP's base formula relative to their contributions to health-related resources, as described herein.
      iii. Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment.
4. A PHP that voluntarily contributes at least one-tenth (0.1) percent of its annual capitation revenue in a Region to health-related resources may be awarded a preference in auto-assignment as defined in the Contract.
5. To promote an equitable distribution of Medicaid Managed Care enrollment among the PHPs, the Department will enforce an auto-assignment floor of ten percent (10%) and a ceiling of forty percent (40%) percent of Medicaid Managed Care Members per Region.
6. At redetermination after Medicaid Managed Care launch, the Member will be auto-assigned into the same PHP from the prior year, provided that the PHP continues to participate in Medicaid Managed Care and the Member does not request enrollment in a different PHP.
   i.
7. Auto-assignment may also be used in the following instances:
   a. For Medicaid Managed Care Members whose PHP has been discontinued. The Member will be auto-assigned using the same algorithm used for new beneficiaries.
   b. For beneficiaries who lose, but then regain, Medicaid eligibility. The beneficiary will be auto-assigned into the beneficiary's previous PHP, unless the PHP is no longer participating in Medicaid Managed Care or the beneficiary indicates that he or she wishes to enroll in another PHP. If the PHP is no longer participating in Medicaid Managed Care, the beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.
   c. For Members who have been disenrolled based upon the request of the PHP. The Member will be assigned to a new PHP based on the same auto-assignment algorithm used for new beneficiaries except that the Member will not be reassigned to the PHP that requested disenrollment.
   d. For beneficiaries who are determined Medicaid Managed Care mandatory or exempt who are discharged from a long-term stay in a nursing facility (including a state-owned Neuro-Medical Center or a DMVA-operated Veterans Home) after Medicaid Managed Care implementation. The beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.

f) **Prepaid Health Plan Disenrollment**

i. Member disenrollment from a PHP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from one PHP to be enrolled into a different PHP.

ii. Disenrollment requested by a Member

1. A Member may request disenrollment from a PHP "without cause" during the time periods specified in Section f.ii.4. or, at any time, for any of the "with cause" reason specified in Section f.ii.5.
2. A Member, or an authorized representative, may submit an oral or written request for disenrollment from the PHP to the Enrollment Broker by phone, mail, in-person, or electronically.
3. At the time of the disenrollment request, the Enrollment Broker will offer choice counseling to the Member, or his or her authorized representative, and capture the new PHP and AMH/PCP preference.
4. Without cause disenrollment requests
   a. Consistent with 42 C.F.R. § 438.56(c), a Member may change his or her PHP without cause at the following times:
      i. During the initial ninety (90) calendar days following the effective date or date of notice of new PHP enrollment (referred to as the choice period).
      ii. At least once every twelve (12) months that coincides with the Member's redetermination period.
      iii. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, during the period when the redetermination decision is delayed.
      iv. When the temporary loss of Medicaid eligibility has caused the Member to miss his or her annual disenrollment opportunity.
      v. If the Department imposes temporary management in accordance with 42 C.F.R. § 438.706, suspends new enrollment in accordance with 42 C.F.R. § 438.702(a)(4), or grants Members the right to terminate enrollment without cause in accordance with 42 § C.F.R. 438.702(a)(3) as intermediate sanctions against the PHP.[7]
   b. The following populations may disenroll from a PHP without cause at any time upon request to the Enrollment Broker:
      i. Members of federally recognized tribes.
      ii. Members receiving long-term services and supports (LTSS) in institutional or community-based settings.
   c. Unless otherwise notified by the Department of a without cause opportunity to disenroll from the PHP, to initiate a without cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.
   d. The Enrollment Broker will process without cause disenrollment requests in accordance with the following:
      i. The Enrollment Broker will evaluate the request and decide whether to approve or deny.
      ii. The Enrollment Broker will notify the Department of its decision by the next calendar day following receipt of the request.
   e. Notice of disenrollment determination
      i. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective date within seven (7) days of receipt of the request by the Enrollment Broker.
      ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination

[7] If the Department imposes any of these intermediate sanctions against a PHP, the Department will notify the affected Members of their right to disenroll without cause.

within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[8]

5. With cause disenrollment requests
   a. Consistent with 42 C.F.R. § 438.56(c)(1), a Member, or an authorized representative, may request disenrollment from his or her PHP with cause at any time.
   b. The following are with cause reasons to request disenrollment from the PHP:
      i. The Member moves out of the PHP Region(s).[9]
      ii. The PHP does not, because of moral or religious objection, cover a service the Member seeks.[10]
      iii. The Member needs concurrent, related services that are not all available within a PHP's provider network, and the Member's provider determines receiving services separately would subject the member to unnecessary risk.[11]
      iv. A Member receiving LTSS would be required to change his or her residential, institutional or employment supports provider based on a change in status from in-network to out-of-network.[12]
      v. The Member's complex medical condition(s) would be better served under a different PHP, or the Medicaid Fee-For-Service/LME/MCO delivery system in the case of a Medicaid Managed Care Member who meets BH I/DD Tailored Plan eligibility (including having a qualifying event, as defined by the Department) prior to launch of the BH I/DD Tailored Plans. A Member is considered to have a complex medical condition if the condition could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
      vi. A family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the Member.
      vii. Poor performance of the PHP, as determined by the Department, after evaluation of PHP performance.
      viii. Other reasons, including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need, as defined by the Department.[13]
   c. The existence of a with cause reason for disenrollment does not automatically disenroll a Member from the PHP. To initiate a with cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.
   d. The Enrollment Broker will process with cause disenrollment requests in accordance with the following:
      i. For clinical-related with cause disenrollment requests, including requests based on the need for concurrent related services, complex medical conditions, or urgent medical need, the Enrollment Broker will transmit clinical-related with cause requests to the Department for evaluation within twelve (12) hours of receipt. The Department will decide whether to approve or deny clinical-related disenrollment requests.

[8] 42 C.F.R. § 438.56(e).
[9] 42 C.F.R. § 438.56(d)(2)(i).
[10] 42 C.F.R. § 438.56(d)(2)(ii).
[11] *See* 42 C.F.R. § 438.56(d)(2)(iii).
[12] *See* 42 C.F.R. § 438.56(d)(2)(iv).
[13] 42 C.F.R. § 438.56(d)(2)(v).

ii. For all other with cause disenrollment requests, the Enrollment Broker will evaluate the request and notify the Department of its decision to approve or deny within three (3) calendar days of receipt of the request.

e. Notice of disenrollment determination

i. The Department will notify the Member, or authorized representative, and the PHP of the denial or approval of the disenrollment request and, if approved, the disenrollment effective date within seven (7) days of receipt of the request by the Enrollment Broker.

ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[14]

6. Expedited review of with cause requests for disenrollment

a. A Member, or an authorized representative, may request an expedited review of his or her with cause disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the PHP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

b. The Enrollment Broker will process requests for expedited review in accordance with the following:

i. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.

ii. The Department will evaluate and decide whether to approve or deny the request.

c. Notice of expedited disenrollment determination. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the expedited disenrollment request, and, if approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.

iii. Disenrollment requested by a PHP

1. In accordance with 42 C.F.R. §§ 438.56(b)(2)-(3), the PHP is prohibited from requesting disenrollment of a Member because of an adverse change in the Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs.
2. The PHP may only submit requests for Member disenrollment if the following occurs:
   a. The Member's behavior seriously hinders the PHP's ability to care for the Member, or other Members of the PHP; and
   b. The PHP has documented efforts to resolve the Member's issues that form the basis of the request for disenrollment of the Member.
3. To initiate a disenrollment request, the PHP must contact the Enrollment Broker and provide the information required to support its request for disenrollment.
4. The Enrollment Broker will process requests for disenrollment received from the PHP in accordance with the following:
   a. The Enrollment Broker will transmit the request to Department for evaluation within three (3) calendar days of receipt of the request.
   b. The Department evaluate and decide whether to approve or deny the request.
5. Notice of disenrollment determination

[14] 42 C.F.R. § 438.56(e).

a. If the Department denies a disenrollment requests made by the PHP, the Department will notify the PHP of the decision within seven (7) calendar days of receipt of the request by the Enrollment Broker.
b. If the Department approves a disenrollment requests made by the PHP, the Department will notify the PHP, the Member, or authorized representative, of the decision and the effective date of the disenrollment within seven (7) calendar days of receipt of the request by the Enrollment Broker.
c. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the PHP requests disenrollment. If the Department fails to make a disenrollment determination within the timeframes specified in this subsection, the disenrollment is considered approved for the effective date that would have been established had the Department made a determination in the specified timeframe.[15]

iv. Disenrollment required by the Department

1. The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:
   a. Loss of eligibility
      i. If the Department determines that a member is no longer be eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the PHP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.
      ii. If a Member is disenrolled from a PHP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the PHP.[16]
   b. Change in Medicaid eligibility category
   c. Nursing facility long-term stays
      i. A Member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from Medicaid Managed Care on the first day of the next month following the ninetieth (90th) day of stay and receive services through Medicaid Fee-For-Service.[17]
      ii. The PHP will have a process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) calendar days.
      iii. To monitor and report a Member's length of stay in a nursing facility the PHP must use the following process:
         i. Within thirty (30) days of admission to a nursing facility, the PHP will assess a Member's health care needs and estimate the potential length of stay. If the Member requires a stay for longer than ninety (90) calendar days, the PHP must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.
         ii. The PHP is responsible for tracking the total continuous length of stay for each Member residing in a nursing facility.

[15] Id.
[16] 42 C.F.R. § 438.56(g).
[17] Session Law 2015-245, as amended by Session Law 2018-49.

iii. The Department will send the PHP and the Member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the Member's disenrollment from the PHP.

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

v. Coverage of the Member by the PHP will end on the effective date provided by the Department.

iv. Neuro-Medical Centers and Veterans Homes

i. A beneficiary, otherwise eligible for enrollment in Medicaid Managed Care, residing in a state-owned Neuro-Medical Center[18] or a DMVA-operated Veterans Home[19] when the Department implements Medicaid Managed Care are excluded and will receive care in these facilities through Medicaid Fee-For-Service.

ii. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation will be disenrolled from the PHP by the Department.

1. The Neuro-Medical Center or Veterans Home will submit the Member's information including date of admission to the Department within fourteen (14) calendar days of admission.
2. The Department will notify the Member and the PHP of the disenrollment and the disenrollment effective date.
3. Coverage of the Member by the PHP will end on the effective date provided by the Department.

g) **Appeals**

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

h) **Managed Care Enrollment Policy Changes**

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

[18] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities.

[19] Department of Military and Veterans Affairs, North Carolina State Veterans Homes: https://www.milvets.nc.gov/services/nc-state-veterans-homes.

2. Advanced Medicaid Home Program Policy

1. Background

The Advanced Medical Home (AMH) program refers to an initiative under which the PHP delegates care management responsibilities and functions to State-designated AMH practices to provide local care management services. Refer to *Section III.C.6. Care Management* for additional detail regarding the AMH Program. An AMH "practice" will be defined by a NPI and service location.

2. Scope

The scope of this Policy covers the agreement between the PHP and primary care providers participating in the AMH program outlined below and in the Contract.

3. Standard Terms and Conditions for PHP Contracts with All Advanced Medical Home Providers

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

4. Standard Terms and Conditions for PHP Contracts With Tier 3 AMH Providers

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements. The PHP shall maintain a contractual relationship with the AMH (not the CIN).

a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
    i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the PHP are reconciled with the practice's panel list and up to date in the clinical system of record.
    ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
    iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the PHP with clinical information to score and stratify the patient panel.
    iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.
    v. The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
    vi. The Tier 3 AMH practice must define the process and frequency of risk score review and validation.
b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
    i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
    ii. The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
        1. Patient's immediate care needs and current services;
        2. Other state or local services currently used;
        3. Physical health conditions, including dental;
        4. Current and past behavioral and mental health and substance use status and/or disorders;
        5. Physical, intellectual developmental disabilities;
        6. Medications – prescribed and taken;
        7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
        8. Available informal, caregiver, or social supports, including peer supports.
    iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.
    iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.
    i. The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.
    ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.
    iii. The Tier 3 AMH practice must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:
    1. Measurable patient (or patient and caregiver) goals
    2. Medical needs including any behavioral health and dental needs;
    3. Interventions, including medication management and adherence;
    4. Intended outcomes; and
    5. Social, educational, and other services needed by the patient.
v. The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.
vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.
vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.
viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.
ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)
    1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
    2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
    3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

d. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.
    i. The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:
        1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits
        2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
        3. NICU discharges;
        4. Clinical complexity, severity of condition, medications, risk score.
    ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
    iii. The Tier 3 AMH practice must include the following elements in transitional care management:
        1. Ensuring that a care manager is assigned to manage the transition

2. Facilitating clinical handoffs;
3. Obtaining a copy of the discharge plan/summary;
4. Conducting medication reconciliation;
5. Following-up by the assigned care manager rapidly following discharge;
6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
7. Developing a protocol for determining the appropriate timing and format of such outreach.

e. Tier 3 AMH practices must use electronic data to promote care management.
   i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

Section VII. Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (The age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes.)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

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13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

3. Pregnancy Management Program Policy

1. **Background**

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

2. **Scope**

The scope of this Policy covers the requirements that must be in agreement between the PHP and providers who offer prenatal, perinatal and postpartum services and thus are a part of the Pregnancy Management Program outlined below and in *Section III.C.6. Care Management*.

3. **Pregnancy Management Program Requirements**

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

a. Complete the standardized risk-screening tool at each initial visit.
b. Allow PHP or PHP's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
c. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation;
d. Commit to decreasing the cesarean section rate among nulliparous women;
e. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation;
f. Complete a high-risk screening on each pregnant Medicaid Managed Care Member in the program and integrate the plan of care with local pregnancy care management;
g. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate; {Note: the Department will set the rate annually, which will be at or below twenty percent (20%)};
h. Ensure comprehensive post-partum visits occur within fifty-six (56) days of deliver; and.
i. The PHP shall require that its network providers send all screening information and applicable medical record information for Members in the Care Management of High-Risk Pregnancies to the applicable PHPs and the LHDs or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the provider completing the screening.

4. Care Management for High-Risk Pregnancy Policy

1. **Background**

Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments. Refer to the Contract for additional detail regarding Care Management for High-Risk Pregnancy

2. **Scope**

The scope of this Policy covers the agreement between the PHP and LHD providers offering Care Management for High-Risk Pregnancy, as outlined below and in the Contract.

3. **General Contracting Requirement**
    a. LHDs shall accept referrals from the PHP for Care Management for High-Risk Pregnancy Services.

4. **Care Management for High-Risk Pregnancy: Outreach**
    a. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
    b. LHD shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

5. **Care Management for High-Risk Pregnancy: Population Identification and Engagement**
    a. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) calendar days of receipt of risk screening forms.
    b. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome.
    c. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.
    d. LHD shall review available PHP data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.
    e. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

6. **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**
    a. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support
    b. LHD shall utilize assessment findings, including those conducted by the PHP to determine level of need for care management support.
    c. LHD shall document assessment findings in the care management documentation system.

d. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained.
e. LHD shall assign case status based on level of patient need.

7. **Care Management for High-Risk Pregnancy: Interventions**
    a. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.
    b. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
    c. LHD shall develop patient-centered care plans, including appropriate goals, interventions and tasks.
    d. LHD shall utilize NC Resource Platform and identify additional community resources once the Department has certified it as fully functional.
    e. LHD shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Member 's PHP network.
    f. LHD shall document all care management activity in the care management documentation system.

8. **Care Management for High-Risk Pregnancy: Integration with the PHP and Healthcare Providers**
    a. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
    b. LHD shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
    c. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county.
    d. LHD shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
    e. LHD shall ensure awareness of PHP Members' "in network" status with providers when organizing referrals.
    f. LHD shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

9. **Care Management for High-Risk Pregnancy: Collaboration with PHP**
    a. LHD shall work with the PHP to ensure program goals are met.
    b. LHD shall review and monitor PHP reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk.
    c. LHD shall communicate with PHP regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
    d. LHD shall participate in pregnancy care management and other relevant meetings hosted by the PHP.

10. **Care Management for High-Risk Pregnancy: Training**
    a. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by PHP and/or the Department, including webinars, new hire orientation or other programmatic training.

b. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by PHP and/or the Department.
c. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
d. LHD shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

11. **Care Management for High-Risk Pregnancy: Staffing**
    a. LHD shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:
        i. Registered nurses;
        ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Care Managers for High- Risk Pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.
    b. LHD shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
    c. LHD shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team.
    d. If the LHD only has a single Care Manager for High-Risk Pregnancy, the LHD shall ensure access to individual (s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
    e. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
    f. LHD shall ensure that Pregnancy Care Managers must demonstrate:
        i. A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
        ii. Proficiency with the technologies required to perform care management functions
        iii. Motivational interviewing skills and knowledge of adult teaching and learning principles;
        iv. Ability to effectively communicate with families and providers; and
        v. Critical thinking skills, clinical judgment and problem-solving abilities.
    g. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
        i. Provision of program updates to care managers.
        ii. Daily availability for case consultation and caseload oversight.
        iii. Regular meetings with direct service care management staff.
        iv. Utilization of reports to actively assess individual care manager performance.
        v. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.
    h. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following PHP/Department guidance about communication with PHP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
    i. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by PHPs.

5. Care Management for At-Risk Children Policy

1. **Background**

   Care Management for At-Risk Children are care management services provided by Local Health Departments to a subset of the Medicaid population ages 0-5 identified as being "high-risk." Refer to the Contract for additional detail regarding the Care Management for At-Risk Children Program.

2. **Scope**

   The scope of this Policy covers the required terms that must be in agreements between the PHP and Local Health Department providers offering Care Management for At-Risk Children outlined below and in the Contract.

3. **Care Management for At-Risk Children: General Requirements**

   LHD shall accept referrals from the PHP for children identified as requiring Care Management for At-Risk Children.

4. **Care Management for At-Risk Children: Outreach**
   a. LHD shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources.
   b. LHD shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services.
   c. LHD shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
   d. LHD shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population.
   e. LHD shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the Department.

5. **Care Management for At-Risk Children: Population Identification**
   a. LHD shall use any claims-based reports and other information provided by PHPs, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations.
   b. LHD shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.
   c. LHD shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

6. **Care Management for At-Risk Children: Family Engagement**
   a. LHD shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
   b. LHD shall foster self-management skill building when working with families of children.
   c. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

7. **Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level**
   a. LHD shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description.

b. LHD shall review and monitor PHP reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
c. LHD shall use the information gained from the assessment to determine the need for and the level of service to be provided.

8. **Care Management for At-Risk Children: Plan of Care**
   a. LHD shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.
   b. LHD shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home.
   c. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals.
   d. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need.
   e. LHD shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

9. **Care Management for At-Risk Children: Integration with PHPs and Health Providers**
   a. LHD shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs.
   b. LHD shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team.
   c. Where care management is being provided by a PHP and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the PHP/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services
   d. LHD shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical home PCP and/or care team and to the PHP.
   e. LHD shall ensure awareness of PHP Member's "in network" status with providers when organizing referrals.
   f. LHD shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

10. **Care Management for At-Risk Children: Service Provision**
    a. LHD shall document all care management activities in the care management documentation system in a timely manner.
    b. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

11. **Care Management for At-Risk Children: Training**
    a. LHD shall participate in Department/PHP-sponsored webinars, trainings and continuing education opportunities as provided.
    b. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

12. **Care Management for At-Risk Children: Staffing**
    a. LHD shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications:
       i. Registered nurses;

ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program.
    1. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines.

b. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.

c. LHD shall ensure that Care Management for At-Risk Children Care Managers must demonstrate:
    i. Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system;
    ii. Ability to effectively communicate with families and providers; and
    iii. Critical thinking skills, clinical judgment and problem-solving abilities.
    iv. Motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles

d. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.

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

f. LHD shall maintain services during the event of an extended vacancy.

g. In the event of an extended vacancy, LHD shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

h. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.

i. LHD shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

j. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    i. Provision of program updates to care managers.
    ii. Daily availability for case consultation and caseload oversight.
    iii. Regular meetings with direct service care management staff.
    iv. Utilization of monthly and on-demand reports to actively assess individual care manager performance.

k. LHD shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

6. Uniform Credentialing and Re-credentialing Policy

1. **Background**

   This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a Prepaid Health Plan (PHP) in determining whether to allow a provider to be included in the PHP's network using objective quality standards in making a Quality Determination, subject to certain Department requirements.

2. **Scope**

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

3. **Policy Statement**

   The PHP shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of their medical service providers. Each PHP must ensure that the responsibility for recommendations regarding objective quality determinations (i.e., network contracting decisions) will rest with a Provider Network Participation Committee.

   a. **Centralized Provider Enrollment and Credentialing**

      i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

         a) The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in the State Medicaid program.
            1. The information shall be collected, verified, and maintained as required to participate in the Medicaid program.
            2. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.
         b) The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
         c) The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.
         d) Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid enrolled provider, with the application serving for enrollment as a Medicaid Fee-for-Service provider as well as a Medicaid managed care provider.
            1. The Department shall not mandate Medicaid managed care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

e) Providers will be reverified and recredentialed every three years, except as otherwise specifically permitted by the NC DHHS in the Contract.
f) A PHP shall use its Provider Credentialing and Re-credentialing Policy to decide whether to contract with a Medicaid enrolled provider in accordance with the standards contained in this Policy.

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

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

a) Meet the requirements specified in 42 C.F.R. § 438.214;
b) Meet the requirements specified in this Contract;
c) Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;
d) Establish that the PHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.
e) Establish a documented process for making Quality Determinations using objective quality standards;
f) Identify objective quality standards for Quality Determinations that must:
1. Assess a provider's ability to deliver care;
2. Include specific defined thresholds for adverse quality determinations;
3. Meet standards established by the National Committee on Quality Assurance (NCQA); and
4. Are not discriminatory.
g) Prohibit PHP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment;
h) Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
i) Prohibit PHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
j) Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and
k) Describe the appeal's process for those providers for whom PHP makes an adverse Quality Determination in accordance with standards found in *Section V.D.5. Provider Grievances and Appeals* in the PHP Contract.
l) Describe the information that providers will be requested to submit as part of the contracting process.
m) Describe the process by which the PHP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).
n) If PHP requires a provider to submit additional information as part of its contracting process, the PHP's policy shall include a description of all such information.
1. PHP shall make a Quality Determination based solely upon the credentialing information provided by the Department.
2. PHP shall not require a provider to submit any additional information to be used in the Quality Determination.
o) PHP shall re-credential providers as follows:

1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
2. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.

p) Include all previous versions, be published on the PHP's website and include the Policy effective dates.

ii. PHP shall follow this Policy and its Provider Credentialing and Re-credentialing Policy when making a Quality Determination and contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state network providers.

iii. PHP shall have discretion to make Quality Determinations consistent with the Policy and the PHP's Provider Credentialing and Re-credentialing Policy.

iv. PHP shall publish its approved Provider Credentialing and Re-credentialing Policy, including all previous versions, on the PHP's website and include the effective date of each Policy.

7. Management of Inborn Errors of Metabolism Policy

1. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.
2. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.
3. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that PHP cover the full cost of therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized care plan.
4. Once a client is established with a specialized treatment facility a nutrition care plan is developed and products prescribed. The current system of product coverage is four pronged:

    a. Clients with health insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers. Certificate of Medical Necessity/Prior Approval Form (triplicate DMA form), Prescription and Oral Nutrition Product Request Form (DMA form) are required.

    b. Clients with Medicaid or Health Choice coverage are served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form (triplicate DMA form), Prescription and Oral Nutrition Product Request Form (DMA form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product.

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

    d. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

5. The PHP will need to establish working relationships with each product provision entity or other entity to provide coverage of the prescribed metabolic formulas.

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

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

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

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

8. Behavioral Health Service Definition Policy

1. **Background**

The Behavioral Health Service Definition Policy provides the Prepaid Health Plans (PHPs) a detailed description of the Department's definitions of required Behavioral Health Service for the purpose of appointment wait time standards and routine, urgent and emergent care.

2. **Behavioral Health Services Definitions**

a. Opioid treatment (adults only): a location-based service for the purpose of network adequacy standards.
b. Adult Facility-Based Crisis Services: a crisis service for the purpose of network adequacy standards.
c. Child Facility-Based Crisis Services: a crisis service for the purpose of network adequacy standards.
d. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of network adequacy standards.
e. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
f. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
g. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
h. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
i. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
j. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
k. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
l. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
m. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
n. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
o. Acute Care Hospitals with Child Inpatient Psychiatric Beds as inpatient BH services for the purpose of network adequacy standards.
p. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
q. Specialized Services: as partial hospitalization for children and adults for the purposes of the network adequacy standards.
r. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.
s. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm

to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

t. Urgent care for SUD:
    i. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
    ii. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.
u. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.
v. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.
w. Urgent Care for Mental Health:
    i. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
    ii. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.
x. Routine Services for Mental Health:
    i. Services to treat a person who describes signs and symptoms resulting in impaired behavioral functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.
    ii. Services to treat a person who describes signs and symptoms resulting in impaired mental functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.
    iii. Services to treat a person who describes signs and symptoms resulting in impaired emotional functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.

Attachment N. Business Continuity Management Plan

The Offeror may use the Business Continuity Management Program Sample Template. The MS Word template of the Offeror's Proposal and Response may be requested by contacting Medicaid.Procurment@dhhs.nc.gov.

Doc. Version No.	
Date Prepared	
Prepared By	
Division Director Signature	
Date Approved	

INTRODUCTION

(Who is this document for?) *This document is intended for use by management, the business owner, technical experts, and business continuity staff who interact with this system. It provides a strategy for business recovery and work around procedures should the system and its infrastructure fail. Possible events taken into account in developing this plan are disasters, both natural and man-made, up to and including complete destruction of the facility*

PLAN OBJECTIVES

This business recovery plan:

- Captures the essential aspects of the business process supported by the system.
- Documents a way to continue business should the system fail.
- Documents the business recovery procedures for return to operational status.
- Documents a way to convert back to business as usual after the system is available.

SYSTEM OVERVIEW

How does this application/system operate and what does it do?

COMMUNICATION PLAN

Notification

When the application is unavailable, who is notified and how?

ROLES, RESPONSIBILITIES AND AUTHORITY

List areas of support and roles of each.

Example:

Application Support:

An Application analyst is responsible for the following:

Hardware Support

A MaPS Systems Engineer is responsible for the following:

Database Support

A DBA is responsible for the following:

Business Recovery Services Vendor for Distributed Platforms:

- Describe services of business recovery vendor, if applicable.

Cross References

PLAN INITIATION

Criteria for Restoration of the Business Process due to a Business Disruption

The business recovery procedures described in this contingency plan will be invoked when one or more of the following takes place:

1.

2.

BUSINESS RECOVERY PROCEDURES

Section I: Application Support

Staffing

(The staff that needs to be involved in the recovery process.)

Equipment and Components

(The equipment and components should be listed in their entirety including quantities and attributes. This is all of the hardware that the business unit must supply. This includes all necessary equipment particular to this application.)

Procedures

(Include plans for acquiring, replacing, and alternate siting of any equipment needed.)

Software and Data Backup Procedures

(This is all of the software that the business unit must supply and how it is backed up.)

Software and Data Recovery Procedures

(How the software in the above procedure is restored.)

Succession Plan

Application Support Order of Succession:

Name	Title	Area Code and Phone Number

Vendor List

Suppliers:

Vendor	Product/Service/Commodities	Area Code and Phone Number

Section II: Hardware Support

Staffing

(The staff that needs to be involved in the recovery process.)

Equipment Types

(Equipment and type)

Client Equipment:

Document any specialty equipment for the client, if any. Consider if workstation equipment requirements should be listed here or are included in a different section of the Business Continuity Plan.

Application Equipment

Document, if any.

Equipment Recovery Procedures

How is equipment recovered?

Software and Data Backup Procedures

The following steps will be taken to begin the business backup process:

Document procedures.

Software and Data Recovery Procedures

The following steps will be taken to begin the business recovery process:

Document procedures.

Succession Plan

Hardware Support Order of Succession:

Name	Title	Area Code and Phone Number

Vendor List

Hardware Services Suppliers:

Vendor	Product/Service/Commodities	Area Code and Phone Number

The remainder of this page is intentionally left blank.

Section VIII. Attachment O.

Table of Contents

VIII. Attachment O: Offeror's Proposal and Response

1. Instructions

The Offeror must complete and submit *Attachment O: Offeror's Proposal and Response* with its offer.

The Offeror's Proposal and Response must be submitted in accordance with Department guidelines and the directives herein. The Offeror's Proposal and Response must be typed, page numbered, single-spaced, and in at least a 12-point font on Letter-sized (8 ½" x 11") paper with 1" margins. Page numbers must be in the format "Page X of Y." The Offeror may use a different, but legible, size font for section headings, footers, tables, graphics, and exhibits. Larger graphics, exhibits, charts, and diagrams may be printed as a foldout on a larger size paper if Letter-sized paper is not feasible.

As described in *Section II. General Procurement Information and Notice to Offerors* of the RFP, the Offeror must submit twenty (20) bound copies of its offer. The order of pages in the Offeror's Proposal and Response cannot be altered from the MS Word template provided by the Department. All supporting documentation should be included at the end of the Offeror's Proposal and Response in the corresponding order of the Offeror's Proposal and Response with notation at the top of each page notating what the documentation is meant to support {example: *Attachment O. 6. PHP Key Personnel: Resume of Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program Director* or *Attachment O 1. Minimum Qualification Table}.* A response whose page order has been altered risks a lower score or elimination from consideration.

The MS Word template of the Offeror's Proposal and Response may be requested by contacting Medicaid.Procurement@dhhs.nc.gov.

2. Minimum Qualifications Table

The Offeror must demonstrate it meets Minimum Qualifications to have its response evaluated by the Department. The Offeror MUST complete this table by providing the appropriate details to support each requirement and the section citation, exhibit name/number and page numbers where details can be found in Offeror's response if not included in this table.

Attachment O. Offeror's Proposal and Response Table 1: Minimum Qualifications Table			
Qualification		**Requirement for Regional Contracts only or Both Regional and Statewide Contracts**	**Offeror's Statement of Demonstration and Capabilities. Include the section citation, exhibit name/number and page numbers where details can be found in Offeror's response if not included in this table.**
1.	Offeror, by responding to this RFP, accepts to all of the Terms and Conditions, including Confidentiality, Privacy and Security Protections and Public Records and Trade Secret Protections, specified herein.	Both Regional and Statewide Contracts	
2.	Offeror confirms compliance with the Conflict of Interest requirements within this RFP.	Both Regional and Statewide Contracts	
3.	Offeror confirms compliance with the Performance Bond requirements within this RFP.	Both Regional and Statewide Contracts	
4.	Offeror shall submit proof, in the form of a copy of the acknowledgement from DOI, that the Offeror submitted an Application for PHP Licensure or a LHO Request for PHP Authority to DOI.	Both Regional and Statewide Contracts	
5.	Offeror certifies the Offeror is not located outside of the United States in accordance with 42 C.F.R. § 438.602(i).	Both Regional and Statewide Contracts	
6.	Offeror confirms that for any proposals to participate in more than one Region, those Regions are contiguous. For the purposes of this Contract, contiguous is interpreted to mean each Region shares a boarder with at least one other Region in the Offeror's offer.	Regional Contracts only	

Attachment O. Offeror's Proposal and Response Table 1: Minimum Qualifications Table			
Qualification		**Requirement for Regional Contracts only or Both Regional and Statewide Contracts**	**Offeror's Statement of Demonstration and Capabilities. Include the section citation, exhibit name/number and page numbers where details can be found in Offeror's response if not included in this table.**
7.	Offeror confirms that any proposals to operate in one or more Regions is for the purpose of operating across the entirety of the Regions proposed.	Regional Contracts only	
8.	Offeror shall have and maintain the majority of voting members on the governing body licensed in North Carolina as physicians, physician assistants, nurse practitioners, or psychologists and have treated beneficiaries of North Carolina Medicaid of NC Health Choice.	Both Regional and Statewide Contracts (if Offeror is PLE)	
9.	Offeror shall have at least twenty-five percent (25%) of voting members on their governing body that are physicians who have received reimbursement for the treatment of at least one Medicaid Managed Care beneficiary in the previous twenty-four (24) months.	Both Regional and Statewide Contracts (if Offeror is PLE)	

☐ Offeror accepts all terms and conditions of this RFP as required in *Section II.A.3.* of this RFP. Offeror may request modifications per the instructions in Section II.A.3, and acknowledges these are not part any subsequent Contract unless explicitly accepted by the Department in accordance with Section II.A.3.

_____

Signature Date

_____

Printed Name Title

3. Offeror Response

Offeror must respond to the questions in the Offeror's Proposal and Response. The Department encourages the Offeror to suggest innovative ways to fulfill the requirements of the Contract. The Offeror must confirm adherence to and describe its approach to meet the requirements of the Contract. This includes providing a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature and/or detailed information specifically tailored for the North Carolina Medicaid Managed Care program.

The Department requests the Offeror adhere to the page guidelines for each section listed *Attachment O. Offeror's Proposal and Response Table 2: Response Page Guidelines* below. The page guidelines assigned in the table below are not related to the evaluation scoring criteria and should not be interpreted as a reference to scoring weight or importance. Completion of tables within questions will not be counted toward page guidelines where noted within each evaluation question. Supplemental materials, such as samples, draft plans and policies, requested as part of the Offeror's Proposal and Response will not be counted toward page guidelines where noted within each evaluation question. The Offeror's detailing of any limitations and/or issues with meeting the Department's expectations or requirements will not be counted toward page guidelines. The Offeror must describe these limitations/issues in the separate field provided within the evaluation question. Additional supplemental materials provided beyond what is requested in the evaluation questions may not be considered for evaluation.

The Offeror may use an additional ten (10) pages in total if it needs additional space to provide a complete response to questions in the Offeror's Proposal and Response. The Offeror may use the ten (10) pages on one question or spread the additional pages across several questions, so as long as the total number of additional pages does not exceed ten (10) pages. The Offeror shall indicate in each question if the additional pages are utilized.

For each question, the Offeror shall describe the fully integrated approach the Offeror will provide to fulfill the requirements of the Contract, as well as identify the entity whose experience is included and that the Offeror is proposing to perform the requirements of the Contract. For specific evaluation questions, the Department requests that the experience and proposed approach of specific partner(s) be reflected in the response.

Attachment O. Offeror's Proposal and Response Table 2: Response Page Guidelines	
RFP Section	**Number of Pages**
General	**N/A**
Offeror Qualifications/Experience	**15**
Scope of Services	**375**
Administration and Management	*28*
Program Administration	2
Entity Requirements	4
National Committee for Quality Assurance (NCQA) Accreditation	2
PHPs and Related Providers	4
Implementation and Readiness Review	5
Non-Discrimination	2
Advance Directives	2

Attachment O. Offeror's Proposal and Response Table 2: Response Page Guidelines	
RFP Section	**Number of Pages**
Staffing and Facilities	7
Members	*38*
Eligible for Medicaid Managed Care, Medicaid Managed Care Enrollment and Disenrollment	7
Member Engagement	12
Marketing	7
Member Rights and Responsibilities	2
Member Grievances and Appeals	10
Benefits and Care Management	*108*
Medical and Behavioral Health Benefits Package	20
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	8
Pharmacy Benefits	8
Transition of Care	5
Non-Emergency Medical Transportation	5
Care Management	40
Prevention and Population Health Management Programs	11
Opportunities for Health	11
Providers	*51*
Provider Network	15
Provider Network Management	12
Provider Relations and Engagement	7
Provider Payments	7
Provider Grievances and Appeals	10
Quality and Value	*35*
Quality Management and Quality Improvement	20
Value-Based Payments/Alternative Payment Models	15
Stakeholder Engagement	*15*
Engagement with Federally Recognized Tribes	5
Engagement with Community and County Organizations	5
Integration with Other Department Partners	5
Program Operations	*20*
Service Lines	5
Staff Training	5

Attachment O. Offeror's Proposal and Response Table 2: Response Page Guidelines	
RFP Section	**Number of Pages**
Reporting	5
PHP Policies	2
Business Continuity	3
Claims and Encounter Management	*19*
Claims	7
Encounters	12
Financial Requirements	*22*
Capitation Payments	8
Medical Loss Ratio	4
Financial Management	10
Compliance	*25*
Compliance Plan	5
Program Integrity	5
Fraud, Waste, and Abuse	7
Third Party Liability (TPL)	5
Recipient Explanation of Medical Benefits (REOMB)	3
Other	*14*
Confidentiality, Privacy, and Security Protections	7
Technical Specifications	7
Use Cases	**49**
Client References	**N/A**
TOTALS	**439**

The Offeror's Proposal and Response Evaluation Questions are listed below. The Offeror is required to answer the questions as stated herein.

Offeror Qualifications/Experience

Evaluation Question	
1.	The Offeror shall indicate if it is submitting a proposal as a Statewide or Regional contract. Check all that apply.
Response	
Statewide Contract ____ Regional Contract ____	

Evaluation Question	
2.	If the Offeror is submitting a Regional proposal (as indicated in Question #1 above), the Offeror shall indicate the Region(s), as defined in *Section I.B. Table 1: List of Counties by PHP Region*, it is proposing to provide Medicaid Managed Care services and coverage. (If the Offeror is submitting a Statewide proposal, it is presumed that the Offeror is proposing to provide Medicaid Managed Care services and coverage in Regions 1-6 in their entirety and the Offeror shall not be required to make any indication.) Pursuant to Section 4.(6) of Session Law 2015‑245, as amended by Session Law 2016-121, only PLEs are permitted to submit proposals on Regional Contracts, and if proposing multiple Regions, the proposed Regions must be contiguous. For the purposes of this Contract, contiguous is interpreted to mean each Region shares a boarder with at least one other Region in the Offeror's offer. The Department strongly encourages PLEs to submit proposals for more than one Region. The Department will award contracts in the best interest of the State, which includes consideration for ensuring each PHP has a viable risk pool.
Response	
Region 1 ____ Region 2 ____ Region 3 ____ Region 4 ____ Region 5 ____ Region 6 ____	

Evaluation Question	
3.	If the Offeror is submitting a proposal for only one (1) Region as indicated in Question #2, describe the Offeror's approach to meet the minimum 45,000 to 50,000 Member lives necessary to best ensure the financial and administrative viability. (If the Offeror is submitting a Statewide proposal or Regional Proposal for more than one (1) Region, the Offeror shall not be required to respond to this question).
Response	

Evaluation Question	
4.	The Offeror shall provide the following: a. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written b. Federal Employer ID Number (FEIN) c. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers) d. List of board members and their organizational affiliations e. Legal status and whether it is a profit or a nonprofit company
Response	

Evaluation Question	
5.	The Offeror shall provide information requested in *Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience* for each entity, including parent entities, subcontractors, partners, subsidiaries, and any other individual or organization: a. That will perform Core Medicaid Operations Functions, as defined in the Contract, for the Offeror under the Contract; and b. Whose experience has been provided by the Offeror for consideration by the Department for the purposes of this RFP and Contract award, including all entities with experience referenced in responding to the RFP evaluation questions. The Offeror shall be fully transparent in describing the experience of the entity and shall include all experience, both positive and negative, related to the entity's role(s) or responsibilities. The Department may exercise, at

	its sole discretion, in the PHP RFP evaluation process, whether or not to consider the experience or to what extent the experience applies for entities not performing core functions. Offeror must fill out 1 table for each entity, including parent entities, subcontractors, partners, subsidiaries, and any other individual or organization that meet the criteria listed in 5.a. and/or 5.b. Completed tables shall not be counted toward the Offeror's total page guidelines.
Response	

Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience	
Organization/Individual Name _____	Response
Performing Core Medicaid Operations Function [Yes/No]	
Ownership or controlling interest [Yes/No]	
Primary Address	
Mailing Address	
Tax ID (if organization)	
DOB (if individual)	
SSN (if individual)	
Description of the entity's role(s) in performing the functions or responsibilities described in Offeror's Proposal	
Description of the entity's experience related to the role(s) and responsibilities described above (include positive and negative experience)	
Description of how the entity will be integrated into the Offeror's proposal performance of their obligations under the Contract to ensure a streamlined experience for the Members, providers and the Department	

Evaluation Question	
6.	The Offeror shall describe its proposed approach and experience in the provision of services to the populations specified in this Contract, including:

	a. Commitment to integrating the Department's goals for Medicaid Managed Care into its day-to-day operations; b. Experience with Medicaid populations similar to those included in this Contract; and c. Lessons learned from other Medicaid Managed Care programs.
Response	

Evaluation Question	
7.	The Offeror shall provide a list of prior Medicaid Managed Care contracts, including states and regions that operated under a full risk Medicaid Managed Care capitated contract in or since 2012 in *Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience*. The completed table shall include the experience of the Offeror and any entity identified in Question #5. Quality metrics results included in *Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience* shall be for the three (3) consecutive most recent annual HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below and audited by a NCQA-approved auditing firm. Offeror must fill out 1 table for each state, region, and/or contract that met the criteria listed in this question. Completed tables shall not be counted toward the Offeror's total page guidelines.
Response	

Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience			
State / Region _____	Year _____ Measure Result	Year _____ Measure Result	Year _____ Measure Result
Entity (as identified in Question #5)			
Performing Core Medicaid Operations Function (as identified in Question #5)			
Description of the entity's role(s) in performing the			

Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience			
State / Region _____	Year _____ Measure Result	Year _____ Measure Result	Year _____ Measure Result
functions or responsibilities described in Offeror's Proposal (as identified in Question #5)			
Contract Start Date			
Contract End Date			
Number of Beneficiaries Covered			
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)			
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)			
3) Follow-Up After Hospitalization for Mental Illness (FUH): seven (7) and thirty (30) day periods			
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges			
5) Well-Child Visits in the First fifteen (15) Months of Life (6 or More Visits) (W15)			

Evaluation Question	
8.	The Department is seeking a partner with experience overseeing a medical home model to align with the Department's goal of strengthening the role of primary care in care management, care coordination, and quality improvement. Describe the Offeror's experience with a medical home model, highlighting experience with models for Medicaid Managed Care Members, including the number of lives served, number of providers engaged, and populations served. The Offeror's response shall include information for the Offeror, as well as all entities performing care management functions as identified in Question #5.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing care management functions related to this response.	

Response

Evaluation Question	
9.	The Offeror shall disclose, in the *Attachment O. Offeror's Proposal and Response Table 5: Managed Care Contract Termination, Non-Renewal, Withdrawal, or Enrollment Level Reduction in the past 7 years,* whether, in the past seven (7) years, the Offeror has voluntarily terminated all or part of a managed care contract under which it provided health care services as the licensed entity; has had such a contract partially or fully terminated before the contract end date (with or without cause); has had a contract not renewed; has withdrawn from a contracted service area; or has had a re duction of enrollment levels imposed. The Offeror's response shall include information for the Offeror as well as all entities identified in Question #5. a. If so, the Offeror shall describe the type of contract and the services provided; the month and year of the contract action; the reason(s) for the termination, non-renewal, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. b. If the Contract was terminated/non-renewed based on the Offeror's performance, The Offeror shall describe any corrective actions taken to prevent any future occurrence of the problem leading to the termination/non-renewal. c. If the violation(s) was the subject of an administrative proceeding or litigation, the Offeror shall indicate the result of the proceeding/litigation. Offeror must fill out 1 table for each contract. Completed tables shall not be counted toward the Offeror's total page guidelines.
Response	

Attachment O. Offeror's Proposal and Response Table 5: Managed Care Contract Termination, Non-Renewal, Withdrawal, or Enrollment Leve Reduction in the past 7 years	
Entity (as identified in Question #5)	
Type of Contract	
Services Provided	
Month & Year of Corrective Action	

Attachment O. Offeror's Proposal and Response Table 5: Managed Care Contract Termination, Non-Renewal, Withdrawal, or Enrollment Leve Reduction in the past 7 years	
Reason(s) for Termination, Non-Renewal, Withdrawal, or Enrollment Level Reduction	
Involved Parties	
Name of Client/Other Party	
Was the contract terminated/non-renewed based on the Offeror's performance?	
If answered 'Yes' to the question above, describe any corrective actions taken to prevent future occurrence of the problem leading to the termination/non-renewal. If answered 'No' to the question above, insert 'N/A'	
Was the violation the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
10.	The Offeror shall disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven (7) years in the *Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years*. For the purposes of this question, a sanction shall include any monetary penalty, including e.g., civil monetary penalty or liquidated damage. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5. a. If imposed, describe the nature of the sanction, the underlying action leading to the sanction, the market in which the sanction was imposed, and the assessed monetary amount (if applicable). b. Describe any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s). c. If the sanction(s) was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. Offeror must fill out 1 table for each imposed sanction. Completed tables shall not be counted toward the Offeror's total page guidelines.
Response	

Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years	
Entity (as identified in Question #5)	
Type of Contract	
Services Provided	
Describe the nature of the sanction	

Describe the underlying action leading to the sanction	
Describe the market in which the sanction was imposed	
Describe the assessed monetary amount, if applicable	
Describe the corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s)	
Was the sanction the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
11.	The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOI-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs. The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021. A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Scope of Services

Administration and Management

Evaluation Question	
12.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.1. Program Administration*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to integrating feedback from stakeholders, including Member and providers, to drive improvements in the Program.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
13.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.2. Entity Requirements*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): a. Draft PLE Governance Plan (if applicable) b. The PLE shall provide a signed attestation affirming that a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts or North Carolina Medicaid and NC Health Choice providers as described under the Contract. A nonprofit entity submitting an offer as a PLE shall provide a signed attestation affirming that the primary business purpose of the entity is the operation of one or more capitated contracts or North Carolina Medicaid and NC Health Choice providers. The attestation must be signed by a Corporate Officer with authority to bind the PLE (if applicable).
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
14.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.3. National Committee for Quality Assurance (NCQA) Accreditation*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include expected timeline to receive NCQA accreditation for the North Carolina Medicaid Market.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
15.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.4. PHP and Related Providers*, including the PHP's approach to preventing anti-competitive or self-dealing behavior. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Description of Offeror's proposed approach to contracting with related providers, as applicable; b. Any differences in the proposed contracting approach with related compared to non-related providers; and c. Approach to ensuring compliance with Related Provider payment limitations.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
16.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.5. Implementation* and *Section V.A.6 Readiness*

	Review. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Offeror's draft Implementation Plan (from Contract Award through sixty (60) days after Phase 2 of the cross over population). The plan shall include: a. Key milestones, activities and Deliverables; b. Proposed staffing and resources to support implementation and readiness; c. System and operational implementation milestones; and d. Required PHP, Department and other partner resources to ensure successful implementation.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

17.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.7. Non-discrimination*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
18.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.8. Advance Directives*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
19.	The Offeror shall confirm its adherence to the Department's expectations and requirements for staffing and facilities as stated in *Section V.A.9. Staffing and Facilities*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to ensuring the appropriate staff are in place and properly trained to fulfill all the duties and responsibilities of the Contract, including Member Services, Care Management, and Provider Relations staff. b. Approach must include an estimate of the number of staff anticipated to fulfill all duties and responsibilities of the Contract, including those delineated by the categories found in *Attachment A: PHP Organization Roles & Positions*. c. Location of key personnel and offices providing Core Medicaid Operations Function. d. Approach to recruitment and retention of Key Personnel and how the Offeror proposes minimizing employee turnover. e. A description of the Offeror's internal organizational structure highlighting the Offeror's management structure, including: i. Definitions of the lines of responsibility, authority, communication and coordination across the organization. ii. A description of how the organizational structure supports Members, providers, advocates, community partners, and the Department and facilitates creative thinking and innovative solutions while ensuring compliance with federal, state and contractual requirements.

	f. A description of the Offeror's efforts in other markets to address potential PHP workforce shortages (i.e. care management and UM staff, clinical expertise, provider contract management, call center staff), the interventions PHP used to address them, and the outcomes. g. A description of how the Offeror will establish an organizational structure and culture that supports whole-person integrated care, including partnerships among PHPs and LME/MCOs, BH I/DD TPs upon launch, providers, advocates, community based organizations, and Members with regards to BH-related issues. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): a. Draft Organizational Charts
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Members

Evaluation Question	
20.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1. Eligibility for Medicaid Managed Care*, *Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment*, and the Managed Care Enrollment Policy. The Offeror shall detail

	any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Necessary system interfaces to accept and process Member enrollment and disenrollment; and b. Integration approach with Enrollment Broker and local DSS offices or EBCI Public Health and Human Services (PHHS) offices.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
21.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for engaging Members prior to and after Medicaid Managed Care launch, as outlined in *Section V.B.3. Member Engagement*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Overall approach to educating and engaging Members on Medicaid Managed Care, accessing care, and improving overall health;

	b. Key integration points with other Departments, local DSS offices, and other local partners operating within Medicaid Managed Care; c. Methods of leveraging appropriate communication to meet the diverse needs and communication preferences of Members, including individuals with LEP and needing adaptive communication; d. Commitment and process for making qualified interpreters (including sign language) available to Members and potential Members when requested, and at other times as needed in accordance with the Contract; e. Description of how oral, written and sign language translation or interpreter services are certified; f. Method to ensure Member language preferences and communication needs are documented in Offeror's information system; g. Proposed approach to assess Member satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends in Member satisfaction to support ongoing improvement to the program; and h. Examples of the Offeror's Member incentive programs from other states or markets, including results and outcomes of program. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Draft Welcome Packet and Member ID card aligned with the requirements of the Contract 2. Sample Member Handbook 3. Sample educational materials with taglines (up to 3 samples) 4. Sample education materials demonstrating ability to meet Contract's requirements for translation, accessibility and cultural competency (up to 3 samples)
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
22.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.4. Marketing*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Proposed marketing locations, distribution methods, and activities planned for the time period between six (6) months prior to and three (3) months after the Offeror has enrolled its first Member; b. Demonstration of understanding of the diverse populations that the Offeror may serve throughout its covered Region(s) (e.g., individuals living in different geographic locations, individuals with different racial backgrounds, individuals with different literacy levels) and approach for how the Offeror will adapt its marketing materials to reach the various populations and audiences within its covered service are; and c. Process to ensure marketing materials are widely available throughout the Offeror's covered Region(s) to Members and potential Members, and a plan for how the Offeror intends to prevent the selective distribution of its marketing materials throughout its covered Region(s). PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include up to five (5) samples of marketing material. Samples may include brochures, giveaways, radio/TV ads, flyers, billboards.

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.
Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
23.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.5. Member Rights and Responsibilities*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
24.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.6. Member Grievances and Appeals,* including how the Offeror intends to identify, track and analyze Member grievances, appeals, and State Fair Hearing data. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach for educating Members about the grievance and appeals process; b. Confirmation of the ability to process standard and expedited appeal and grievance requests within the timeframes described in the Contract; c. Approach to meeting each of the applicable appeal and grievance timely processing standards processing of requests; d. Process for acknowledging receipt of Member appeals and grievance requests; e. Protocols, procedures and staffing levels and requirements for reviewing Member appeals and grievances; f. How information and data resulting from the grievance and appeals system is tracked and trended, including how the Offeror uses the data to make program improvements; and

	g. Methods and strategies used throughout the Offeror's proposed approach to resolve grievance and appeals efficiently and effectively at the lowest level of escalation that meets a Member's needs and in a manner, which does not discourage Member's from exercising their rights. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): a. Grievance and appeals process flows detailing the process for standard and expedited review;
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Benefits and Care Management

Evaluation Question	
25.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.1. Medical and Behavioral Health Benefit Package*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Experience and approach to ensure Members experience whole-person care that integrates their medical and behavioral health benefits;

	b. Experience and approach to providing substance use disorder services, including opioid and MAT treatment; c. Experience with innovative telemedicine modalities and pilot programs in other states/markets, and the proposed telemedicine approach to encourage use of telemedicine, including types of programs, and targeted providers, geographies (including rural), services, and members; and d. Experience with and approach for integration with carved-out services (i.e. dental services, LEAs, CDSAs, eyeglasses).
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
26.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's Utilization Management expectations and requirements outlined in *Section V.C.1. Medical and Behavioral Health Benefit Package*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to align the Offeror's Utilization Management (UM) program with the Department's required clinical coverage policies;

	b. Proposed evidence-based decision support tool; c. Approach to reduce provider administrative burden under the PHP's UM Program, including overall provider experience for prior authorization requests; d. Methods and approach to balance timely access to care for Members with the administration of the UM Program; e. Approach to integrate medical and behavioral health services in the UM program; f. Role of behavioral health assessment in the Offeror's UM Program; and g. Approach to ensure UM Program is compliant with mental health parity.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
27.	The Offeror shall describe the ILOS and value-added services that the Offeror plans to propose to the Department for approval. The response shall include: a. Description of the service,

	b. Proposed population to cover, and c. Rationale to provide those services based on NC Medicaid and NC Health Choice population needs. Response to this question will not count toward the Offeror's page count limit.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
28.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment* (EPSDT). The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to ensuring Members and providers are aware of the EPSDT program; b. Description of medical necessity review process, including examples of how the Offeror has applied the process in other markets on at least two (2) approved and two (2) denied services; and c. Outreach methods to remind Members of missed screenings and preventive services.

	PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror's draft EPSDT Policy

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.
Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
29.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.3. Pharmacy Benefits*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Methods to ensure adherence to the PDL under this Contract; b. Approach to engage Members in understanding the pharmacy benefit and to providing medication-related clinical services which promote appropriate medication use and adherence; c. Prior authorization process, including overall prescriber experience when requesting prior authorization; d. Description of process and procedures to ensure access to medications during a state of emergency or disaster;

	e. Integration approach with PBM (if applicable); and f. Approach to provide timely, accurate and complete data to support the Department's rebate claiming process and ensure the Department maintain current rebates levels.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
30.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.4. Transition of Care*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): a. Offeror's draft PHP Transition of Care Policy b. Offeror's draft Provider Transition of Care Policy
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
31.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.5. Non-Emergency Medical Transportation*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to building an adequate NEMT network; b. Innovative transportation solutions to most effectively meet needs of Members; and c. Oversight model of NEMT providers to ensure Member rights and maintain high Member satisfaction. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): Offeror's draft NEMT Policy
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
32.	The Offeror shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for care management and care coordination as stated in *Section V.C.6. Care Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to addressing the Department's vision for care management including plan to ensure high levels of care management penetration across all priority populations, including: i. Description of levels of Member stratification (i.e. risking risk, low, medium, high risk), interventions, and staffing for each level of Member stratification; and ii. Expected levels of penetration across priority populations; b. Approach for local care management detailing how the Offeror expects to work with Network Providers, Advanced Medical Homes and Local Health Departments to provide care management and care coordination for all priority populations, including what the Offeror envisions designating to approved entities;

	c. Plan for ensuring that the majority of the Offeror's Members requiring care management receive it through local care management including: i. Advanced Medical Homes; and ii. Designated Care Management Entities. d. Proposed subcontracting with any designated care management entities other than Advanced Medical Homes and Local Health Departments. e. Necessary technology to support care management, including: i. Solutions to facilitate coordinated care and communication among the PHP, providers (including facility based providers), Members, and care managers; ii. Data sharing with other health plans' systems and designated care management entities in the case of Member transfer or overlap in programs; and iii. Experience using ADT feeds and/or HIE; and f. Offeror's experience, including lessons learned, in other states or markets, including historical cost and quality outcomes.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
33.	The Offeror shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for the care management continuum as stated in *Section V.C.6. Care Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Conduct Care Needs Screenings, including but not limited to: i. Question/domains and method for screening based on historical experience, tailored to specific populations; ii. Prior experience with and success rates in administering screenings within required timelines and results of those efforts; iii. Expected Care Needs Screening rates, strategies to increase completion rates, and processes and timelines for reassessment based on PHP analytics or other best practices; and iv. Proposed strategies to use over time to screen Medicaid Managed Care Members for unmet health-related resource needs routinely, in addition to at initial enrollment. b. Risk scoring and stratification, including but not limited to: i. Required sources of data are incorporated; ii. Method to identify Members of each of North Carolina's priority populations; iii. Additional priority populations the Offeror proposes in addition to the required populations; iv. Definition of "rising risk" and overview of methodology for identifying the rising risk group; and v. Evidence of effectiveness of the PHP's risk scoring and stratification approach in identifying Members for care management, including cost and quality outcomes. c. Comprehensive Assessment, including but not limited to: i. Required components; ii. Variation in Comprehensive Assessment based on population;

	iii. Expected volume of Comprehensive Assessment by priority population monthly and annually; and iv. How it will work with designated care management entities, including AMH practices, to carry out the Comprehensive Assessment process; and d. Care plan development with Members including: i. Approach for involving multi-disciplinary care team; ii. Process for individualized and person-centered care plans and ensuring the Member and the Member's family, advocates, caregivers, and/or legal guardians are actively involved; and iii. Process for and frequency of Care Plan updates. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Care Management workflow for other states or regions; 2. Four (4) Care Plan examples, including one (1) care plan for each of the following: adult, child, individual with LTSS, individual with high unmet resource needs; and 3. Comprehensive assessment tool—including assessment portions aimed at specific populations (i.e. LTSS, children).
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
34.	The Offeror shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for the providing transitional care management in *Section V.C.6. Care Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Risk methodology for identifying Members who would benefits from transitional supports, including method for identifying the type and duration of support needed; b. Plans for and experience in other states using ADT feeds and similar techniques to identify high-risk transitions, and the results of those efforts; c. Plans for and experience with developing processes and partnerships with SNF, NICUs, hospitals, rehabs, and other levels of care in order to facilitate transitions; d. Plans to partner with AMHs to provide transitional care—including data shared, roles/responsibilities; e. Any examples or plans for customization of care management, including the assessment, medication reconciliation etc., to support transitional care that differentiates the Offeror from other respondents; f. Staffing model and approach for transitional care management; and g. Examples from other states of outcomes/return-on-investment of the Offeror's Transitional Care management model.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
35.	Describe PHP's adherence and approach to meeting Department's expectations and requirements for care management for populations requiring LTSS in *Section V.C.6. Care Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Conduct care needs screenings, including but not limited to: i. Prior experience with and success rates in administering screenings within required timelines and results of those efforts, specific to individuals with LTSS needs; ii. Questions aimed at identifying specific needs for individuals with LTSS needs; iii. Expected Care Needs Screening rates, strategies to increase completion rates, and processes and timelines for reassessment based on PHP analytics or other best practices; and iv. Proposed strategies to use over time to screen Medicaid Managed Care Members for unmet health-related resource needs routinely, in addition to at initial enrollment. b. Risk scoring and stratification, including but not limited to: i. Required sources of data; ii. Method to identify Members with LTSS needs; and iii. Evidence of effectiveness of the PHP's risk scoring and stratification approach in identifying Members with LTSS needs for care management, including cost and quality outcomes.

	c. Comprehensive Assessment, including: i. Contents of the comprehensive assessment used to assess beneficiaries requiring LTSS; ii. How it will work with designated care management entities, including AMH practices, to carry out the Comprehensive Assessment; iii. Approach to developing a "person-centered" care plan for Members determined to need LTSS based on the comprehensive assessment; and iv. Strategies for reassessing Members with LTSS needs. d. Providing initial and ongoing training and support for care managers in LTSS-specific care management techniques; and e. Differentiating your LTSS care management approach from other PHPs, including the use of NCQA standards in developing an LTSS care management program.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

36.	The Offeror shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for integrating Opportunities for Health into Care Management stated in *Section V.C.6. Care Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. The PHP's methodology for identifying Members with "unmet health-related resource needs" for care management (methodology must address unmet resource needs in at least one of the priority domains); and b. Planned and Historic Examples of Methods to: i. Partner with Community Based Organization (CBOs) and state, regional or private human service agencies to address unmet health-related resource needs of Members; ii. Offer non-medical resource supports to Members; iii. Provide in-person assistance securing health-related services that can improve health and family well-being (i.e., assistance filling out and submitting applications for government assistance programs); iv. Assist individuals in securing and maintaining safe and stable housing; and v. Provide access to medical-legal support for legal issues adversely affecting health. c. Experience and effectiveness in identifying and addressing ACEs and trauma, and how that experience would be applied in North Carolina.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
37.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.7. Prevention and Population Health Management Programs*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. The PHP's planned prevention and population health management program designs in priority domains (tobacco cessation, pregnancy intendedness, birth outcomes, diabetes prevention, hypertension), early childhood interventions, and in other areas of clinical focus. Include description of program, planned interventions at provider, Member, system level and expected outcomes; b. Experience and approaches used to address opioid misuse. Three examples including different locations (state or North Carolina counties/region) interventions, impact and outcomes; c. Experience and approaches used to reduce tobacco use in populations. Three examples including different (state or North Carolina counties/region) where full population health programs used, including outcomes; and d. Describe of up to five initiatives the PHP has deployed to collaborate or align with public health programs at the community level (for example, with health departments) or the state level. Response shall include, one community and one state-level example, the objective of each, the methodology and the outcome.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
38.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for addressing Members' unmet health-related resource needs as outlined in *Section V.C.8. Opportunities for Health*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. Response shall include: a. Experience and success within North Carolina or in other states or regions with addressing unmet health related resource needs for populations similar to those included under this Contract; and b. Experience and success within North Carolina or in other states or regions in collaborating with health and health-related community stakeholders in addressing Members' unmet health-related resource needs, including with: i. Health care providers (e.g., primary care provider, care manager); ii. Local public agencies (e.g., local health departments or departments of social services); and iii. Community-based organizations (e.g., homeless shelters, food banks). c. Strategies the Offeror would employ to address key Opportunities for Health domains (housing, food, transportation and interpersonal safety), and other Opportunities for Health domains identified by the PHP, in each of North Carolina's Regions that the PHP is submitting an offer on, including: i. Specific strategies the Offeror intends to employ in North Carolina to address unmet resource needs for individual Members based on needs documented through Care Needs Screening, Care Management Assessment, or other identification method.

	ii. Experience in other states to address unmet resource needs in at the community or population-level based on aggregate population needs. Detail types of community-based intervention, rationale behind activities, and health outcomes related to the population interventions.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
39.	Describe any services the Offeror proposes not covering for Members based on the Offeror's moral or religious objection. Response to this question will not count toward the Offeror's page count limit.
Response	

Providers

	Evaluation Question
40.	The Offeror shall describe its provider network development strategy for each Region the Offeror is submitting and offer in, including, but not limited to ensuring the development of a comprehensive network of specialty and behavioral health providers for children and adults as required in *Section V.D.1. Provider Network*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Innovative approaches that will be used to develop and maintain the PHP's provider network to ensure network adequacy standards and highest quality care; b. Methods for monitoring and ensuring compliance with access to care standards, including the frequency of reviewing of these standards; c. Methods for ensuring all covered services are available and accessible to Members in a timely manner, including: i. Offeror's plan to address the needs of all Members, including those with limited English proficiency or illiteracy, and ii. Offeror's plan to ensure that Network Providers provider physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities; d. Description of how the Offeror will ensure access to care on an out-of-network basis when timely access to a Network Provider is not possible., including the Offeror's plan to educate Members on accessing out-of-network benefits; e. Methods to educate providers on North Carolina's Medicaid Managed Care program and ease the transition from Medicaid Fee-for-Service to Medicaid Managed Care; f. Description of how PHP will meet required time and distance standards and appointment wait time standards for adult service and pediatric service providers; g. Address specific health needs of specific populations by Region and identify any opportunities or challenges in addressing those needs with the existing provider availability;

	h. Strategies to recruit providers in traditionally underserved areas, by health need, and overcome expected accessibility challenges; i. Strategies to support and sustain providers, including hospitals, in rural and other traditionally underserved areas; and j. Strategies to ensure access for children to the full range of age-appropriate health care providers, subspecialists and facilities.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
41.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.D.2. Provider Network Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. Response shall include:

a. A description of the PHP's process and policies for terminating a provider from its network. Provide up to three examples of the PHP terminating a provider with cause;

b. A description of the process for notifying Members and ensuring a Member's continued access to covered services in the event of provider termination. Include details as to how PHP will assign a new PCP as well as maintain continuity of care for Members who had scheduled appointments with the terminated provider;

c. A description of PHP's practices, procedures, and Objective Quality Standards used to make provider Quality Determinations for contracting into its network, including how the PHP will ensure that contracting will be limited to Medicaid Enrolled Providers only. Include up to five examples of the conditions under which the PHP would issue to a provider an adverse quality determination during the contracting process;

d. A description of the Offeror's practices and procedures to ensure the quality of contracted Local Health Departments and Advanced Medical Homes;

e. PHP's specific policies and procedures that identify and implement Objective Quality Standards used in the selection and retention of network providers;

f. A description of the policies, procedures and processes the PHP will utilize to ensure 100% of provider quality determinations are completed within 45 days of receipt of complete credentialing information for a provider;

g. A description of PHP's plan for establishing and maintaining a Provider Network Participation Committee. Include a description of provisions that will be implemented for Committee Members to make fair quality determinations and how decisions will be monitored to ensure fairness;

h. A description of the operational policies, procedures and processes the PHP will utilize to load the terms of the provider contracts into the PHP claim payment platform to accurately pay providers consistent with agreed upon contract terms; and

i. A description of PHP's process for enrolling providers in its network consistent with the operational timeframes and requirements including communication of the welcome notice, enrollment information, onboarding, and training.

j. A description of the PHP's strategy for developing and monitoring the consumer-facing Provider Directory, including innovative strategies for ensuring data accuracy, timely updates, and accessibility to Members, including those with limited English proficiency or illiteracy.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Offeror's proposed practitioner Provider contract template.
2. Offeror's proposed facility Provider contract template.
3. Offeror's draft Good Faith Provider Contracting Policy.
4. Offeror's draft Credentialing and Re-credentialing Policy.

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.
Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
42.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.D.3. Provider Relations and Engagement*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. A description of the Online Provider Portal, including information topics accessed there and key functionality in the Online Provider Portal useful to providers. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Draft Provider Manual 2. Sample Online Provider Portal screen shots
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
43.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.D.4. Provider Payments.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Description of the processes the PHP will have in place to ensure provider payment requirements are met. Include in your response how quickly the PHP can update its claim system to incorporate changes to provider contracting terms or to rate floors or schedules. b. Description of the PHP's approach to negotiating rates with providers. c. Description of any alternative payment arrangements the PHP plans to offer providers in lieu of the rate floor.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
44.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.D.5. Provider Grievances and Appeals.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. A description of the PHP's grievance and appeals processes. b. A description of the PHP's approach to educate Providers on their rights within the Grievance and Appeals process. Provide up to three (3) examples of communication materials. c. Identification of any provider appeal rights that will be provided in addition to those required in the Contract. d. A description of the Offeror's process to self-audit the Provider Grievance and Appeals determinations, including the frequency and how the results are used to drive improvements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Provide up to three (3) examples of provider complaints, grievances, and/or appeals that have been received and resolved in the past.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Quality and Value

Evaluation Question	
45.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in *Section V.E. 1. Quality Management and Quality Improvement.* The Offeror shall include in its approach a description of the PHP's quality management strategy, a description of the PHP's quality management program including staffing and tools, a description of the PHP's IT infrastructure and data analytics capabilities to support quality and value, including a description of how such systems can support stratification and analysis of quality measures at a regional level, and all associated standing (permanent) and innovative QM/QA/QI programs. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5. The response shall include: a. Two state samples of multi-year (at least three years) QAPIs that demonstrate measure targets and planned interventions—as well as annual updates to the QAPI. At least one measure and one QI intervention should focus on children and one measure and one QI intervention should focus on pregnancy/maternal health. Those QAPIs should include: i. IT infrastructure used to support measure analysis and quality improvement efforts;

ii. Measures results compared to national benchmarks; including measures that did not meet state targets;

iii. Evidence of measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation;

iv. Two specific QI and two specific PIP programs. At least one PIP example should focus on children and one PIP example should focus on pregnancy/maternal health to drive improvement needed;

v. Associated quality improvement training plans—including methodology to target Providers; macro and micro practice interventions, methodology for sharing data and tools and any relationship to advanced payment (AP) or other incentive methods;

vi. Associated examples of how quality data was shared with providers. Describe utilization penetration rates among providers and outcomes of using the data and tools/applications; and

vii. Overall impact of the QI interventions and PIPs.

NOTE: *The two state samples of multi-year QAPIs will not be counted toward the Offeror page count.*

b. Examples of at least 10 HEDIS measures stratified by geography, race/ethnicity, and gender. The Offeror shall describe the IT infrastructure and data analytic capabilities used to support the analysis, analysis of the measures, and associated QI programs implemented to address health disparities. Include measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation; interventions; planned metrics, realized metrics, and overall impact of the QI/PIP; and

c. Two state examples of using public health measures (i.e. BRFSS, state health statistics) and data on unmet resource needs in the development of quality improvement activities and PIPs. Include IT infrastructure, data used and data/metrics collected, collaboration strategies with State and local agencies, quality improvement interventions, and overall impact of the QI/PIP. Using NC state health statistics to then demonstrate how the Offeror might develop a similar program here and measure outcomes.

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
46.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for Value Based Payments stated in *Section V.E.2. Value Based Payments/Alternative Payment Models*, including a description of the PHP's approach to ensuring payments to Providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Offeror shall also include a description of its IT infrastructure and how that system will support moving toward value-based payment, including shared savings and/or risk-sharing across different provider types, care settings and locations. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. A description of value-based payment arrangements the Offeror has used in up to 2 other locations (e.g., another state or region). Include the corresponding LAN frameworks, the location, the volume of payments and patients, and the percent of total premium flowing to providers through shared savings and other incentive arrangements in the response. The Offeror shall include how the PHP made progress over time and used VBP to improve outcomes. Include outcome and cost measures in your response; b. A description of the value-based payment/alternative payment models the Offeror has used to date for contracting with Medicaid, Medicare and Commercial providers in North Carolina, plans to align Medicaid payment models in NC with the Offeror's other payor contracts, and a description of the Offeror's plans to meet the required levels of value-based payment for the Medicaid Managed Care Program by the end of Year 2. The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by 20 percentage points or represent at least 50% of total medical expenditures over Year 1; c. A description on the Offeror's IT capabilities and how it proposes to build out these capabilities, over time, in order meet the Department's goals on ensuring that provider payments are increasingly

	focused on measures related to value. The description should include specific IT, data sharing and data analytic capabilities currently in place versus those planned that will support shared savings and risk models, including total cost of care. Specific functionalities to address include: i. Risk adjustment, ii. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers and the Department, iii. Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts, iv. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts, v. Reporting capabilities, and vi. Payment functions. d. Based on the Offeror's assessment of the North Carolina landscape and Medicaid Transformation design, explain three approaches for developing value-based payment arrangements with providers used in other state Medicaid programs and how the Offeror would employ or modify them over the initial 3 years of managed care in NC.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Stakeholder Engagement

Evaluation Question	
47.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.1 Engagement with Federally Recognized Tribes.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to design and implement the Tribal Engagement Strategy; b. Approach to integrate with EBCI Public Health and Human Services (PHHS) offices; c. Experience working with members of Federally recognized tribes in which culturally competent care is achieved, including the following metrics: i. Number of beneficiaries the Offeror serves who are members of Federally recognized tribes by state; and ii. Volume, type, and availability of services. d. Experience and approach for working with IHCP providers, including: i. Proposed training methods for Tribal Provider Contracting Specialist. ii. Proposed plan to contract with IHCPs as required under the Contract. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include a Draft Tribal Engagement Plan that reflects the unique needs of the North Carolina Medicaid and NC Health Choice program and tribal Members in North Carolina, including EBCI.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
48.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.2. Engagement with Community and County Organization*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to design and implement Local Community Collaboration Strategy; b. Prior experiences supporting and working with communities and community-based organizations and implementing a similar strategy that the Department is looking to implement through the Contract; c. Considerations for magnitude of the state/number of county and community based services while remaining cost effective; and d. Approach to reducing burden on agencies/partners. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Offeror's draft Local Community Collaboration Strategy that demonstrates an understanding of the North Carolina Medicaid and NC Health Choice program, the state's geographic and cultural diversity and the different types of community of agencies engaged with Members.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
49.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.3. Integration with Other Department Partners*, including the Enrollment Broker, Ombudsman Program and county DSS offices. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Program Operations

Evaluation Question	
50.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.1. Service Lines*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to ensure all pharmacy prior authorization requests are processed within 24 hours; b. Experience, approach and policies with operating a behavioral health crisis line; c. Approach to customizing and training Member Service and provider relations staff on North Carolina Medicaid Managed Care program and providing specific responses to potential customer service inquiries; and d. Process to integrate the Nurse Line into the Offeror's Care Management and health care delivery model.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
51.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.2. Staff Training*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Experience and approach in developing market specific trainings for staff with varying backgrounds, and educational levels; b. Description of the Offeror's process and methods for providing North Carolina Medicaid Managed Care training to its personnel, including: i. A description of each staff training program (i.e. Member services, provider relations, county and Department staff), including a summary of the topics, the materials used, and the media used in the training. ii. Frequency of the initial and updated training; and c. Approach to ensuring cross-functional training with other Department Medicaid Managed Care partners (including the Enrollment Broker, the Ombudsman program, and local DSS staff).
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
52.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.3. Reporting* and *Attachment J. Reporting Requirements.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror's proposed reporting templates and/or key fields for Reports included in *Attachment J: Reporting Requirements.*
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
53.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.4. PHP Policies*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
54.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.5. Business Continuity*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to meeting the Department's restoration of service timing expectations including failover site approach (active/active, active/passive and cold, warm, or hot site), technical staffing coverage, data replication and recovery processes, and approach to testing including frequency and testing coverage; b. Approach for maintaining data security during an event that causes the implementation of the business continuity plan; c. Description of the differentiation between the technical approach (system failover, data recovery, etc.) and the business approach (alternate procedures, staffing, training, etc.) including how critical functions will be met during the initial twenty-four (24) hour recovery window. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror's draft Business Continuity Plan
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Claims and Encounter Management

Evaluation Question	
55.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.H.1. Claims.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The completed table shall include the experience of the Offeror and any entity proposed to process and pay claims in Question #5. The response shall include: a. Description of policies and procedures to meet performance standards and prompt pay requirements; b. Market specific strategies for addressing potential provider payment issues, beginning with the contracting process and technical provider contract setup, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education; and c. Proposed average days to payment from claims submission for the Offeror's proposed claims platform for pharmacy claims and medical claims (days should be separately for medical and pharmacy).
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
56.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.H.2 Encounters*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Performance management strategies to ensure complete, accurate and timely encounter data submissions are made to the Department and meet the standards required under the Contract; b. Demonstrated understanding of the importance of accurate, complete and timely Medical and Pharmacy encounter data to the Department for use in the North Carolina Medicaid and NC Health Choice programs. In addition, Offeror shall specifically include steps to support drug rebates and steps to support capturing all applicable diagnosis information on encounters to support risk adjustment; c. Operating model including staffing to support the encounter development and submission process; d. Description of the Offeror's past performance in complying with encounter submission SLAs for other Medicaid customers including the acceptance rates as percentages; e. Leading practices it has adopted to improve data quality in encounter submission, include applicable policies and procedures and the Offeror's use of the Post Adjudicated Claims Data Reporting (PACDR) version of the X12 837 transaction; f. Procedure to work with providers and internal operations in correcting Encounter errors; and g. Describe the challenges and associated mitigation approaches with encounter data submission (including managing denied claim submission, duplicate submissions, sub capitated claims, value-based arrangements, or non-traditional services such as ILOS, value-added services, health-related resources) and specific steps taken to remediate issues. Include specific data on outcomes achieved. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include a Draft Encounter Implementation Approach
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Financial Requirements

Evaluation Question	
57.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements as outlined in *Section V.I.1. Capitation Payments* and the attached Draft Rate Book. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. For all entities proposed to assume risk through the capitated contract as listed in Question #5, provide the net underwriting gain or loss for Medicaid lines of business for the last two completed contract years, by state of operation and year (for all entities proposed to bear risk). Include relevant details on context for any losses; b. Approach to managing utilization and expenditures within the capitation payments while meeting or exceeding quality standards; c. Methods for reducing administrative costs to and maintaining financial predictability of the North Carolina Medicaid Managed Care program; d. Tools and measures the Offeror uses to track actual and anticipated expenditures relative to the capitation rates to mitigate losses; and e. Measures and the targets for each measure that the Offeror will use to demonstrate value to the Department.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
58.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in *Section V.I.2. Medical Loss Ratio*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
59.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in *Section V.I.3. Financial Management*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Approach to managing financial risk, including how financial risk will be shared across partnering entities; b. Approach to strong financial stewardship and protecting against insolvency, including plans for purchasing reinsurance/ stop loss or a proposed alternative arrangement; c. Sources and amounts of capital available to the Offeror, including the Offeror's plan for finding additional capital should the Offeror experience financial hardship; and d. For all entities proposed to assume risk through the capitated contract as listed in Question #5, provide any regulatory actions related to solvency and any bankruptcy or solvency during the past ten years, including all relevant details on the context and proceedings. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) for the Offeror or any entities identified to assume risk in Question #5: 1. Balance sheet as of the end of the month immediately preceding the month in which the Proposal is submitted. (NOTE: Offerors may provide the balance sheet from the latest filed quarterly statutory

	filing in lieu of the balance sheet as of the end of the month immediately preceding the month in which the Proposal is submitted.) 2. Documentation of lines of credit that are available, including maximum credit amount and available credit amount. 3. Proposed reinsurance arrangement or alternative mechanism for managing financial risk.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Compliance

Evaluation Question	
60.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.1. Compliance Program.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror's draft Compliance Plan

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.
Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
61.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.2. Program Integrity.* The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
62.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.3. Fraud, Waste and Abuse Prevention*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. a. Examples (up to three) of initiatives to proactively prevent fraud/waste/abuse previously enacted and the outcomes achieved; include any work with law enforcement in criminal or civil prosecution fraud cases. b. Approach to design and uphold a proactive fraud prevention, detection and referral process. Include description of both internal and external policies and procedures. c. Staffing model for the SIU and how the SIU would work with state or federal investigators. d. Description of how the Offeror will work with the Department, MID or the OIG to investigate and prosecute potential fraud/waste/abuse. e. Description of how the Offeror will balance the tensions between paying Providers timely and accurately with the Offeror's responsibility: i. To monitor potential fraud/waste/abuse; and ii. Cost avoidance and cost recovery. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror's draft Fraud, Waste and Abuse Plan

List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.
Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
62.5	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.4. Third Party Liability*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
63.	The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.5. Recipient Explanation of Medical Benefit*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Procedures to exclude mailing REOMBs containing potentially sensitive clinical information; and b. Actions taken based on data from REOMB mailing responses.
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Other

Evaluation Question	
64.	The Offeror shall confirm its adherence and describe its approach to managing sensitive and confidential data as described *Section III.E. Confidentiality, Privacy and Security Protections*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include: a. Overall approach to customer and Member data protection including internal programs and policies that minimize the risk of data breaches such as a Customer Data Protection policy. b. Experience in complying with Federal rules and regulations including HITECH and HIPAA; c. Experience with Risk Analysis and Assessments associated with NIST standards; d. Description of software and infrastructure development and release cycles including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software). e. Description of the vulnerability and breach monitoring processes including internal Network Operations Centers, use of external parties such as US Cert, or other monitoring tools or processes. Note: If the response includes a cloud or vendor hosted solutions, these are considered extensions of the Offeror's infrastructure and should be included in the responses to the questions above PROVIDE SUPPORTING DOCUMENTATION (not part of page count): 1. Offeror's draft Security Compliance Plan 2. Offeror's SOC 2 Type II Report and corrective action plan (or alternative certification as described in the Section III of the RFP)
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
65.	The Offeror shall confirm its adherence and describe its approach to work with the State and State Contractors to implement and manage data integrations as described in *Section V.L. Technical Specifications*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include at a minimum: a. Experience and approach to developing data exchanges and interfaces, including response batch, EDI, real time, and APIs. b. Innovative approaches and experience with data exchanges focused on transmitting only necessary data for business purposes (including data sharing such as data hubs and real-time data services); c. Approach to comply with the current data exchanges detailed in the Contract; d. Approach to system and service availability including the recoverability of platforms to avoid impacts to the delivery of services to Members; e. Approach to functionally testing new software releases, upgrades, and fixes prior to releasing into production (this is differentiated from the questions above around vulnerability testing);

	f. Approach to comply with the reconciliation processes for Member, Provider and AMH, including and any gaps in the reconciliation process as well as innovative approaches to reconciliation the Offeror has implemented with other States or clients; g. Approach and experience in conducting root cause analysis when failures or problems are identified; h. Method to create, maintain and transmit the Provider Directory; and i. Approach to follow the Department's Enterprise Architecture standards when creating the System Interface Design and throughout the maintenance of this documentation. PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Draft System Interface Design
List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.	
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

4. Use Case Scenarios

The Offeror must submit its response to the following Use Cases. The Department encourages the Offeror to suggest innovative ways to fulfill the requirements of this Contract.

The use cases represent hypothetical Members, providers, or entities at a specific point in time. Responses must include, at a minimum, the program and services listed within each use case, but the Offeror is not limited to responding only to those areas. The Offeror should include any limitations or exceptions to providing the programs and services listed.

The Offeror's response may not exceed seven (7) pages per Use Case, and may include a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature or detailed information specifically tailored for the North Carolina Medicaid Managed Care to demonstrate its ability to meet or exceed requirements.

Use Case Scenario 1	
1.	Emily, age 26, wants to be a good mother, but fears the odds are against her. Physically and sexually abused as a child, she began taking drugs to ease her emotional pain and eventually dropped out of high school. Starting with prescription opioids as a teenager, Emily transitioned to IV heroin use by age 20. When she became pregnant, her boyfriend left and Emily has not been able to contact him. Afraid of being ostracized by providers, she avoided prenatal care altogether. Her baby, Timothy, was born prematurely at 28 weeks with neonatal abstinence syndrome. Though released from the neonatal intensive care unit, Timothy still requires ongoing specialty care (ophthalmology, gastroenterology, pulmonology, physical therapy, primary care). On her own and with limited transportation and social supports, Emily is overwhelmed and fraught with guilt. She was encouraged when she obtained Medicaid near the end of her pregnancy, but that coverage is expected to end eight (8) weeks after delivery. Emily does not know how to enroll Timothy in Medicaid or whether Timothy qualifies for the managed care program. The Offeror must describe how it would address Emily and Timothy's situation. At a minimum, the Offeror shall address the following programs and services in its response: a. Early and Periodic Screening, Diagnostic, and Treatment; b. Care Management; c. Care for At-Risk Children; d. Working with DSS, Enrollment Broker, Ombudsman; e. Transition of Care; f. Family Planning; g. Transportation; h. Family Support and Resiliency; i. Trauma Informed Care; and j. Behavioral Health/Addiction Services.
Response	

Use Case Scenario 2	
2.	Francisco, age 15, has moderate persistent asthma. He sees a primary care doctor regularly. However, this year, he had several emergency department visits and one hospitalization related to his asthma. Francisco uses his limited Spanish skills to interpret medical information for his mother, Lenita, who speaks limited English. Being a teenager, Francisco does not always understand what the doctor is saying. As a result, he relies on TV for information. Francisco has recently stopped using his asthma control medicine after seeing several TV commercials for asthma medication with long lists of side effects, some life threatening. Francisco's father, whom he adores, lives outside the U.S. and Francisco is depressed and anxious about the separation. Francisco and Lenita's apartment is full of mold and pests, but Lenita, who is undocumented, is fearful that complaining to the landlord might lead to an eviction or involvement of immigration authorities. Francisco and Lenita live in a violent neighborhood, but Francisco is worried that if he reports gang activity and threats to the police, his mother will also be deported. The emotional and physical stress has caused Francisco's schoolwork to suffer. The Offeror must describe how it would address Francisco's situation. At minimum, the Offeror shall address the following programs and services in its response: a. Care Management; b. Motivational Interviewing; c. Housing Quality; d. Social Determinants of Health; e. Community Engagement; and f. Language Accessibility.
Response	

Use Case Scenario 3

3.	Laura, age 36, is a single mother who is three months into her third pregnancy. She hopes for a healthy pregnancy, but is not optimistic. Her first child, Amelia, now age 6, was born prematurely at 32 weeks with low birth weight. Her second child was born prematurely at 27 weeks and died shortly after birth. Laura moved in with the father of her unborn child, but was forced to flee with Amelia when he became violent and emotionally abusive. Now Laura and Amelia live in temporary housing and are unable to rely on regular meals. Laura does not have time to update her address with her local DSS office because it changes so often and she uses a prepaid "throw away" phone only if she has the extra money. Laura works two jobs and relies on public transportation. Because her work is shift-based, Laura misses the bus when she must work overtime. Lately, Amelia has been missing her primary care doctor appointments due to Laura's unpredictable work hours and lack of reliable transportation. The Offeror must describe how it would address Laura and Amelia's situation. At minimum, the Offeror shall address the following programs and services in its response: a. Pregnancy Management Program Care for High-Risk Pregnant Women; b. DSS, Ombudsman; c. Population Health Programs; d. Transportation, Food Insecurity, Housing Instability; e. Trauma Informed Care; and f. Early and Periodic Screening, Diagnostic, and Treatment
Response	

Use Case Scenario 4	
4.	Maggie, age 51, is a widowed mother of two school-aged children and lives in rural eastern North Carolina, where she grew up to be strong-minded and independent. She married in her early 30s and embraced her new role as wife and mother, becoming involved in improving her community and she is proud of her reputation for seeing difficult projects through to completion. When her husband died in a car accident several years ago, Maggie began experiencing symptoms of depression. These symptoms have grown steadily worse as she became overwhelmed by having to care for a family on her own, yet feels she should be able to manage it and has not discuss her symptoms with anyone. To hide her depression, she has become disengaged from her family and community. Maggie has an array of health issues: obesity, type 2 diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), osteoarthritis, and a history of stroke, all which contribute to her lack of physical activity. Her diet is high in salt, fat, and sugar. She has been smoking since age 14 and now smokes a pack of cigarettes a day. Without public transportation in her community, Maggie must rely on family members for transportation. Not wanting to burden them, Maggie has missed doctor appointments and often

	runs out of one or more of her ten (10) medications. She has been to the emergency department ten (10) times in the past two years. The Offeror must describe its approach for coordinating care for Maggie's needs, including a detailed description demonstrating at minimum how the following programs and services will be incorporated: a. Care Management; b. Pharmacy Care Management/pharmacy coordination; c. Transportation Support; d. Telemedicine; and e. Rural Health.
Response	

Use Case Scenario 5	
5.	Hank, age 30, has been married to Elizabeth for five years. Hank was diagnosed with HIV/AIDS at age 21 and, before marrying, he promised Elizabeth that he would strictly follow his regimen of medication, regular visits to his infectious disease specialist, and discordant couples counseling. Hank stayed true to his word and the couple had a daughter, Annie, now three years old, who has asthma. A year ago, Hank was paralyzed from the waist down in an accident. Elizabeth stays home full-time to provide Hank with the in-home care he needs. Hank was prescribed oxycodone to manage pain and now has several prescriptions filled by different doctors. Hank has started missing appointments with his specialist and neglects to regularly take his HIV medications. Annie has stopped routinely seeing a pediatrician. Recently, Hank overdosed on oxycodone, which required Elizabeth to call 911. Elizabeth's overriding concern is that Hank's doctors, whom they know well, will not be part of their PHP's network. The Offeror must describe how it would address Hank and his family's situation. At minimum, the Offeror shall address the following programs and services in its response: a. Long Term Services and Support; b. Care Management; c. Opioid Misuse Prevention Program; d. Advanced Medical Home; and e. Network Adequacy.
Response	

Use Case Scenario 6	
6.	Karen is a 37-year-old family practice physician at a mixed-specialty practice based in a suburban community in North Carolina. Her practice is a credentialed Medicaid provider and was designated as a Tier 2 Advanced Medical Home, with the goal of being designated Tier 3. The Offeror must describe how it would anticipate working with Karen's practice. At minimum, the Offeror shall address the following programs and services in its response: a. Provider Quality Network Review Process; b. Provider Satisfaction; c. Provider Training; d. Quality Measure Tracking; e. Advanced Medical Home Support; and f. Value Based Payment.
Response	

Use Case Scenario 7	
7.	Dr. Charles Xavier is a licensed clinician who provides a diverse range of services to his local community in rural North Carolina. He is an integral member of this community with large Hispanic and elderly populations, and he speaks both English and Spanish. Dr. Xavier had a medical malpractice issue five (5) years ago and has since undergone training and made improvements to his practice to remediate this issue and future issues. The Offeror must describe how it would assess the quality of Dr. Xavier's practice. At minimum, the Offeror shall address the following in its response: a. Network Adequacy; b. Provider Contracting;

	c. Provider Support; d. Cultural Competency; and e. Community Engagement.
Response	

The remainder of this page is intentionally left blank.

5. Offeror's Client References

The Offeror must provide four (4) client references for which it has provided services of similar size and scope to that requested herein. The Department prefers at least three (3) references from state Medicaid programs. If three (3) state Medicaid programs are not provided, Offeror must include a statement explaining why. The Department may take this into consideration when scoring the Offeror's Client References.

The Offeror must complete the reference table below for each client reference, and sign the bottom of this Form to include in its proposal. The Offeror should indicate in the Offeror Name field the actual organization that held the contract with the submitted client reference (e.g., the Offeror, one of the Offeror's subcontractors, joint venture partner) and state the relationship to the Offeror if applicable. The Offeror shall ensure that the Contact Person listed in the table is qualified and well-versed to elaborate and verify the information provided by the Offeror. The Department may contact these clients to determine the services provided are substantially similar in scope to those proposed herein, and that Offeror's performance has been satisfactory. The information obtained in this attachment and obtained from the client will be considered in the evaluation of the offer. **The Department will not accept Department of Health and Human Services' employees as references.**

Offeror Name			
Contract Name		Contact Person Name	
Name of Client		Contact Person Title	
Annual Contract Value		Contact Person Telephone Number	
Contract Start Date		Contact Person Email Address	
Contract End Date		Geographic Area Served Under the Contract (e.g., Statewide, Regional)	
Scope of Services Provided Under Contract Listed Above (indicate Yes and number of staff assigned for all that apply)			
Managing Medicaid Managed Care beneficiary lives		Processing and paying claims	
Provider network management		Assuming risk through capitated contracts	
Performing care management functions		Other [Please describe]	
Please describe the services provided under the contract listed above for each part answered "Yes" in Scope of Services Provided Under Contract Listed Above section.			
Please indicate the number of covered lives under contract listed above.			
Please indicate the number of Practitioners and Providers in your network under contract listed above.			

Please describe any key strategies or innovative approaches executed (e.g., system of care, staff, operations, technology, and relationship management) to advance high-value care, financial innovations or increase operational efficiency under contract listed above.
Please provide the results (audited by a NCQA-approved auditing firm) under contract listed above for three (3) consecutive most recent HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below. (If 3 reporting periods are not available, the Department will accept 2 or 1 reporting period measure results, as long as they are within the last 3 years)

	Year _____	Year _____	Year _____
	Measure Result	Measure Result	Measure Result
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)			
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)			
3) Follow-Up After Hospitalization for Mental Illness (FUH): 7 and 30-day periods			
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges			
5) Well-Child Visits in the First 15 Months of Life (6 or More Visits) (W15)			

For any HEDIS metric results above that is less than the national average, please describe your remediation plan to improve performance in the area.
Please describe risks and issues under contract listed above.
Please describe results and value achieved under contract listed above.
Please describe lessons learned under contract listed above.
Please describe any legal or adverse contractual actions, including sanctions and liquidated damages, that were incurred through the duration of contract listed above. Include the area of non-compliance, the date issued, the reason, the entity that issued it, the duration, and the resolution(s).

_____

Signature Date

_____

Printed Name Title

6. PHP Key Personnel

The following must be completed by the Offeror as required by Section V.A.9. Staffing and Facilities.

Attachment O. Offeror's Proposal and Response Table 7: PHP Key Personnel				
Role		***Duties and Responsibilities of the Role***	***Minimum Certifications and/or Credentials Requested by the Department***	***Offeror's Proposed Staff Name. Offeror must attach resume for each Proposed Staff Name.***
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program Director	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	• Must reside in North Carolina	
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program	Individual responsible for accounting and finance operations, including all audit activities	• Must reside in North Carolina	
3.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program	Individual to oversee and be responsible for all clinical activities, including but not limited to the proper provision of covered services to Members, developing clinical practice standards and clinical policies and procedures	• Must reside in North Carolina • Physician, licensed to practice in NC and in good standing (Exception: Medical Director in the event that the CMO is not licensed to practice in NC) • Minimum experience of five (5) years in a health clinical setting and two (2) years in managed care	
4.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program	Individual to oversee and manage all fraud, waste, and abuse and compliance activities	• Must reside in North Carolina	
5.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	• Must reside in North Carolina • Bachelor's Degree in Information Security or Computer Science • CISSP and one of the following certifications: CISM, CISA or GSEC	

Attachment O. Offeror's Proposal and Response Table 7: PHP Key Personnel				
Role		***Duties and Responsibilities of the Role***	***Minimum Certifications and/or Credentials Requested by the Department***	***Offeror's Proposed Staff Name. Offeror must attach resume for each Proposed Staff Name.***
	Managed Care Program			
6.	Quality Director of North Carolina Medicaid Managed Care Program	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances.	• Must reside in North Carolina • More than 5 years of demonstrated quality management/quality improvement experience in a large healthcare corporation serving Medicaid beneficiaries • NC licensed clinician (e.g. LCSW, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred	
7.	Provider Network Director of North Carolina Medicaid Managed Care Program	Individual responsible for providers services and provider relations, including all network development and management issues	• Must reside in North Carolina • At least five (5) years of combined network operations, provider relations, and management experience	
8.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the PHP pharmacy benefits and services.	• Must reside in North Carolina • NC-registered pharmacist with a current NC pharmacist license • Minimum of three working years of Medicaid pharmacy benefits management experience	
9.	Behavioral Health Director of North Carolina Medicaid Managed Care Program	Individuals responsible for providing oversight and leadership of integrated behavioral health benefit, including UM program, network development and care management.	• Must reside in North Carolina • NC-licensed psychiatrist or psychologist • Minimum experience of five (5) years in a BH clinical setting and two (2) years in managed care	

7. Contractor's Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

Contract Administrator regarding day to day activities herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

8. Certification of Financial Condition

The Offeror must complete and sign this Form, and include the required documents as indicated herein.

The undersigned hereby certifies that:

☐ The PHP has included the following documents with this completed Certification of Financial Condition.

a. ☐ Audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant (CPA for the two most recent fiscal years, including at a minimum balance sheet, income statement, and cash flow statement for each year. Must provide the contact information for the CPA/audit firm.

b. ☐ The current Month End Balance Sheet and Year-to-Date Income Statement at the time of proposal submission.

c. ☐ The most recent corporate tax filing OR independent audit report. If submitting the independent audit report, must include contact information for the audit firm.

☐ The PHP is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.

☐ The PHP has included a brief statement outlining and describing its financial stability.

☐ The PHP has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.

☐ The PHP is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.

☐ The PHP acknowledges that this is a continuing certification, and the PHP shall notify the Department

If any one or more of the foregoing boxes is NOT checked, the PHP shall explain the reason in the space below:

The PHP is encouraged to explain any negative financial information in its financial statement below and are encouraged to provide documentation supporting those explanations:

By completing this Certification of Financial Condition and Legal Action Summary, the PHP affirms the ability to financially support implementation and on-going costs associated with this Contract, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the PHP.

_____

Signature Date

_____

Printed Name Title

The remainder of this page is intentionally left blank.

9. Disclosure of Litigation and Criminal Conviction

The Offeror must provide information regarding litigation and criminal conviction in response to the RFP by completing this Form.

1. The Offeror shall disclose, if it, or any of its subcontractors, or their officers, directors, or key personnel who may provide Services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception.
2. The Offeror shall disclose if it, or its any of its subcontractors, are the subject of any current litigation or investigations of noncompliance under federal or state law.
3. The Offeror shall disclose any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its subcontractors during the three (3) years preceding its offer that involve (1) Services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Offeror or subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Offeror or subcontractor.
4. In the event the Offeror, an officer of the Offeror, or an owner of a twenty-five percent (25%) or greater share of the Offeror, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Offeror's business integrity, such Offeror shall be prohibited from entering into a contract for goods or Services with any department, institution, or agency of the State.
5. The Offeror shall disclose any legal action that could adversely affect the Offeror's financial conditions or ability to meet the requirements any Contract resulting from the RFP.

By signing the RFP, Offeror certifies that the information provided in this response to the RFP is true to the best of its information and belief. Offeror agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFP. By signing the RFP, Offeror further acknowledges the requirements set forth in RFP *Section III.D.15. Disclosure of Litigation and Criminal Conviction* or Adverse Financial Condition, and the resulting obligations should a Contract be awarded to the Offeror.

10. Disclosure of Conflicts of Interest

Offeror must provide conflict of interest information by completing this form in its response to the RFP.

Offeror shall:

1. Disclose any relationship to any business or associate with whom the Contractor is currently doing business that creates or may give the appearance of conflict of interest related to this RFP and any Contract that may be awarded to Offeror because of the RFP.

2. Disclose any firm principal, staff member or subcontractor, known by the Offeror to have a conflict of interest or potential conflict of interest related to this RFP and any Contract that may be awarded to Offeror because of the RFP.

By signing the RFP, Offeror certifies that the information provided in this response to the RFP is true to the best of its information and belief. Offeror agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFP. By signing the RFP, Offeror further acknowledges the requirements regarding conflicts of interest set forth in RFP Section III.D.14. Disclosure of Conflicts of Interest, and the resulting obligations should a Contract be awarded to the Offeror.

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11. Disclosure of Ownership Interest

Offeror must provide information regarding ownership and control as described in 42 C.F.R. § 455.104 by completing this Attachment.

Offeror shall provide, for the Offeror, the following information:

1. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Offeror, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Offeror's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Offeror if that interest equals at least 5% of the value of the Offeror's assets, is an officer or director of a Offeror organized as a corporation, or is a partner in a Offeror organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. § C.F.R 455.100-104);

2. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Offeror, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Offeror's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Offeror if that interest equals at least 5% of the value of the Offeror's assets, is an officer or director of a Offeror organized as a corporation, or is a partner in a Offeror organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. § 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

3. Whether the person (individual or corporation) with an ownership or control interest in the Offeror is related to another person with ownership or control interest in the Offeror as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Offeror has a 5% or more interest is related to another person with ownership or control interest in the Offeror as a spouse, parent, child, or sibling

4. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity, as defined in 42 C.F.R. § 455.101 in which an owner of the Offeror has an ownership or control interest; and

5. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section D, Paragraph 15, Staffing Requirements) of the Offeror as defined in 42 C.F.R. § 455.101.

By signing the RFP, Offeror certifies that the information provided in this response to the RFP is true to the best of its information and belief. Offeror agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFP. By signing the RFP, Offeror further acknowledges the requirements set forth in RFP Section

12. Subcontractor Identification

The Offeror must identify and provide the information below for all subcontractors that will be used in meeting Contract requirements should a contract be awarded to Offeror.

Legal Name of Contractor and name used for business (if different) and FEIN	Term of Contract between PHP and Subcontractor	Description of Services Provided by Subcontractor as it relates to RFP Requirements	Estimated Value of the Contract

By signing the RFP, Offeror:

1. Certifies that the information provided in this Response to *Attachment O.12. Subcontractor Identification is* true to the best of its information and belief;
2. Acknowledges the requirements set forth in RFP Section III.D.43. Subcontractors, requiring Department approval of any subcontractors used in the performance of any Contract awarded as a result of the RFP; and
3. Attests that it understands, pursuant to NCGS §58-56-26, that, in the event of Contract award, Offeror is solely responsible to provide competent administration of its claims duties.

13. Business Associate Agreement

NORTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the _____of _____, 20___, by and between the North Carolina Department of Health and Human Services ("Covered Entity") and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____, whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.

c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

d. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. § Part 160 and Part 164.

e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.

h. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
   1) would not violate the Privacy Rule if done by Covered Entity; or
   2) would not violate the minimum necessary policies and procedures of the Covered Entity.
b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
   1) The disclosures are Required by Law; or
   2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. Term. This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or

3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. Effect of Termination.

1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2) If Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. If a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

_____	_____
Signature of Authorized Representative	Name of Entity
_____	_____
Name and Title	DATE

14. Location of Workers Utilized by the Contractor

Upon Contract Award, the successful Offeror becomes a Contractor providing goods and or services to the State. In addition to any other evaluation criteria identified in this RFP, the Department may, for purposes of evaluating proposed or actual contract performance outside of the United States, also consider how that performance may affect the following factors to ensure that any award will be in the best interest of the Department:

1. Total cost to the Department;
2. Level of quality provided by the Contractor;
3. Process and performance capability across multiple jurisdictions;
4. Protection of the State's information and intellectual property;
5. Availability of pertinent skills;
6. Ability to understand the Department's business requirements and internal operational culture;
7. Identified risk factors such as the security of the State's information technology;
8. Relations with citizens and employees; and
9. Contract enforcement jurisdictional issues.

In accordance with G.S. § 143-59.4, the Contractor shall detail the location(s) at which performance will occur, as well as the way it intends to utilize resources or workers outside of the United States in the performance of this Contract. The Department will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Items a, b, and c below MUST BE COMPLETED.

a) Will any work under this Contract be performed outside the United States?

☐ YES

☐ NO

If the Contractor answered "YES" above, the Contractor shall complete items 1 and 2 below:

1. List the location(s) outside the United States where work under this Contract will be performed by the Contractor, any subcontractors, employees, or other persons performing work under the Contract:

2. Describe the corporate structure and location of corporate employees and activities of the Contractor, its affiliates, or any other subcontractors that will perform work outside the U.S.:

b) The Contractor agrees to provide notice, in writing to the Department, of the relocation of the Contractor, employees of the Contractor, subcontractors of the Contractor, or other persons performing services under the Contract outside of the United States

☐ YES

☐ NO

NOTE: All Contractor or subcontractor personnel providing call or contact center services to the State of North Carolina under the Contract **shall** disclose to inbound callers the location from which the call or contact center services are being provided.

c) Identify all U.S. locations at which performance will occur:

_____	_____
Signature of Authorized Representative	Name of Entity
_____	_____
Name and Title	DATE

15. State Certifications – Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 133-32: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): http://www.ethicscommission.nc.gov/library/pdfs/Laws/EO24.pdf
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
- G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

CERTIFICATIONS

(1) **Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009)**, the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.

(2) **Pursuant to G.S. 143-48.5 and G.S. 143-133.3,** the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov

(3) **Pursuant to G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:

(a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); and

(b) [check one of the following boxes]

☐ Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; or

☐ The Contractor or one of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 but the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.

(4) **Pursuant to G.S. 143-59.2(b),** the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within ten (10 years immediately prior to the date of the bid solicitation.

(5) **Pursuant to G.S. 143B-139.6C,** the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.

(6) The undersigned hereby certifies further that:

(a) He or she is a duly authorized representative of the Contractor named below;

(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and

(c) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1and -59.2 shall be guilty of a Class I felony.

Contractor's Name: _____

Contractor's Authorized Agent: Signature _____ Date _____

Printed Name _____ Title _____

Witness: Signature _____ Date _____

Printed Name _____ Title _____

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.

16. Federal Certifications

The undersigned states that:

(a) He or she is the duly authorized representative of the Contractor named below;

(b) He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:

a. The Certification Regarding Nondiscrimination;
b. The Certification Regarding Drug-Free Workplace Requirements;
c. The Certification Regarding Environmental Tobacco Smoke;
d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
e. The Certification Regarding Lobbying;

(c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;

(d) [Check the applicable statement]

[ ] He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

OR

[ ] He or she **has not completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has not made**, and **has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

(e) The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

_____

Signature **Title**

_____

Contractor Name **Date**

[This Certification Must be Signed by the Same Individual Who Signed the Proposal Execution Page]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Contractor certifies that it will provide a drug-free workplace by:

    a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

    b. Establishing a drug-free awareness program to inform employees about:

        i. The dangers of drug abuse in the workplace;

        ii. The Contractor's policy of maintaining a drug-free workplace;

        iii. Any available drug counseling, rehabilitation, and employee assistance programs; and

        iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

    c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

    d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

        i. Abide by the terms of the statement; and

        ii. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

    e. Notifying the Department within ten days after receiving notice under subparagraph (d)(ii) from an employee or otherwise receiving actual notice of such conviction;

    f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(ii), with respect to any employee who is so convicted:

i. Taking appropriate personnel action against such an employee, up to and including termination; or

ii. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):

Address

Street

_____

City, State, Zip Code

_____

Street

_____

City, State, Zip Code

_____

3. Contractor will inform the Department of any additional sites for performance of work under this agreement.

4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. § 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 C.F.R. Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or

voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies,** by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

VI. Disclosure Of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

1. Identify the status of the covered Federal action.

2. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

3. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

4. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

5. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

6. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

7. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

8. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

9. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

10. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

11. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

12. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.

13. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

14. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

15. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Disclosure Of Lobbying Activities
(Approved by OMB 0344-0046)
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	☐ a. initial filing ☐ b. material change **For Material Change Only:** Year_____ Quarter_____ Date Of Last Report:_____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier (if known) _____ Congressional District (if known) _____	Congressional District (if known) _____
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number (if applicable) _____
8. Federal Action Number (if known)	9. Award Amount (if known) $
10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)
11. Amount of Payment (*check all that apply*): $ _____ actual planned 12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. In-kind; specify: Nature _____ Value _____	13. Type of Payment (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: _____

14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11(*attach Continuation Sheet(s) SF-LLL-A, if necessary*):

15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____

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17. Request for Proposed Modifications to the Terms and Conditions

Offeror may submit proposed modifications to the terms and conditions of the RFP for consideration by the Department. The proposed modifications do not alter the terms and conditions of the RFP and have no force or effect on the RFP or any contract unless accepted by the Department and incorporated through a BAFO, negotiation document, addenda to the RFP or amendment to the Contract.

The Department at its sole discretion may consider any proposed modifications submitted in this Attachment.

	RFP Citation	**Redline of Proposed Modification**
	(i.e., section & page number)	(i.e., include text as published in RFP and strikethrough words, phrases or sentences proposed to be deleted and underline words, phases, or sentences proposed to be added)
1.		
2.		

Section IX. Medicaid Managed Care Draft Rate Book (SFY 2020)
North Carolina Department of Health and Human Services

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Department of Health and Human Services (DHHS) is implementing managed care in a way that advances high-value care, improves population health, engages and supports providers and establishes a sustainable program with predictable costs. At the core of these efforts is the goal to improve the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care, which addresses medical and non-medical drivers of health. In managed care, DHHS will remain responsible for all aspects of the Medicaid and NC Health Choice programs. However, as directed by the General Assembly, DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive capitation payments and will contract with providers to deliver health services to their members.[1]

DHHS has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop the PHP capitation rates. As such, Mercer has produced the Draft Rate Book for DHHS as documentation of the development of the draft capitation rates effective in Contract Year 1 of managed care for the proposed Standard Plan population. The capitation rates will be certified as actuarially sound in accordance with applicable laws and regulations, including Actuarial Standards of Practice, to comply with the Center for Medicare and Medicaid Services (CMS) regulations. Per 42 CFR 438.4(a), "actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in [42 CFR 438.4(b)]." Moreover, the capitation rates are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care program designed for the proposed Standard Plan population.

Following initial implementation of managed care and the rollout to the proposed Standard Plan population, additional populations will be phased-in over a five year period, as proposed by DHHS. However, information for these populations is outside of the scope of the Draft Rate Book.

Contract Year 1 Standard Plan Draft Capitation Rates

The Contract Year 1 draft capitation rates were developed for non-dual Medicaid and NC Health Choice beneficiaries in the Standard Plan, assuming Contract Year 1 runs from July 1, 2019 – June 30, 2020. Final rates will reflect any changes in the Contract Year 1 start date or duration. For purposes of capitation rate development, the Standard Plan population was stratified by Aged, Blind, Disabled (ABD) and Temporary Assistance for Needy Families and Other Related Children/Adults (TANF) beneficiaries. The capitation rates will be paid on a per member per month (PMPM) basis, along with a one-time Maternity Event payment in the instance of a live birth event. The table below reflects the draft base capitation rates; detailed summaries by region, population and service category are provided in Section 14 of the Draft Rate Book.

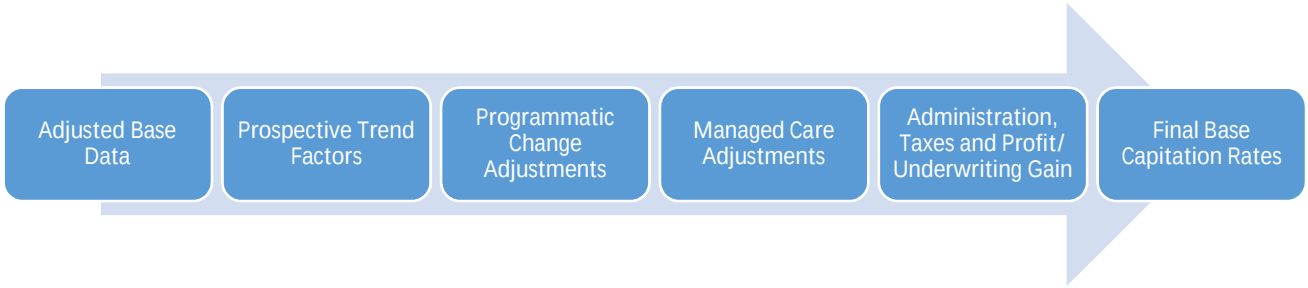
Category of Aid	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,373.30	$1,356.05	$1,529.02	$1,415.53	$1,278.26	$1,158.50
TANF, Newborn (<1)	$749.33	$707.22	$736.81	$660.06	$736.49	$563.56
TANF, Child (1-20)	$166.46	$148.78	$141.55	$141.70	$147.03	$136.70
TANF, Adult (21+)	$413.55	$437.60	$394.18	$385.86	$422.14	$373.97
Maternity Event Payment	$9,555.60	$9,760.42	$9,431.17	$8,857.91	$10,192.86	$8,844.00

[1] Prepaid Health Plans in North Carolina Medicaid Managed Care. May 16, 2018. https://files.nc.gov/ncdhhs/documents/PHPs-in-Medicaid-Managed-Care-PolicyPaper_revFINAL_20180516.pdf

The base capitation rates will also be risk adjusted, as required by Session Law (S.L.) 2015-245[2], to reflect the underlying health risk of the members enrolled in each PHP. Risk adjustment differentiates capitation payments to PHPs; however, this modeling has not yet occurred and will be forthcoming for final capitation rates. Additionally, DHHS will institute a Medical Loss Ratio (MLR) reporting and remittance process for all PHPs.

Capitation Rate Development Methodology

The rate-setting process is the means for determining the capitation payments DHHS will pay to the PHPs for each beneficiary enrolled in the program, regardless of the amount of future services that beneficiary receives. This process involves summarizing historical claims and eligibility data that represent the covered populations and services and projecting future medical claims costs on a per member per month basis into the rating period.



Mercer leveraged two years of historical claims and encounter data for the State Medicaid and NC Health Choice program to summarize cost and utilization information for the proposed Standard Plan population. This data includes experience for services covered under the State fee-for-service (FFS) program, as well as behavioral health (BH) services covered under the Medicaid BH managed care program currently operated by the Local Management Entity/Managed Care Organizations (LME/MCOs). Mercer used this information as the basis for capitation rate development. For service category detail, please see Section 5 of the Draft Rate Book. Mercer also used member-level eligibility information provided by DHHS to summarize the data and identify the Standard Plan population.

The base data has been adjusted to account for historical program changes and considerations for the proposed future managed care design. Detailed methodology and impact of base data adjustments is outlined in Section 6 of the Draft Rate Book. Historical data summaries by region, population and service category are included in Section 7 of the Draft Rate Book.

Prospective adjustments were applied to the base data to project the historical information to the future rating period. Medical trend was evaluated and unit cost and utilization trend factors were developed for each of the major service categories. Programmatic design changes were also considered to account for known design elements that are anticipated to impact projected claims expenditures, for example, hospital reimbursement considerations. Managed care adjustments were applied to capture assumed future changes in the utilization of certain services as a result of PHP utilization and care management initiatives. Further detail and methodology regarding prospective adjustments can be found in Section 9 through Section 12 of the Draft Rate Book.

The final component of the capitation rate development is application of the non-benefit expense load. This portion of the capitation rates accounts for PHP administration costs and care management costs incurred to operate the Medicaid managed care program. The non-benefit load considerations were developed to reflect the PHP contract requirements as defined by DHHS. The non-benefit expense load includes consideration for general administration (including program management, administrative operations and utilization management personnel), care management, profit/underwriting gain and premium taxes imposed on the PHPs. In DHHS'

[2] SL 2015-245 An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs https://www.ncleg.net/Sessions/2015/Bills/House/PDF/H372v8.pdf

approach to managed care, care management is foundational to the success of North Carolina's health care system for Medicaid and NC Health Choice beneficiaries, supporting high-quality delivery of the right care at the right place and at the right time in the right setting. Beneficiaries will have access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care and community-based resources. Access to local care management will draw from the Advanced Medical Home (AMH) model and participation from the Local Health Departments; additionally, DHHS is committed to providing care management for beneficiaries to address the four priority domains of opportunities for health: housing, food, transportation, and interpersonal safety. Mercer has aligned the care management modeling with DHHS care management strategy. Section 13 of the Draft Rate Book provides additional information on the non-benefit expense considerations.

Outstanding Rate Considerations

The capitation rates put forth in the Draft Rate Book are subject to change. Due to the timing of legislative changes made during the 2018 legislative session, the draft rates contained herein do not reflect the most recent legislation. The following items have not yet been reflected in the capitation rates; impact of these items on the capitation rates will be evaluated and reflected in the final rate development.

- PHP Contract Period – The draft capitation rates have been developed assuming a 12-month contract period of July 1, 2019 through June 30, 2020. The PHP RFP indicates that the Standard Plan Contracts will begin November 1, 2019. Additionally, S.L. 2018-49[3] allows DHHS to phase-in populations by region over a five month period. Information on the phase-in schedule will be released after PHP contract award. As such, the final capitation rates will reflect the appropriate contract period duration, including an adjustment to the number of trend months applied, and the assumed level of managed care savings to be achieved in Contract Year 1 of the program. The Department intends to have the rate period end on June 30, 2020 to align the future rate periods with the state fiscal year.
- Base Data – The base data underlying the draft capitation rates reflects July 1, 2015 – June 30, 2017 claims experience and eligibility information. This base data will be updated to include more recent information and reflect July 1, 2016 – June 30, 2018 experience for purposes of final rate development.
- BH and Intellectual/Developmental Disability (BH I/DD) Tailored Plan Populations — Per S.L. 2018-48[4], the BH I/DD Tailored Plan will be implemented one year following the first contracts for the Standard Plan benefit. Prior to implementation of the BH I/DD Tailored Plan, beneficiaries meeting BH I/DD Tailored Plan eligibility criteria will be defaulted into their current delivery system (FFS and LME/MCO for most beneficiaries), and have the option to enroll in a Standard Plan. The draft capitation rates assume eligibility for BH I/DD Tailored Plans based on criteria proposed by DHHS in the Fall of 2018. S.L. 2018-48 includes additional eligibility criteria not reflected in the draft capitation rates. Additionally, the draft capitation rates do not account for the potential that a BH I/DD Tailored Plan eligible beneficiary may choose to enroll in a Standard Plan. Both of these items have a potential cost impact that is not yet reflected in the draft capitation rates.
- Tribal Member Choice — Members of federally recognized tribes will have the choice to enroll in a PHP and will be exempt from mandatory enrollment into managed care. This has a potential cost impact that is not yet reflected in the draft capitation rates.
- Final Provider Reimbursement Arrangements — The capitation rates reflect adjustments for historical provider reimbursement arrangements and historical supplemental payments. To the extent there are expected reimbursement changes under managed care program design, an impact to the capitation rates will need to be evaluated. This includes potential future fee schedule changes prior to or

[3] SL 2018-49/House Bill 156 Medicaid PHP Licensure & Transformation Mods. https://www2.ncleg.net/BillLookUp/2017/h156

[4] SL 2018-48/House Bill 403 Medicaid and Behavioral Health Modifications. https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf

concurrent with managed care implementation, provider rate floors, and reimbursement requirements for hospitals and Federally Qualified Health Centers and Rural Health Clinics.

- Extended Coverage for Services Delivered in an Institution for Mental Disease (IMD) — It is anticipated that this provision will have minimal impact to the Standard Plan member costs; however, this will continue to be evaluated for final rate development.
- Substance Use Disorder (SUD) Service Array Expansion — The State is working on updates to the SUD service array, which may require updates to the State Plan. No adjustment is currently reflected in the draft capitation rates for SUD service array changes.
- Number of PHPs — The non-benefit load rate considerations are dependent upon an assumed number of PHPs administering the program, and their allocation across the six proposed PHP regions. The modeling currently reflects four statewide PHPs and four regional provider-led entities (PLEs). Upon contract award, this assumption will be updated to reflect the actual number of PHPs operating within/across regions.
- AMH Tier 3 Beneficiaries — Currently, the draft rates reflect an assumption that 65.0% of beneficiaries will receive care management through an AMH Tier 3 practice; this assumption will be revisited for final rate determination.
- Premium Tax — The rates reflect consideration for a premium tax component and regulatory surcharge, which is consistent with the legislative intent included in S.L. 2018-49.
- Health Insurer Provider Fee (HIPF) — The HIPF is considered a cost of doing business that is appropriate to recognize in the payments to PHPs. Currently, there is a moratorium on the HIPF for premiums earned in 2018 and uncertainty with respect to the applicability of the HIPF in the future, so at this point the draft rates do not reflect consideration for the HIPF.
- Performance Withholds — DHHS plans to include a performance-based incentive system financed through a withhold as part of the program design. Per S.L. 2018-49, the withhold program will not begin until at least 18 months after managed care implementation.
- Optical Services – This Draft Rate Book reflects the removal of optical services including services for eyeglasses frames, lenses, lens treatment, fabrication and fittings. Should additional legislation not be put forth, an adjustment to the draft capitation rates will be made to include the costs associated with eyeglass fittings.
- Fraud, Waste, and Abuse Recoveries – The base data reflected in this Draft Rate Book does not include an adjustment for recoveries collected for fraud, waste, and abuse. Mercer is working with DHHS to obtain more detailed information on these recoveries for Medicaid and NC Health Choice beneficiaries under the FFS program to evaluate potential impact to the Standard Plan.

Mercer and DHHS have agreed to reevaluate the appropriateness of the capitation rates using more recent claims and encounter experience before managed care implementation, along with considering applicable changes to legislation, regulation, state plan, waivers, federal guidance or policy decisions that may not have been reflected in draft rates. As such, the capitation rates will be finalized at a later point in time, and the base data, adjustments and capitation rates reflected in the Draft Rate Book are considered draft and are subject to change.

1 INTRODUCTION

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has produced this Draft Rate Book for the State of North Carolina (State) Department of Health and Human Services (DHHS) as documentation of the development of the draft capitation rates effective in Contract Year 1 of managed care (assumed July 1, 2019 through June 30, 2020) for the Standard Plan population. Following initial implementation of managed care and the rollout to the Standard Plan population, additional populations will be phased-in over a five year period, as proposed by DHHS. However, detailed cost and utilization information for these populations is outside of the scope of this Draft Rate Book.

As a part of capitation rate development for the Standard Plan population, Mercer leveraged claims and encounter data for the State Medicaid and NC Health Choice programs to summarize cost and utilization information for the Standard Plan population. This data includes experience for services covered under the State fee-for-service (FFS) program, as well as behavioral health (BH) services covered under the Medicaid BH managed care program currently operated by the Local Management Entity/Managed Care Organizations (LME/MCOs). Mercer used this information as the basis for capitation rate development.

The intent of the Draft Rate Book is to summarize historical data and outline key prospective rate considerations for the Standard Plan population for purposes of providing transparency into the current program costs and utilization along with insight into the rate development process for potential Prepaid Health Plans (PHPs) and other interested stakeholders. The Draft Rate Book includes information on the cost and utilization patterns of Medicaid and NC Health Choice eligibles by region, rate cell and category of service (COS). Sections 2 through 7 provide information on the data summarization process including an outline of population and service groups, adjustments applied to the base data, and detailed summaries by region, rate cell and COS.

Additionally, the Draft Rate Book outlines key components of the capitation rate development process, including information on specific prospective adjustments along with non-benefit cost considerations. Sections 8 through 14 provide information on the key steps of the rate development process, details on trend, programmatic considerations, managed care adjustments and non-benefit load assumptions, with detailed rate development summaries by region, rate cell and COS.

Finally, Section 15 provides details on other considerations for rate development and potential adjustments that may be forthcoming between the draft rates outlined in this Draft Rate Book and the final capitation rates for the implementation of managed care.

The users of this Draft Rate Book are cautioned against relying solely on the data contained herein. DHHS and Mercer provide no guarantee, either written or implied, that this book is 100% accurate or error-free. Additionally, it is important to note that information contained in this Draft Rate Book is considered draft. Mercer and DHHS have agreed to reevaluate the appropriateness of the capitation rates using more recent claims and encounter experience before managed care implementation, along with considering applicable changes to legislation, regulation, state plan, waivers, federal guidance or policy decisions that may not have been reflected in draft rates. Refer to Section 15 for examples of such items that may require adjustments to final rates. As such, the content of this Draft Rate Book and final capitation rates are subject to change pending updated base experience, possible adjustments not included in draft rates, additional guidance from DHHS on policy determination, and/or final program design elements currently pending legislation.

2 DATA SOURCES

Mercer used the FFS claims data from the DHHS Medicaid management information system, NC Tracks, which was provided by DHHS, and the BH encounter data provided to Mercer directly from the LME/MCOs to form the base data. This data is summarized on a date of service (incurred) basis and includes actual experience from July 1, 2015 through June 30, 2017 paid through September 30, 2017. For the base data development, this data is summarized by state fiscal year (SFY) 2016 (July 1, 2015 through June 30, 2016) and SFY 2017 (July 1, 2016 through June 30, 2017).

As a part of the data summarization process, Mercer also analyzed eligibility information from the member extract file provided by DHHS in October 2017. Eligibility information was used to categorize recipient-level claims experience into the populations outlined in Section 4. This information was also used to summarize the member month (MM) information reflected in various summaries throughout the Draft Rate Book.

Mercer also leveraged other data sources supplied by DHHS to calculate specific data adjustments outlined in Section 6, such as:

- State Medicaid monthly enrollment counts
- Member-level information from the North Carolina Families Accessing Services through Technology (NC FAST) system related to member retroactive eligibility and/or application period
- Information provided by DHHS on historical Graduate Medical Expense (GME) expenditures
- Non-Emergency Medical Transportation (NEMT) payments made outside of the FFS claims system
- Third Party Liability (TPL) monthly costs and, where available, member-level information for Medicaid participants
- Fraud, waste and abuse recovery information for payments collected specific to the Medicaid and NC Health Choice population
- LME/MCO data adjustment information leveraged from the BH LME/MCO rate-setting process

For final capitation rate development, the base data will be updated to reflect more recent experience and will include SFY 2017 and SFY 2018 (July 1, 2017 through June 30, 2018) data.

The users of this Draft Rate Book are cautioned that direct comparisons cannot be made between the information in the data summaries and raw claims data. The data received was summarized on a date of service (incurred) basis, and Mercer applied additional adjustments to the summarized raw data. Mercer has used and relied upon eligibility, claims, encounter and supplemental data and information supplied by both DHHS and the LME/MCOs. Aforementioned parties are solely responsible for the validity and completeness of these supplied data and information. Mercer has reviewed the summarized data in compliance with the Actuarial Standard of Practice (ASOP) on data quality (ASOP 23), which included checks for: completeness of data, accuracy of the data and consistency of data across data sources and years, including comparisons of BH encounter data to financial reports provided by the LME/MCOs. However, Mercer did not perform a complete audit.

3 PHP REGIONS

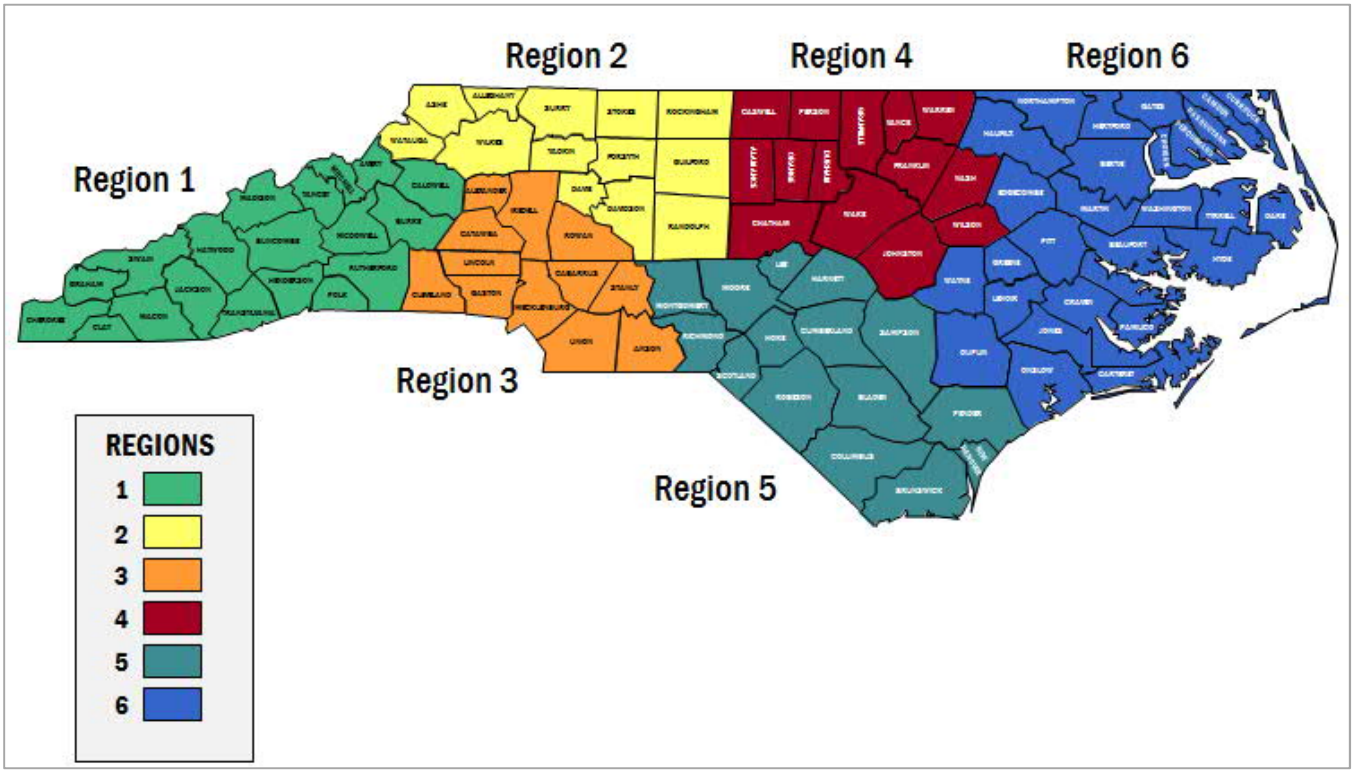
DHHS has defined six regions for the Standard Plan population. Table 1 outlines the counties included in each of the six PHP regions and Figure 1 illustrates the PHP regions in map format. Base data and capitation rates contained in this Draft Rate Book are summarized and developed by the six regions. Note that the capitation rates are developed for all regions for a managed care effective date of July 1, 2019. However, DHHS will phase the regions into managed care; information on the phase-in schedule will be released after PHP contract award.

As a part of final capitation rate development, Mercer will evaluate further regional breakouts that may be necessary due to meaningful cost and utilization variances within certain regions beyond those addressed through rate cells and risk adjustment.

Table 1: List of Counties in PHP Regions

PHP Regions	Counties
Region 1	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region 2	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
Region 3	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Region 4	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
Region 5	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
Region 6	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

Figure 1: Map of PHP Regions



4 POPULATION GROUPINGS

DHHS will reimburse PHPs using full-risk capitation payments for eligible populations. Mercer determined rate cells for the Standard Plan population to account for material cost differences amongst populations. Since the managed care population will have choice of PHPs, the rate cell structure is intended to differentiate payments to PHPs where disproportionate enrollment of certain populations may occur. However, since the State has chosen to risk adjust the capitation rates, fewer rate cells are necessary since a risk adjustment model accounts for much of the age/gender risk within a population and differentiates payments to PHPs based on their enrolled population risk profile. Alongside the monthly per member capitation rates, DHHS will make a one-time Maternity Event payment that will cover prenatal, delivery and postpartum care for the mother. The final rate cell structure for the Standard Plan population is outlined in Section 4.1.

While the base data and rate development outlined in this Draft Rate Book is specific to the Standard Plan population, identification logic for future managed care populations and permanently excluded populations is outlined in Sections 4.2 and 4.3, respectively.

4.1 Standard Plan Population

The information summarized in this Draft Rate Book is specific to the Standard Plan population, including both Medicaid and NC Health Choice beneficiaries. As outlined, initial program implementation would enroll all non-dual beneficiaries into the Standard Plan who are otherwise not eligible for the BH and Intellectual/Developmental Disability (BH I/DD) Tailored Plan or fall into another excluded or delayed population as proposed by DHHS[5].

Based on a review of the Standard Plan population membership levels and cost variances by population, historical cost/utilization experience and rates for the Standard Plan population are summarized and developed for the following rate cells. Please see Appendix C for an overview of the rate cell determination process.

- Aged, Blind, Disabled (ABD), all ages
- Temporary Assistance for Needy Families (TANF) and Other Related Children (ages <1)
- TANF and Other Related Children (ages 1–20)
- TANF and Other Related Adults (ages 21+)
- Maternity Event, all ages

The table below outlines the logic used to summarize the broader categories of aid (COA) for the Standard Plan population; this includes information on detailed eligibility codes and sub-population groups.

Table 2: Standard Plan Population Criteria[6]

COA	Detailed Population Group	Program Aid Code/Eligibility Code
ABD	Aged	MAABN, MAACY, MAAMN , MAANN, MAAQN, MAAQY, SAABN, SAACN, SAACY, SAAQN, SAAQY
	Blind	MABBN, MABCY, MABMN, MABNN, MABQN, MABQY
	Disabled	MADBN, MADCY, MADMN, MADNN, MADQN, MADQY, SADBN, SADCN, SADCY, SADQN, SADQY

[5] Information on proposed program design can be found in the Policy Papers published by DHHS: https://www.ncdhhs.gov/concept-papers

[6] For specific program eligibility requirements, refer to the NC Basic Medicaid Income Eligibility Chart (https://files.nc.gov/ncdma/documents/files/BASIC_MEDICAID_INCOME_ELIGIBLITY_CHART_2017_03_10.pdf).

COA	Detailed Population Group	Program Aid Code/Eligibility Code
TANF and Other Related Children/Adults	Aid to Families with Dependent Children	AAFCN, AAFCY
	Other Children	MAFCN, MAFMN, MAFNN
	Pregnant Women	MPWNN
	Infants and Children	MICNN
	Breast and Cervical Cancer (BCC)	MAFWN
	Legal Aliens (Full Medicaid)	Eligibility codes with a fourth character of G, P, I or T
	NC Health Choice	MICAN, MICJN, MICKN, MICSN
	NC Health Choice — Extended Coverage[7]	MICLN
	Medicaid-Children's Health Insurance Program (M-CHIP)	MIC1N
Maternity Event	N/A	Cost summarized for pregnancy-related services for beneficiaries with a live birth event. The live birth event is identified by Current Procedural Terminology (CPT) codes or Diagnosis-Related Groups (DRGs). Prenatal services are included 8 whole months prior to the live birth event, and postpartum services are included 2 whole months following the live birth event. Please see Appendix A for the detailed logic used to identify these pregnancy-related services.

Members of federally recognized tribes are eligible to participate in managed care but are not required to enroll in PHPs. Members may voluntarily enroll in PHPs on an opt-in basis and may dis-enroll without cause at any time. For purposes of draft capitation rates, cost and utilization associated with members of federally recognized tribes have not been separately identified nor excluded for purposes of base data development. Mercer is working with DHHS to evaluate the impact of cost and enrollment considerations for this population; please see Section 15.1.1 for more information on this population.

Members of the Standard Plan population and the future BH I/DD Tailored Plan population will have the ability to shift between plans under specific circumstances under managed care. Given the cost profile of these members, this could have implications on the capitation rates. No considerations have been made in the draft rates for any shifting expectation at this point. Mercer and DHHS will continue to discuss this issue and may incorporate consideration into risk adjustment or an adjustment into final rate development. Please refer to Appendix F for more detail on potential cost implications for this group.

4.2 Future Managed Care Populations

Following initial implementation of managed care and the rollout to the Standard Plan population, additional populations will be phased-in over a five-year period, pursuant to Session Law (S.L.) 2015-245[8], as amended. The table below outlines the treatment of each of these population cohorts for Contract Year 1. As mentioned, detailed cost and utilization information for populations other than the Standard Plan population is outside the scope of this Draft Rate Book.

[7] NC Health Choice extended coverage is optional coverage for beneficiaries at 211%-225% Federal Poverty Level (FPL); beneficiaries may remain on NC Health Choice for a period not to exceed one year (NC DHHS On-Line Manual, https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/MA3255-05.htm).

[8] SL 2015-245 An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs https://www.ncleg.net/Sessions/2015/Bills/House/PDF/H372v8.pdf

Table 3: Future Managed Care Population Cohorts

Special Population	Standard Plan PHP Status for Contract Year 1
Standard Plan	Mandatory
Foster Children and Adopted Children	Excluded
BH I/DD Tailored Plan (including both non-dual and dual eligibles)	Exempt; choice of current delivery system or Standard Plan enrollment
Medicaid-only beneficiaries receiving long-stay nursing home services	Excluded
Dual Eligibles with full Medicaid benefits	Excluded

Please see Appendix B for detailed data summarization logic for the identification of the future managed care populations.

4.3 Excluded Populations

The following populations are permanently excluded from PHP enrollment, pursuant to S.L. 2015-245, as amended:

- Beneficiaries eligible for Medicare, but not full Medicaid benefits, including beneficiaries in those categories limited to Medicare cost sharing programs.
- Beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE).
- Beneficiaries enrolled in North Carolina's Health Insurance Premium Program.
- Beneficiaries enrolled in Medicaid for emergency services only.
- Medically needy beneficiaries.
- Beneficiaries eligible for family planning services only
- Beneficiaries who are inmates of prisons.
- Expenditures for periods of presumptive eligibility.
- Beneficiaries being served through the Community Alternatives Program for Children (CAP/C) waiver
- Beneficiaries being served through the Community Alternatives Program for Disabled Adults (CAP/DA) waiver

Additionally, refugees receiving coverage through the Refugee Medical Assistance program are excluded from PHP enrollment.

Please see Appendix B for the detailed data summarization logic for the identification of the permanently excluded populations.

5 SERVICE CATEGORIES

DHHS will reimburse PHPs using full-risk capitation payments for eligible services. Mercer has summarized the cost and utilization information from the historical FFS data and the LME/MCO encounter data into major COS.

The table below shows how the detailed service categories covered by the Standard Plans were grouped for purposes of this report and the exhibits in Section 7. Please refer to the Request for Proposal (RFP) for details on the covered and excluded services for the Standard Plan population.

Table 4: Standard Plan COS Groupings

COS Grouping	FFS Data Detailed COS	Encounter Data Detailed COS	Unit Type
Inpatient — Physical Health (PH)	Inpatient	N/A	Days
Inpatient — BH	N/A	Inpatient	Days
Outpatient Hospital	Outpatient	N/A	Visits
Emergency Room	Emergency Room	Emergency Room	Visits
Physician	Physician	N/A	Visits
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	FQHC RHC	N/A	Visits
Other Clinic	Free-standing Clinics Health Check — Health Department Family Planning Services	N/A	Visits
Other Practitioner	Chiropractic Podiatry	N/A	Visits
Therapies	Physical Therapy Speech Therapy Occupational Therapy	N/A	Visits
Prescribed Drugs	Prescribed Drugs	N/A	Scripts
Other BH Services	Mental Health services for non-LME/MCO population (Ages 0–3 and NC Health Choice)	Crisis Services Outpatient (including psychotherapy and alcohol/drug services) Partial Hospitalization	Procedure Count
Long Term Services and Supports (LTSS) Services	Home Health Hospice Nursing Home Personal Care	N/A	Procedure Count
Durable Medical Equipment	Durable Medical Equipment	N/A	Procedure Count
Lab and X-Ray[9]	Lab and X-Ray	N/A	Procedure Count
Optical	Optical, excluding costs for eyeglasses frames, lenses, lens treatments, fabrication and fittings	N/A	Procedure Count

[9] To support the data summarization process eviCore (previously MedSolutions) capitation payments for lab and radiology services were removed in order to not duplicate actual cost and utilization reflected in the FFS data.

COS Grouping	FFS Data Detailed COS	Encounter Data Detailed COS	Unit Type
Limited Dental Services[10]	Into the Mouth of Babes program	N/A	Procedure Count
Transportation	Ambulance NEMT	N/A	Claim Count
Medical Home Payments	Historical payments made to practices in Carolina ACCESS (CA) program (practices in CA I receive fees of $1.00 per member per month [PMPM] and practices in CA II receive fees of $2.50 or $5.00 PMPM)	N/A	Claim Count
Obstetric Care Management (OBCM) Payments	OBCM Payments	N/A	Claim Count
Care Coordination for Children (CC4C) Payments	CC4C Payments	N/A	Claim Count

Note that there are additional covered services specific to populations that will phase into managed care after Contract Year 1. Specifically, there are services unique to the BH I/DD Tailored Plan population and individuals enrolled in a 1915(c) waiver. See below for a list of covered services for the delayed populations that are assumed to not be covered under Standard Plans for purposes of these draft rates.

- The following Medicaid COS are proposed to be covered under the LME/MCOs and subsequently BH I/DD Tailored Plan, and not the Standard Plans:
    - 1915(b)(3) Services
    - Innovations Waiver Services
    - Intermediate Care Facility for beneficiaries with I/DDs
    - Traumatic Brain Injury (TBI) Waiver Services
    - Other BH Services
        - Assertive Community Treatment
        - Child and Adolescent Day Treatment Services
        - Community Support Team
        - Intensive In-home Services
        - Multi-systemic Therapy Services
        - Psychiatric Residential Treatment Facilities
        - Psychosocial Rehabilitation
        - Residential Treatment Facility Services
        - Substance Abuse Medically Monitored Residential Treatment
        - Substance Abuse Non-medical Community Residential Treatment
- The following COS are covered for the LTSS 1915(c) waiver populations, and thus excluded from Standard Plans in Contract Year 1:
    - CAP/C Waiver Services
    - CAP/DA Waiver Services

Covered services that are excluded from PHPs, and continue under FFS, are summarized below:

- Children's Developmental Services Agencies
- Dental services not identified in the COS table above
- Local Education Agency

[10] Costs associated with oral/maxillofacial surgery and adjunctive general dental services will be covered by PHPs when billed as a medical or professional claim; based on the COS mapping logic, these costs are captured in the above medical/professional service lines and thus not captured under the 'Limited Dental Services' COS.

- Optical services for eyeglasses frames, lenses, lens treatments, fabrication and fittings are considered non-covered services in this Rate Book, however this is subject to change pending legislation

As outlined in Table 4, Medical Home and Local Health Department (LHD) OBCM and CC4C PMPM payments are included in draft rate development since DHHS is requiring that PHPs continue these payments to those providers. Other historical payments made through Community Care of North Carolina (CCNC) were not included in the data summaries in Section 7 (identified as Excluded Patient-Centered Medical Home [PCMH] Payments in Appendix D). These costs were related to monthly per member payments to coordinate and manage care for members along with payments made to administer the Health Check and Pregnancy Medical Home (PMH) programs. Additionally, Mercer did not include costs related to case management for Human Immunodeficiency Virus (HIV) members as consideration for these care management activities is included as a non-benefit component of the rate development process.

Appendix D contains detailed coding logic used to define all detailed categories noted above.

6 HISTORICAL DATA ANALYSIS

This section provides an overview of the adjustments Mercer made to the data sources summarized in this report. These adjustments are reflected in the exhibits shown in Section 7.

6.1 MMs Adjustment

Medicaid eligibility data provided by DHHS was used to summarize MM information throughout this Rate Book. Use of this information ensures consistency in claims and MM summarization for the PMPM calculation. Mercer observed declines in eligibility counts in the later months of SFY 2017 when comparing to other eligibility data sources. Thus, Mercer calculated an adjustment to the MMs to account for the observed lag in the membership counts for more recent months in the base data.

The adjustment was developed based on a review of the enrollment trends by population for the July 2015 through September 2017 time period in the detailed Medicaid eligibility data compared to other State monthly Medicaid enrollment information available on the DHHS website[11]. Notable membership lag was observed beginning in February 2017 for the TANF population, while changes to the enrollment pattern for the ABD population were not observed until the last few months of SFY 2017. Mercer did not adjust the count of deliveries, tied to the Maternity Event payment, as these are calculated utilizing the live birth events as outlined in Section 4.

The tables below reflect the impact of the MM adjustment. Note that these MMs represent membership prior to the removal of MMs associated with the retroactive eligibility or application lag period.

Table 5: SFY 2017 Impact of MM Adjustment by COA

COA	Unadjusted MMs	Adjustment MMs	Final MMs
ABD	1,643,081	1,230	1,644,312
TANF, Newborn (<1)	849,190	516	849,705
TANF, Children (1-20)	13,251,138	90,754	13,341,893
TANF, Adults (21+)	2,871,705	42,871	2,914,576
Total Standard Plan	18,615,114	135,372	18,750,485

Table 6: SFY 2017 Impact of MM Adjustment by Month

Month	Unadjusted MMs	Adjustment MMs	Final MMs
July 2016	1,546,766	0	1,546,766
August 2016	1,554,328	0	1,554,328
September 2016	1,557,288	0	1,557,288
October 2016	1,557,384	0	1,557,384
November 2016	1,558,362	0	1,558,362
December 2016	1,557,646	0	1,557,646
January 2017	1,558,724	0	1,558,724
February 2017	1,556,196	10,449	1,566,645
March 2017	1,553,372	20,824	1,574,196
April 2017	1,544,809	30,600	1,575,409
May 2017	1,539,275	36,489	1,575,764

[11] https://dma.ncdhhs.gov/documents/medicaid-and-health-choice-enrollment-reports

Month	Unadjusted MMs	Adjustment MMs	Final MMs
June 2017	1,530,962	37,010	1,567,972
Total Standard Plan	18,615,114	135,372	18,750,485

6.2 Retroactive Eligibility and Application Period

The retroactive eligibility period reflects a period of Medicaid coverage that provides retrospective coverage of claims prior to the date of Medicaid application. In these instances, the PHPs are not responsible for coverage per legislation. In order to ensure the data summarization reflects only cost and utilization that will be the responsibility of the PHPs, an adjustment was applied to remove the cost, utilization and MMs associated with the retroactive eligibility period.

The application period represents the time between initial application for Medicaid eligibility and Medicaid eligibility determination. Proposed policy indicates that PHP enrollment and responsibility for beneficiaries will be effective the first day of the month of eligibility determination. Therefore, Mercer has excluded the application period from the base data, which is considered to be from the first of the month of the application filing up to the first of the month of eligibility determination.

Mercer received eligibility files from NC FAST that indicated recipient-level retroactive eligibility and application periods. Mercer used this information to identify the retroactive eligibility and application periods within the base data. The files provided by NC FAST were summarized based on disposition date, or date of eligibility determination, and went through June 2017. As such, a lag was observed in the data in more recent months for applications in which the eligibility determination had not yet been made. To account for this lag, Mercer leveraged the impact from the July through December 2016 time period and applied a similar impact to the January through June 2017 time period, where the lag was observed.

The tables below summarize the combined impact for the proposed Standard Plan population, by COA and by region. For the Standard Plan population, the retroactive eligibility period adjustment has a -1.3% and -1.0% PMPM impact in SFY 2016 and SFY 2017, respectively; and the application lag period adjustment has a -1.1% and -1.1% PMPM impact in SFY 2016 and SFY 2017, respectively. In total, for the Standard Plan population, this amounts to an overall PMPM impact of -2.3% and -2.1% in SFY 2016 and SFY 2017, respectively (as shown in the table below). The most impacted service for both the retroactive eligibility and application lag period combined was Inpatient — PH.

Table 7: Combined Impact of Retroactive Eligibility Period and Application Period Adjustments by COA

	SFY 2016			SFY 2017		
COA	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact
ABD	-7.5%	-4.0%	-3.7%	-6.6%	-3.1%	-3.7%
TANF, Newborn (<1)	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
TANF, Children (1-20)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TANF, Adults (21+)	-0.4%	-0.3%	-0.1%	-0.3%	-0.2%	-0.1%
Maternity Event	-0.5%	0.0%	-0.5%	-0.5%	0.0%	-0.5%
Total Standard Plan	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%

Table 8: Combined Impact of Retroactive Eligibility Period and Application Period Adjustments by Region

Region	SFY 2016			SFY 2017		
	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact	Aggregate Dollar Impact	Member Month Impact	PMPM/ Payment Impact
Region 1	-3.0%	-0.6%	-2.5%	-2.5%	-0.4%	-2.2%
Region 2	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%
Region 3	-2.7%	-0.4%	-2.4%	-2.2%	-0.3%	-1.9%
Region 4	-2.8%	-0.4%	-2.4%	-2.3%	-0.3%	-2.0%
Region 5	-2.6%	-0.4%	-2.2%	-2.4%	-0.3%	-2.1%
Region 6	-2.8%	-0.4%	-2.3%	-2.5%	-0.4%	-2.2%
Total Standard Plan	-2.8%	-0.4%	-2.3%	-2.4%	-0.3%	-2.1%

6.3 Completion Factors

The summarized data include claims for dates of service for SFY 2016 and SFY 2017. Mercer developed completion factors to estimate incurred-but-not-reported (IBNR) claims (those claims not yet adjudicated). The FFS data and the LME/MCO encounter data reflect payments through September 2017. The following factors are applied to both dollars and utilization.

Table 9: Completion Factors

COS	Data Factors	
	SFY 2016	SFY 2017
Inpatient — PH	1.008	1.065
Inpatient — BH	1.001	1.047
Outpatient Hospital	1.000	1.023
Emergency Room	1.000	1.026
Physician	1.001	1.030
FQHC/RHC	1.001	1.030
Other Clinic	1.001	1.029
Other Practitioner	1.001	1.030
Therapies	1.001	1.032
Prescribed Drugs	1.000	1.001
Other BH Services	1.001	1.010
LTSS Services	1.000	1.012
Durable Medical Equipment	1.000	1.026
Lab and X-Ray	1.000	1.026
Optical	1.000	1.024
Limited Dental Services	1.000	1.026
Transportation	1.000	1.051
Medical Home Payments	1.000	1.021
OCBM Payments	1.000	1.000
CC4C Payments	1.000	1.000
Total Standard Plan	1.001	1.024

6.4 GME Adjustment

DHHS will make GME payments directly to eligible hospitals, as permitted under 42 CFR 438.6(a). As a result, PHPs will not be required to make GME payments to hospitals. Under FFS, historically DHHS has reimbursed providers through both a GME add-on paid through the base rate captured in the historical FFS claims expenditures and as a part of the supplemental payments made outside of the claims system. As such, Mercer calculated an adjustment to exclude the GME portion of the Inpatient claims in the base FFS data. To calculate this adjustment, Mercer relied on the GME payment information provided by DHHS that listed GME add-on amount by hospital. The total historical GME add-on amount for all populations is approximately $90 million in both SFY 2016 and SFY 2017. Note that the impacts cited for the total population and in the table below are after the removal of the retroactive eligibility and application lag period. The table below illustrates the adjustment applied to each base year for the Standard Plan.

Table 10: GME Adjustment Impact

		SFY 2016		SFY 2017	
Region	COS	Dollar Amount	Percentage Impact	Dollar Amount	Percentage Impact
Region 1	Inpatient — PH	$(3,557,761)	-5.8%	$(3,199,160)	-5.1%
Region 2	Inpatient — PH	$(13,728,862)	-12.5%	$(14,306,477)	-12.4%
Region 3	Inpatient — PH	$(8,837,844)	-6.3%	$(8,328,723)	-5.8%
Region 4	Inpatient — PH	$(19,443,789)	-15.1%	$(20,482,036)	-15.0%
Region 5	Inpatient — PH	$(11,107,776)	-9.2%	$(12,062,262)	-9.6%
Region 6	Inpatient — PH	$(11,218,598)	-11.6%	$(11,527,158)	-11.6%
Total Standard Plan	Inpatient — PH	$(67,894,630)	-10.3%	$(69,905,815)	-10.2%

Please see Section 11.1 and Appendix G of this Rate Book for information on how GME will be factored into future hospital reimbursement requirements.

6.5 TPL Adjustment

The FFS claims data from NC Tracks reflects the reduction for TPL if the amount is reported on the claim submitted by the provider. However, NC Tracks data is not subsequently adjusted for TPL recoveries collected by DHHS. In the proposed policy, PHPs will have the responsibility of collecting TPL for all recovery types with the exception of Trust and Estate recoveries. The following table illustrates the total TPL recoveries for all populations (including those excluded from PHPs) by type for the SFY 2016 and SFY 2017 time periods for the recovery types to be collected by the PHPs.

Table 11: Total TPL Recovery Amounts

Recovery Type	SFY 2016 Recovery Amount	SFY 2017 Recovery Amount
Commercial Insurance	$(51,144,021)	$(52,255,224)
Medicare	$(1,620,651)	$(2,465,439)
Casualty	$(16,698,729)	$(18,021,105)
Credit Balance	$(7,603,627)	$(3,888,072)
Total	$(77,067,028)	$(76,629,840)

Mercer utilized TPL recovery information provided by DHHS to calculate a downward adjustment to reflect the TPL recoveries that are not present in the claims data and are anticipated to be collected by the PHPs. Mercer

leveraged member-level recovery information to allocate the adjustment by population. The table below illustrates the TPL recoveries removed for the Standard Plan population for the base time periods.

Table 12: TPL Adjustment Amount for Standard Plan Population

COA	SFY 2016 Dollar Adjustment	SFY 2017 Dollar Adjustment
ABD	$(9,106,020)	$(7,005,985)
TANF, Newborn (<1)	$(1,405,814)	$(241,136)
TANF, Children (1-20)	$(12,680,291)	$(13,593,281)
TANF, Adults (21+)	$(8,683,166)	$(8,087,896)
Maternity Event	$(2,503,874)	$(2,393,280)
Total Standard Plan	$(34,379,165)	$(31,321,578)

6.6 NEMT Adjustment

Historically, payments for NEMT providers were processed outside of NC Tracks; DHHS supplied information on NEMT payments for the SFY 2016 and SFY 2017 time periods. Effective September 2016, DHHS began to process NEMT payments for pilot counties through NC Tracks. Mercer leveraged the SFY 2016 and SFY 2017 NEMT payments provided by DHHS and the distribution of NEMT costs after September 2016 in the FFS data to allocate the historical NEMT costs across the population groupings. Mercer leveraged the PMPM for the piloted counties within a region to project the costs for counties without SFY 2017 claims experience.

The total NEMT spend across all populations is approximately $60 million in both SFY 2016 and SFY 2017. For SFY 2016, Mercer built in the full NEMT costs provided by DHHS, and for SFY 2017 Mercer built in the difference between the full NEMT costs provided by DHHS and the amount reflected in the base FFS experience given the pilot began during the SFY 2017 time period. The table below illustrates the allocated NEMT costs for the Standard Plan population for the base time periods.

Table 13: NEMT Adjustment Amount

	SFY 2016	SFY 2017		
COA	Total Dollars	Base FFS Dollars	Adjustment Dollars	Total Dollars
ABD	$8,374,742	$1,551,023	$7,041,725	$8,592,747
TANF, Newborn (<1)	$117,353	$21,397	$99,011	$120,407
TANF, Children (1-20)	$1,318,991	$244,962	$1,108,364	$1,353,326
TANF, Adults (21+)	$1,552,060	$314,757	$1,277,705	$1,592,462
Maternity Event	$899	$179	$744	$922
Total Standard Plan	$11,364,044	$2,132,317	$9,527,548	$11,659,865

6.7 Fraud, Waste and Abuse Recoveries Adjustment

CMS is committed to combating Medicaid provider fraud, waste and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees[12]. Based on information provided by DHHS, the total annual recovery amount was $28.6 million in SFY 2016 and $8.0 million in SFY 2017. Mercer is working with DHHS to obtain more detailed information related to fraud, waste and abuse recoveries for Medicaid and NC Health Choice beneficiaries under the FFS program, and how these recoveries may be attributable to covered populations and services. Note that based on the annual recovery information above,

[12] https://www.medicaid.gov/medicaid/program-integrity/index.html

this could necessitate up to a 0.6% downward adjustment to the Standard Plan population claims; however, at this point no adjustment has been applied to the base data.

6.8 LME/MCO Data Adjustments

The following represents adjustments specific to the LME/MCO encounter data.

6.8.1 Patient Liability Adjustment

In the North Carolina BH managed care program operated by the LME/MCOs under concurrent 1915(b)/(c) waiver authority, certain beneficiaries receiving services in Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IIDs) have patient liability responsibilities through post-eligibility treatment of income to contribute to the reimbursement of their services. In the Medicaid FFS program, the ICF/IID collects these patient liability payments directly from the beneficiary and submits a FFS claim to Medicaid identifying the collected patient liability and the remaining expense eligible for Medicaid reimbursement.

Under the LME/MCO BH managed care program, DHHS has been following a similar transactional process, where the ICF/IID continues to collect the patient liability directly from the beneficiary and submits a claim to the LME/MCO for the balance of the charges. Mercer has reviewed the patient liability required for the impacted beneficiaries each month from the statewide eligibility file and compared to the patient liability collected and documented by the LME/MCO. Based on this review of ICF/IID encounter claims, an adjustment was made to account for the difference between the required amount and reported amount of patient liability observed in the documentation provided by the LME/MCO. The adjustment ensures the base data reflects claims expenses that are the responsibility of the LME/MCOs.

The patient liability adjustment is applied to the LTSS Services COS, for LME/MCO beneficiaries. As mentioned, this adjustment is only applicable to the LME/MCO encounter data since there is a process in place to account for patient liability during FFS claims processing. The overall impact across all populations is approximately $(30,000) in SFY 2016 and SFY 2017, which rounds to a 0.0% overall adjustment in each year. There is no impact to the Standard Plan population for this adjustment; however, the impact applies to future managed care populations.

6.8.2 Payments Made Outside of the Claims System

LME/MCOs have historically documented payments for services paid outside of the claims system that were not otherwise represented in the base data. LME/MCOs provided Mercer with documentation of these payments by COS and date of service. Mercer used this information to build in an adjustment to the historical experience to ensure that the data was fully representative of all BH service costs. For the Standard Plan, this adjustment increased the SFY 2016 and SFY 2017 LME/MCO BH encounter data by approximately 1.5% each year, which rounds to a 0.0% adjustment as a percentage of total Standard Plan program costs (both FFS claims and LME/MCO BH encounter data).

7 HISTORICAL DATA EXHIBITS

Mercer summarized the base data experience for the Standard Plan population in the following exhibits. These summaries reflect the base data adjustments outlined in Section 6 of the narrative and are shown on a regional basis.

The top of each exhibit includes the following identifying information:

- Time Period: SFY 2016 or SFY 2017
- Region: Regional breakouts based on Section 3 of the narrative
- COA: Specific COA group for the Standard Plan population as defined in Section 4.1 of the narrative:
    - ABD
    - TANF
    - Maternity Event
    - All COAs combined
- Age Grouping: Specific age groups as defined in Section 4.1 of the narrative

Below the population criteria is information on the following metrics associated with the population selections:

- MMs/Deliveries: MMs reflect a count of monthly eligibles for the historical time period; Deliveries represents the count of live birth events related to the Maternity Event payment.
- Average Monthly Members/Deliveries: MMs or Deliveries divided by 12.
- Eligibles: Reflect a unique count of eligibles for the time period and population indicated.
- COS: As described in Section 5, each of the covered services is listed.
- Incurred Claims: Amount paid for each service line item based on the paid amount field included in both the FFS data provided by DHHS and the encounter data provided by the LME/MCOs; these amounts are based on date of service and reflect the applicable data adjustments outlined in Section 6.
- Utilization: Utilization for each service line item. This represents the number of visits, days, services or scripts for each category as reported in the data after application of adjustments outlined in Section 6; see Table 4 in Section 5 for the unit types used to define utilization for the various service categories.
- Users: Unique user count for each service.
- Utilization per 1,000: Annual utilization for each service divided by total MMs multiplied by 12,000.
- Unit Cost: Average cost of each service line item; paid claims divided by the utilization of services delivered.
- PMPM/Payment: PMPM is the incurred claims divided by total MMs; the Maternity Event payment is the incurred claims divided by the Deliveries.

7.1 SFY 2016 Exhibits

Cost and utilization information for the July 1, 2015 through June 30, 2016 (SFY 2016) time period is illustrated in Section 7.1.

7.1.1 SFY 2016 Region 1 Exhibits

Exhibit 1

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	148,496
Average Monthly Members/Deliveries:	12,375
Eligibles:	15,638

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,105,350	18,289	2,317	1,478	$ 1,044.61	$ 128.66
Inpatient — BH	$ 1,201,247	1,421	266	115	$ 845.37	$ 8.09
Outpatient Hospital	$ 17,235,526	41,158	8,846	3,326	$ 418.77	$ 116.07
Emergency Room	$ 8,978,926	18,173	6,929	1,469	$ 494.07	$ 60.47
Physician	$ 15,472,795	116,916	11,959	9,448	$ 132.34	$ 104.20
FQHC/RHC	$ 1,758,848	13,792	3,255	1,115	$ 127.53	$ 11.84
Other Clinic	$ 1,020,955	3,751	2,332	303	$ 272.15	$ 6.88
Other Practitioner	$ 168,032	2,191	616	177	$ 76.71	$ 1.13
Therapies	$ 334,646	3,156	162	255	$ 106.03	$ 2.25
Prescribed Drugs	$ 62,314,043	493,975	11,989	39,918	$ 126.15	$ 419.63
Other BH Services	$ 2,025,598	34,240	2,999	2,767	$ 59.16	$ 13.64
LTSS Services	$ 5,302,014	710,667	1,080	57,429	$ 163.71	$ 35.70
Durable Medical Equipment	$ 5,090,039	1,759,092	3,861	142,152	$ 2.89	$ 34.28
Limited Dental Services	$ 2,184	89	34	7	$ 24.53	$ 0.01
Optical	$ 126,122	1,834	1,160	148	$ 68.78	$ 0.85
Lab and X-Ray	$ 1,412,335	74,497	5,008	6,020	$ 18.96	$ 9.51
Transportation	$ 1,619,999	27,127	2,470	2,192	$ 59.72	$ 10.91
Subtotal (Medical)	$ 143,168,658	3,320,368	13,675			$ 964.12
CC4C LHD Payments	$ 713	158	N/A	13	$ 4.51	$ 0.00
OBCM LHD Payments	$ 115,319	23,487	N/A	1,898	$ 4.91	$ 0.78
Medical Home Payments	$ 559,250	120,171	N/A	9,711	$ 4.65	$ 3.77
Subtotal (LHD/Medical Home Payments)	$ 675,282	143,816	N/A			$ 4.55
Total (Medical + LHD/Medical Home)	$ 143,843,939	3,464,184	N/A			$ 968.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 2

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	83,575
Average Monthly Members/Deliveries:	6,965
Eligibles:	13,657

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,843,523	24,693	6,054	3,546	$ 641.62	$ 189.57
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,539,559	9,727	3,955	1,397	$ 158.28	$ 18.42
Emergency Room	$ 1,395,662	6,016	3,603	864	$ 232.00	$ 16.70
Physician	$ 6,139,695	71,067	11,516	10,204	$ 86.39	$ 73.46
FQHC/RHC	$ 780,550	6,193	1,280	889	$ 126.04	$ 9.34
Other Clinic	$ 2,881,190	30,145	10,345	4,328	$ 95.58	$ 34.47
Other Practitioner	$ 5,002	164	47	24	$ 30.47	$ 0.06
Therapies	$ 67,043	812	175	117	$ 82.61	$ 0.80
Prescribed Drugs	$ 1,121,377	26,052	6,772	3,741	$ 43.04	$ 13.42
Other BH Services	$ 3,964	239	8	34	$ 16.58	$ 0.05
LTSS Services	$ 175,369	4,931	230	708	$ 35.56	$ 2.10
Durable Medical Equipment	$ 781,572	185,881	1,506	26,690	$ 4.20	$ 9.35
Limited Dental Services	$ 142,761	5,779	2,399	830	$ 24.71	$ 1.71
Optical	$ 787	10	8	1	$ 78.73	$ 0.01
Lab and X-Ray	$ 42,938	2,116	1,058	304	$ 20.29	$ 0.51
Transportation	$ 103,428	1,204	346	173	$ 85.92	$ 1.24
Subtotal (Medical)	$ 31,024,420	375,027	12,602			$ 371.22
CC4C LHD Payments	$ 373,167	82,565	N/A	11,855	$ 4.52	$ 4.47
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 156,930	64,349	N/A	9,240	$ 2.44	$ 1.88
Subtotal (LHD/Medical Home Payments)	$ 530,097	146,914	N/A			$ 6.34
Total (Medical + LHD/Medical Home)	$ 31,554,518	521,941	N/A			$ 377.56

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 3

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,201,019
Average Monthly Members/Deliveries:	100,085
Eligibles:	118,468

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 4,512,089	4,336	959	43	$ 1,040.71	$ 3.76
Inpatient — BH	$ 1,092,262	1,243	190	12	$ 878.76	$ 0.91
Outpatient Hospital	$ 19,020,503	81,676	33,437	816	$ 232.88	$ 15.84
Emergency Room	$ 14,661,088	49,031	30,011	490	$ 299.01	$ 12.21
Physician	$ 25,651,627	366,338	83,459	3,660	$ 70.02	$ 21.36
FQHC/RHC	$ 4,563,549	32,924	11,155	329	$ 138.61	$ 3.80
Other Clinic	$ 6,679,000	63,001	52,689	629	$ 106.01	$ 5.56
Other Practitioner	$ 232,590	4,191	1,271	42	$ 55.50	$ 0.19
Therapies	$ 4,131,823	41,538	3,061	415	$ 99.47	$ 3.44
Prescribed Drugs	$ 47,024,745	496,715	72,501	4,963	$ 94.67	$ 39.15
Other BH Services	$ 8,499,056	113,879	9,648	1,138	$ 74.63	$ 7.08
LTSS Services	$ 439,129	39,450	47	394	$ 133.93	$ 0.37
Durable Medical Equipment	$ 2,742,607	780,094	6,983	7,794	$ 3.52	$ 2.28
Limited Dental Services	$ 350,099	14,214	5,703	142	$ 24.63	$ 0.29
Optical	$ 1,118,143	13,563	12,457	136	$ 82.44	$ 0.93
Lab and X-Ray	$ 765,815	44,454	10,447	444	$ 17.23	$ 0.64
Transportation	$ 621,485	9,108	2,042	91	$ 68.23	$ 0.52
Subtotal (Medical)	$ 142,105,609	2,155,755	99,252			$ 118.32
CC4C LHD Payments	$ 1,263,406	280,424	N/A	2,802	$ 4.51	$ 1.05
OBCM LHD Payments	$ 712,572	145,411	N/A	1,453	$ 4.90	$ 0.59
Medical Home Payments	$ 2,574,411	1,057,454	N/A	10,566	$ 2.43	$ 2.14
Subtotal (LHD/Medical Home Payments)	$ 4,550,389	1,483,289	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 146,655,997	3,639,044	N/A			$ 122.11

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 4

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	276,458
Average Monthly Members/Deliveries:	23,038
Eligibles:	34,961

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,333,312	6,379	1,315	277	$ 1,149.59	$ 26.53
Inpatient — BH	$ 920,217	1,163	245	50	$ 790.96	$ 3.33
Outpatient Hospital	$ 13,668,579	45,643	15,014	1,981	$ 299.47	$ 49.44
Emergency Room	$ 12,332,425	29,363	12,806	1,275	$ 419.99	$ 44.61
Physician	$ 11,676,538	115,387	21,729	5,008	$ 101.19	$ 42.24
FQHC/RHC	$ 1,677,174	13,147	4,374	571	$ 127.57	$ 6.07
Other Clinic	$ 2,510,068	10,784	8,093	468	$ 232.75	$ 9.08
Other Practitioner	$ 138,640	2,652	837	115	$ 52.28	$ 0.50
Therapies	$ 51	1	1	0	$ 51.06	$ 0.00
Prescribed Drugs	$ 24,434,442	335,088	20,962	14,545	$ 72.92	$ 88.38
Other BH Services	$ 1,973,518	27,250	3,895	1,183	$ 72.42	$ 7.14
LTSS Services	$ 357,563	26,745	154	1,161	$ 181.27	$ 1.29
Durable Medical Equipment	$ 1,452,570	648,631	2,749	28,155	$ 2.24	$ 5.25
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 88,942	1,303	854	57	$ 68.23	$ 0.32
Lab and X-Ray	$ 2,762,326	132,365	10,539	5,745	$ 20.87	$ 9.99
Transportation	$ 513,916	7,358	1,767	319	$ 69.84	$ 1.86
Subtotal (Medical)	$ 81,840,280	1,403,259	27,307			$ 296.03
CC4C LHD Payments	$ 9	2	N/A	0	$ 4.40	$ 0.00
OBCM LHD Payments	$ 943,885	193,057	N/A	8,380	$ 4.89	$ 3.41
Medical Home Payments	$ 434,796	184,182	N/A	7,995	$ 2.36	$ 1.57
Subtotal (LHD/Medical Home Payments)	$ 1,378,690	377,241	N/A			$ 4.99
Total (Medical + LHD/Medical Home)	$ 83,218,970	1,780,500	N/A			$ 301.02

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 5

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	5,294
Average Monthly Members/Deliveries:	441
Eligibles:	5,450

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,649,440	14,314	5,168	32,444	$ 744.00	$ 2,011.54
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,317,698	18,194	2,660	41,238	$ 127.39	$ 437.78
Emergency Room	$ 1,333,244	4,004	547	9,076	$ 332.97	$ 251.83
Physician	$ 8,048,706	41,885	5,081	94,939	$ 192.16	$ 1,520.29
FQHC/RHC	$ 838,583	5,266	474	11,936	$ 159.24	$ 158.40
Other Clinic	$ 952,430	7,788	1,254	17,653	$ 122.29	$ 179.90
Other Practitioner	$ 322	12	48	27	$ 26.86	$ 0.06
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 9,645	2,038	8	4,619	$ 4.73	$ 1.82
Durable Medical Equipment	$ 29,121	333	164	755	$ 87.42	$ 5.50
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 200	2	12	5	$ 100.04	$ 0.04
Lab and X-Ray	$ 155,314	7,930	719	17,975	$ 19.58	$ 29.34
Transportation	$ 64,394	604	225	1,369	$ 106.59	$ 12.16
Subtotal (Medical)	$ 24,399,097	102,371	5,416			$ 4,608.67
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 24,399,097	102,371	N/A			$ 4,608.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 6

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	1,709,548
Average Monthly Members/Deliveries:	142,462
Eligibles:	188,174

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 57,443,714	68,011	15,813	477	$ 844.63	$ 33.60
Inpatient — BH	$ 3,213,725	3,827	702	27	$ 839.67	$ 1.88
Outpatient Hospital	$ 53,781,865	196,396	63,912	1,379	$ 273.84	$ 31.46
Emergency Room	$ 38,701,344	106,588	53,896	748	$ 363.09	$ 22.64
Physician	$ 66,989,361	711,593	133,744	4,995	$ 94.14	$ 39.19
FQHC/RHC	$ 9,618,704	71,321	20,538	501	$ 134.86	$ 5.63
Other Clinic	$ 14,043,642	115,470	74,713	811	$ 121.62	$ 8.21
Other Practitioner	$ 544,586	9,209	2,819	65	$ 59.13	$ 0.32
Therapies	$ 4,533,563	45,506	3,399	319	$ 99.63	$ 2.65
Prescribed Drugs	$ 134,894,607	1,351,830	115,478	9,489	$ 99.79	$ 78.91
Other BH Services	$ 12,502,136	175,608	16,703	1,233	$ 71.19	$ 7.31
LTSS Services	$ 6,283,719	783,831	1,519	5,502	$ 164.47	$ 3.68
Durable Medical Equipment	$ 10,095,909	3,374,031	15,263	23,684	$ 2.99	$ 5.91
Limited Dental Services	$ 495,044	20,082	8,136	141	$ 24.65	$ 0.29
Optical	$ 1,334,194	16,712	14,491	117	$ 79.83	$ 0.78
Lab and X-Ray	$ 5,138,727	261,362	27,771	1,835	$ 19.66	$ 3.01
Transportation	$ 2,923,222	45,401	6,850	319	$ 64.39	$ 1.71
Subtotal (Medical)	$ 422,538,064	7,356,779	158,137			$ 247.16
CC4C LHD Payments	$ 1,637,295	363,149	N/A	2,549	$ 4.51	$ 0.96
OBCM LHD Payments	$ 1,771,776	361,955	N/A	2,541	$ 4.90	$ 1.04
Medical Home Payments	$ 3,725,386	1,426,156	N/A	10,011	$ 2.61	$ 2.18
Subtotal (LHD/Medical Home Payments)	$ 7,134,457	2,151,260	N/A			$ 4.17
Total (Medical + LHD/Medical Home)	$ 429,672,521	9,508,039	N/A			$ 251.34

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.2 SFY 2016 Region 2 Exhibits

Exhibit 7

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	265,984
Average Monthly Members/Deliveries:	22,165
Eligibles:	26,813

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 34,460,023	35,532	3,810	1,603	$ 969.84	$ 129.56
Inpatient — BH	$ 1,591,719	2,368	421	107	$ 672.19	$ 5.98
Outpatient Hospital	$ 29,418,670	61,032	12,528	2,754	$ 482.02	$ 110.60
Emergency Room	$ 16,700,555	32,769	11,885	1,478	$ 509.65	$ 62.79
Physician	$ 26,666,391	202,317	20,595	9,128	$ 131.81	$ 100.26
FQHC/RHC	$ 521,458	4,427	1,393	200	$ 117.79	$ 1.96
Other Clinic	$ 2,193,531	7,421	4,322	335	$ 295.60	$ 8.25
Other Practitioner	$ 200,337	2,660	1,069	120	$ 75.32	$ 0.75
Therapies	$ 713,572	5,980	392	270	$ 119.33	$ 2.68
Prescribed Drugs	$ 106,617,766	754,878	19,990	34,057	$ 141.24	$ 400.84
Other BH Services	$ 3,747,230	65,003	5,475	2,933	$ 57.65	$ 14.09
LTSS Services	$ 15,890,578	2,957,310	2,224	133,421	$ 162.49	$ 59.74
Durable Medical Equipment	$ 9,568,592	3,084,897	6,221	139,177	$ 3.10	$ 35.97
Limited Dental Services	$ 11,494	468	166	21	$ 24.55	$ 0.04
Optical	$ 229,609	3,217	2,035	145	$ 71.37	$ 0.86
Lab and X-Ray	$ 3,294,326	182,351	10,915	8,227	$ 18.07	$ 12.39
Transportation	$ 3,190,015	35,059	4,098	1,582	$ 90.99	$ 11.99
Subtotal (Medical)	$ 255,015,865	7,437,689	23,086			$ 958.77
CC4C LHD Payments	$ 2,122	470	N/A	21	$ 4.51	$ 0.01
OBCM LHD Payments	$ 215,412	43,873	N/A	1,979	$ 4.91	$ 0.81
Medical Home Payments	$ 1,055,887	226,172	N/A	10,204	$ 4.67	$ 3.97
Subtotal (LHD/Medical Home Payments)	$ 1,273,422	270,515	N/A			$ 4.79
Total (Medical + LHD/Medical Home)	$ 256,289,287	7,708,204	N/A			$ 963.55

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 8

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	147,905
Average Monthly Members/Deliveries:	12,325
Eligibles:	24,147

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 22,543,143	41,308	11,016	3,351	$ 545.74	$ 152.42
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,886,093	12,602	5,242	1,022	$ 149.67	$ 12.75
Emergency Room	$ 3,196,619	12,729	7,369	1,033	$ 251.13	$ 21.61
Physician	$ 10,165,211	122,217	20,585	9,916	$ 83.17	$ 68.73
FQHC/RHC	$ 571,259	5,220	1,340	423	$ 109.44	$ 3.86
Other Clinic	$ 5,576,307	54,182	19,221	4,396	$ 102.92	$ 37.70
Other Practitioner	$ 1,440	34	13	3	$ 42.30	$ 0.01
Therapies	$ 90,341	841	144	68	$ 107.47	$ 0.61
Prescribed Drugs	$ 1,686,718	43,580	12,060	3,536	$ 38.70	$ 11.40
Other BH Services	$ 6,402	273	54	22	$ 23.45	$ 0.04
LTSS Services	$ 173,286	14,131	119	1,146	$ 12.26	$ 1.17
Durable Medical Equipment	$ 968,409	48,192	1,783	3,910	$ 20.09	$ 6.55
Limited Dental Services	$ 357,285	14,429	6,074	1,171	$ 24.76	$ 2.42
Optical	$ 4,688	51	38	4	$ 91.89	$ 0.03
Lab and X-Ray	$ 111,634	8,204	3,909	666	$ 13.61	$ 0.75
Transportation	$ 144,799	1,498	711	121	$ 96.69	$ 0.98
Subtotal (Medical)	$ 47,483,633	379,490	22,433			$ 321.04
CC4C LHD Payments	$ 658,149	145,621	N/A	11,815	$ 4.52	$ 4.45
OBCM LHD Payments	$ 10	2	N/A	0	$ 4.94	$ 0.00
Medical Home Payments	$ 278,570	112,822	N/A	9,154	$ 2.47	$ 1.88
Subtotal (LHD/Medical Home Payments)	$ 936,729	258,445	N/A			$ 6.33
Total (Medical + LHD/Medical Home)	$ 48,420,362	637,935	N/A			$ 327.37

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 9

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,211,702
Average Monthly Members/Deliveries:	184,308
Eligibles:	216,119

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,910,920	7,935	1,859	43	$ 1,249.08	$ 4.48
Inpatient — BH	$ 2,050,152	3,076	490	17	$ 666.45	$ 0.93
Outpatient Hospital	$ 21,420,811	97,832	42,351	531	$ 218.96	$ 9.69
Emergency Room	$ 29,933,020	96,253	59,143	522	$ 310.98	$ 13.53
Physician	$ 41,004,876	612,460	151,606	3,323	$ 66.95	$ 18.54
FQHC/RHC	$ 2,741,954	25,439	12,228	138	$ 107.78	$ 1.24
Other Clinic	$ 13,199,664	124,161	101,404	674	$ 106.31	$ 5.97
Other Practitioner	$ 248,666	3,292	1,385	18	$ 75.53	$ 0.11
Therapies	$ 6,201,731	51,490	3,753	279	$ 120.45	$ 2.80
Prescribed Drugs	$ 76,749,940	849,725	128,693	4,610	$ 90.32	$ 34.70
Other BH Services	$ 9,856,914	135,954	12,698	738	$ 72.50	$ 4.46
LTSS Services	$ 314,012	32,585	103	177	$ 133.53	$ 0.14
Durable Medical Equipment	$ 4,026,763	1,414,058	11,181	7,672	$ 2.85	$ 1.82
Limited Dental Services	$ 934,170	37,626	14,186	204	$ 24.83	$ 0.42
Optical	$ 2,194,008	26,197	22,729	142	$ 83.75	$ 0.99
Lab and X-Ray	$ 4,162,080	234,768	41,416	1,274	$ 17.73	$ 1.88
Transportation	$ 915,674	9,929	3,994	54	$ 92.22	$ 0.41
Subtotal (Medical)	$ 225,865,354	3,762,781	177,918			$ 102.12
CC4C LHD Payments	$ 2,352,092	522,058	N/A	2,833	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,304,330	266,155	N/A	1,444	$ 4.90	$ 0.59
Medical Home Payments	$ 4,893,899	1,997,152	N/A	10,836	$ 2.45	$ 2.21
Subtotal (LHD/Medical Home Payments)	$ 8,550,322	2,785,365	N/A			$ 3.87
Total (Medical + LHD/Medical Home)	$ 234,415,675	6,548,146	N/A			$ 105.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 10

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	458,696
Average Monthly Members/Deliveries:	38,225
Eligibles:	56,407

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,383,199	10,526	2,253	275	$ 1,081.46	$ 24.82
Inpatient — BH	$ 1,001,470	1,435	382	38	$ 697.65	$ 2.18
Outpatient Hospital	$ 16,008,748	48,723	19,170	1,275	$ 328.56	$ 34.90
Emergency Room	$ 21,734,187	48,143	22,568	1,259	$ 451.45	$ 47.38
Physician	$ 22,293,837	205,138	37,613	5,367	$ 108.68	$ 48.60
FQHC/RHC	$ 322,203	3,026	1,270	79	$ 106.48	$ 0.70
Other Clinic	$ 3,704,218	16,437	13,051	430	$ 225.36	$ 8.08
Other Practitioner	$ 186,991	2,824	1,046	74	$ 66.22	$ 0.41
Therapies	$ 76	2	2	0	$ 37.96	$ 0.00
Prescribed Drugs	$ 45,602,993	542,304	34,295	14,187	$ 84.09	$ 99.42
Other BH Services	$ 3,167,099	43,239	5,095	1,131	$ 73.25	$ 6.90
LTSS Services	$ 900,145	159,622	295	4,176	$ 153.01	$ 1.96
Durable Medical Equipment	$ 2,350,540	1,067,373	4,033	27,924	$ 2.20	$ 5.12
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 198,761	2,959	1,410	77	$ 67.17	$ 0.43
Lab and X-Ray	$ 7,248,529	364,088	23,501	9,525	$ 19.91	$ 15.80
Transportation	$ 1,094,182	11,835	3,249	310	$ 92.45	$ 2.39
Subtotal (Medical)	$ 137,197,178	2,527,674	44,664			$ 299.10
CC4C LHD Payments	$ 31	7	N/A	0	$ 4.42	$ 0.00
OBCM LHD Payments	$ 1,643,881	336,202	N/A	8,795	$ 4.89	$ 3.58
Medical Home Payments	$ 739,829	314,517	N/A	8,228	$ 2.35	$ 1.61
Subtotal (LHD/Medical Home Payments)	$ 2,383,741	650,726	N/A			$ 5.20
Total (Medical + LHD/Medical Home)	$ 139,580,919	3,178,400	N/A			$ 304.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 11

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,229
Average Monthly Members/Deliveries:	769
Eligibles:	9,459

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 17,105,261	25,310	8,954	32,910	$ 675.82	$ 1,853.47
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,496,038	28,212	3,612	36,684	$ 123.92	$ 378.82
Emergency Room	$ 3,325,977	10,840	1,460	14,095	$ 306.82	$ 360.39
Physician	$ 15,821,943	68,707	9,073	89,339	$ 230.28	$ 1,714.41
FQHC/RHC	$ 64,073	470	37	612	$ 136.23	$ 6.94
Other Clinic	$ 605,022	4,201	2,196	5,463	$ 144.00	$ 65.56
Other Practitioner	$ 286	11	16	14	$ 26.00	$ 0.03
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 87	1	153	1	$ 87.19	$ 0.01
LTSS Services	$ 10,526	581	13	756	$ 18.12	$ 1.14
Durable Medical Equipment	$ 23,082	641	207	834	$ 35.99	$ 2.50
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 79	1	24	1	$ 78.45	$ 0.01
Lab and X-Ray	$ 250,289	15,088	2,205	19,619	$ 16.59	$ 27.12
Transportation	$ 104,097	1,085	520	1,410	$ 95.97	$ 11.28
Subtotal (Medical)	$ 40,806,760	155,150	9,401			$ 4,421.68
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 40,806,760	155,150	N/A			$ 4,421.68

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 12

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,084,286
Average Monthly Members/Deliveries:	257,024
Eligibles:	332,945

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 95,402,547	120,610	27,892	469	$ 791.00	$ 30.93
Inpatient — BH	$ 4,643,341	6,880	1,296	27	$ 674.94	$ 1.51
Outpatient Hospital	$ 72,230,360	248,402	82,903	966	$ 290.78	$ 23.42
Emergency Room	$ 74,890,358	200,734	102,425	781	$ 373.08	$ 24.28
Physician	$ 115,952,258	1,210,839	239,472	4,711	$ 95.76	$ 37.59
FQHC/RHC	$ 4,220,946	38,583	16,268	150	$ 109.40	$ 1.37
Other Clinic	$ 25,278,741	206,402	140,194	803	$ 122.47	$ 8.20
Other Practitioner	$ 637,719	8,821	3,529	34	$ 72.30	$ 0.21
Therapies	$ 7,005,720	58,312	4,293	227	$ 120.14	$ 2.27
Prescribed Drugs	$ 230,657,416	2,190,487	201,214	8,523	$ 105.30	$ 74.78
Other BH Services	$ 16,777,732	244,470	23,475	951	$ 68.63	$ 5.44
LTSS Services	$ 17,288,547	3,164,229	2,754	12,311	$ 161.55	$ 5.61
Durable Medical Equipment	$ 16,937,386	5,615,162	23,425	21,847	$ 3.02	$ 5.49
Limited Dental Services	$ 1,302,949	52,523	20,426	204	$ 24.81	$ 0.42
Optical	$ 2,627,144	32,425	26,236	126	$ 81.02	$ 0.85
Lab and X-Ray	$ 15,066,858	804,500	81,946	3,130	$ 18.73	$ 4.89
Transportation	$ 5,448,766	59,406	12,572	231	$ 91.72	$ 1.77
Subtotal (Medical)	$ 706,368,789	14,262,784	277,162			$ 229.02
CC4C LHD Payments	$ 3,012,394	668,156	N/A	2,600	$ 4.51	$ 0.98
OBCM LHD Payments	$ 3,163,634	646,232	N/A	2,514	$ 4.90	$ 1.03
Medical Home Payments	$ 6,968,186	2,650,663	N/A	10,313	$ 2.63	$ 2.26
Subtotal (LHD/Medical Home Payments)	$ 13,144,214	3,965,051	N/A			$ 4.26
Total (Medical + LHD/Medical Home)	$ 719,513,002	18,227,835	N/A			$ 233.28

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.3 SFY 2016 Region 3 Exhibits

Exhibit 13

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	325,282
Average Monthly Members/Deliveries:	27,107
Eligibles:	33,445

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 44,947,199	47,286	4,785	1,744	$ 950.54	$ 138.18
Inpatient — BH	$ 2,222,641	3,870	521	143	$ 574.31	$ 6.83
Outpatient Hospital	$ 32,951,616	75,421	16,183	2,782	$ 436.90	$ 101.30
Emergency Room	$ 22,924,088	44,473	15,197	1,641	$ 515.46	$ 70.47
Physician	$ 36,833,898	276,265	25,568	10,192	$ 133.33	$ 113.24
FQHC/RHC	$ 986,695	9,228	2,924	340	$ 106.92	$ 3.03
Other Clinic	$ 3,142,908	7,396	4,751	273	$ 424.97	$ 9.66
Other Practitioner	$ 304,312	4,082	1,380	151	$ 74.56	$ 0.94
Therapies	$ 1,247,469	11,050	630	408	$ 112.90	$ 3.84
Prescribed Drugs	$ 137,286,703	922,617	24,769	34,036	$ 148.80	$ 422.05
Other BH Services	$ 4,928,674	110,375	7,007	4,072	$ 44.65	$ 15.15
LTSS Services	$ 29,482,325	5,931,807	3,628	218,831	$ 163.66	$ 90.64
Durable Medical Equipment	$ 13,641,280	4,001,788	7,689	147,630	$ 3.41	$ 41.94
Limited Dental Services	$ 8,063	325	116	12	$ 24.80	$ 0.02
Optical	$ 226,009	3,221	1,847	119	$ 70.16	$ 0.69
Lab and X-Ray	$ 3,652,850	198,454	11,618	7,321	$ 18.41	$ 11.23
Transportation	$ 3,489,633	55,881	5,352	2,061	$ 62.45	$ 10.73
Subtotal (Medical)	$ 338,276,362	11,703,538	28,891			$ 1,039.95
CC4C LHD Payments	$ 1,763	391	N/A	14	$ 4.51	$ 0.01
OBCM LHD Payments	$ 260,916	53,141	N/A	1,960	$ 4.91	$ 0.80
Medical Home Payments	$ 1,278,833	268,380	N/A	9,901	$ 4.77	$ 3.93
Subtotal (LHD/Medical Home Payments)	$ 1,541,513	321,912	N/A			$ 4.74
Total (Medical + LHD/Medical Home)	$ 339,817,875	12,025,450	N/A			$ 1,044.69

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 14

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	217,948
Average Monthly Members/Deliveries:	18,162
Eligibles:	35,611

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 34,656,427	62,472	16,039	3,440	$ 554.75	$ 159.01
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,252,725	14,087	7,895	776	$ 159.91	$ 10.34
Emergency Room	$ 4,884,408	19,056	11,005	1,049	$ 256.32	$ 22.41
Physician	$ 15,509,201	181,531	30,438	9,995	$ 85.44	$ 71.16
FQHC/RHC	$ 325,282	3,006	786	166	$ 108.21	$ 1.49
Other Clinic	$ 7,577,368	77,930	27,844	4,291	$ 97.23	$ 34.77
Other Practitioner	$ 11,020	311	63	17	$ 35.41	$ 0.05
Therapies	$ 149,553	1,618	316	89	$ 92.42	$ 0.69
Prescribed Drugs	$ 3,143,156	66,879	17,577	3,682	$ 47.00	$ 14.42
Other BH Services	$ 7,836	447	14	25	$ 17.53	$ 0.04
LTSS Services	$ 375,197	26,734	277	1,472	$ 14.03	$ 1.72
Durable Medical Equipment	$ 1,504,729	61,167	2,782	3,368	$ 24.60	$ 6.90
Limited Dental Services	$ 402,377	16,242	6,807	894	$ 24.77	$ 1.85
Optical	$ 1,890	23	19	1	$ 83.97	$ 0.01
Lab and X-Ray	$ 326,604	11,588	3,917	638	$ 28.19	$ 1.50
Transportation	$ 188,842	2,084	1,006	115	$ 90.63	$ 0.87
Subtotal (Medical)	$ 71,316,613	545,175	32,642			$ 327.22
CC4C LHD Payments	$ 967,322	214,018	N/A	11,784	$ 4.52	$ 4.44
OBCM LHD Payments	$ 15	3	N/A	0	$ 4.85	$ 0.00
Medical Home Payments	$ 379,029	153,708	N/A	8,463	$ 2.47	$ 1.74
Subtotal (LHD/Medical Home Payments)	$ 1,346,366	367,729	N/A			$ 6.18
Total (Medical + LHD/Medical Home)	$ 72,662,979	912,904	N/A			$ 333.40

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 15

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	3,135,185
Average Monthly Members/Deliveries:	261,265
Eligibles:	311,208

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,829,192	10,815	2,432	41	$ 1,093.79	$ 3.77
Inpatient — BH	$ 2,101,819	3,698	543	14	$ 568.36	$ 0.67
Outpatient Hospital	$ 25,303,002	98,593	55,107	377	$ 256.64	$ 8.07
Emergency Room	$ 40,795,473	134,717	82,521	516	$ 302.82	$ 13.01
Physician	$ 65,482,259	874,336	217,046	3,347	$ 74.89	$ 20.89
FQHC/RHC	$ 1,754,241	16,222	6,655	62	$ 108.14	$ 0.56
Other Clinic	$ 17,279,207	173,069	143,265	662	$ 99.84	$ 5.51
Other Practitioner	$ 595,096	7,449	2,361	29	$ 79.89	$ 0.19
Therapies	$ 8,335,611	80,393	6,317	308	$ 103.69	$ 2.66
Prescribed Drugs	$ 108,757,643	1,158,392	176,790	4,434	$ 93.89	$ 34.69
Other BH Services	$ 15,497,836	212,892	19,931	815	$ 72.80	$ 4.94
LTSS Services	$ 845,706	130,962	232	501	$ 6.46	$ 0.27
Durable Medical Equipment	$ 5,614,221	1,617,871	16,386	6,192	$ 3.47	$ 1.79
Limited Dental Services	$ 947,407	38,340	14,894	147	$ 24.71	$ 0.30
Optical	$ 2,031,904	24,308	22,627	93	$ 83.59	$ 0.65
Lab and X-Ray	$ 4,238,985	252,883	45,724	968	$ 16.76	$ 1.35
Transportation	$ 1,276,706	17,385	6,432	67	$ 73.44	$ 0.41
Subtotal (Medical)	$ 312,686,309	4,852,327	248,053			$ 99.73
CC4C LHD Payments	$ 3,330,399	739,202	N/A	2,829	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,826,970	372,824	N/A	1,427	$ 4.90	$ 0.58
Medical Home Payments	$ 6,626,707	2,696,457	N/A	10,321	$ 2.46	$ 2.11
Subtotal (LHD/Medical Home Payments)	$ 11,784,076	3,808,483	N/A			$ 3.76
Total (Medical + LHD/Medical Home)	$ 324,470,385	8,660,810	N/A			$ 103.49

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 16

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	692,636
Average Monthly Members/Deliveries:	57,720
Eligibles:	85,395

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 14,127,689	13,080	2,828	227	$ 1,080.11	$ 20.40
Inpatient — BH	$ 1,348,824	2,233	432	39	$ 604.10	$ 1.95
Outpatient Hospital	$ 22,634,076	74,930	30,094	1,298	$ 302.07	$ 32.68
Emergency Room	$ 33,660,655	76,800	33,982	1,331	$ 438.29	$ 48.60
Physician	$ 31,986,827	292,460	54,068	5,067	$ 109.37	$ 46.18
FQHC/RHC	$ 955,471	9,164	3,673	159	$ 104.26	$ 1.38
Other Clinic	$ 4,851,825	23,088	18,618	400	$ 210.15	$ 7.00
Other Practitioner	$ 282,315	4,695	1,582	81	$ 60.13	$ 0.41
Therapies	$ 1,487	31	31	1	$ 47.89	$ 0.00
Prescribed Drugs	$ 61,141,743	741,867	50,424	12,853	$ 82.42	$ 88.27
Other BH Services	$ 4,851,614	87,596	7,403	1,518	$ 55.39	$ 7.00
LTSS Services	$ 1,648,739	342,972	517	5,942	$ 148.35	$ 2.38
Durable Medical Equipment	$ 3,919,781	1,550,837	5,579	26,868	$ 2.53	$ 5.66
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 141,413	2,118	1,128	37	$ 66.77	$ 0.20
Lab and X-Ray	$ 8,886,430	428,004	28,077	7,415	$ 20.76	$ 12.83
Transportation	$ 1,245,218	16,518	5,204	286	$ 75.38	$ 1.80
Subtotal (Medical)	$ 191,684,109	3,666,392	65,506			$ 276.75
CC4C LHD Payments	$ 164	38	N/A	1	$ 4.33	$ 0.00
OBCM LHD Payments	$ 2,485,588	508,368	N/A	8,808	$ 4.89	$ 3.59
Medical Home Payments	$ 1,102,731	457,965	N/A	7,934	$ 2.41	$ 1.59
Subtotal (LHD/Medical Home Payments)	$ 3,588,484	966,371	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 195,272,593	4,632,763	N/A			$ 281.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 17

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	13,143
Average Monthly Members/Deliveries:	1,095
Eligibles:	13,431

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 25,429,311	35,907	12,640	32,784	$ 708.21	$ 1,934.84
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,036,284	30,623	5,372	27,961	$ 131.80	$ 307.11
Emergency Room	$ 5,263,196	14,246	2,045	13,007	$ 369.45	$ 400.46
Physician	$ 20,059,949	85,503	12,818	78,068	$ 234.61	$ 1,526.30
FQHC/RHC	$ 47,046	401	14	366	$ 117.24	$ 3.58
Other Clinic	$ 2,706,459	16,181	3,197	14,774	$ 167.26	$ 205.93
Other Practitioner	$ 9,067	246	52	225	$ 36.85	$ 0.69
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 71,521	5,936	21	5,420	$ 12.05	$ 5.44
Durable Medical Equipment	$ 12,069	497	327	454	$ 24.27	$ 0.92
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ -	-	-	-	$ -	$ -
Lab and X-Ray	$ 354,777	15,021	2,024	13,715	$ 23.62	$ 26.99
Transportation	$ 166,153	1,818	750	1,660	$ 91.40	$ 12.64
Subtotal (Medical)	$ 58,155,832	206,380	13,380			$ 4,424.91
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 58,155,832	206,380	N/A			$ 4,424.91

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 18

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	4,371,052
Average Monthly Members/Deliveries:	364,254
Eligibles:	479,090

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 130,989,817	169,560	38,724	465	$ 772.53	$ 29.97
Inpatient — BH	$ 5,673,285	9,801	1,499	27	$ 578.85	$ 1.30
Outpatient Hospital	$ 87,177,702	293,655	114,651	806	$ 296.87	$ 19.94
Emergency Room	$ 107,527,820	289,291	144,750	794	$ 371.69	$ 24.60
Physician	$ 169,872,133	1,710,095	339,938	4,695	$ 99.33	$ 38.86
FQHC/RHC	$ 4,068,736	38,022	14,052	104	$ 107.01	$ 0.93
Other Clinic	$ 35,557,767	297,664	197,675	817	$ 119.46	$ 8.13
Other Practitioner	$ 1,201,811	16,783	5,438	46	$ 71.61	$ 0.27
Therapies	$ 9,734,120	93,092	7,294	256	$ 104.56	$ 2.23
Prescribed Drugs	$ 310,329,245	2,889,755	277,585	7,933	$ 107.39	$ 71.00
Other BH Services	$ 25,285,961	411,311	34,610	1,129	$ 61.48	$ 5.78
LTSS Services	$ 32,423,488	6,438,412	4,675	17,676	$ 161.73	$ 7.42
Durable Medical Equipment	$ 24,692,080	7,232,161	32,763	19,855	$ 3.41	$ 5.65
Limited Dental Services	$ 1,357,847	54,907	21,817	151	$ 24.73	$ 0.31
Optical	$ 2,401,215	29,669	25,641	81	$ 80.93	$ 0.55
Lab and X-Ray	$ 17,459,646	905,951	91,360	2,487	$ 19.27	$ 3.99
Transportation	$ 6,366,552	93,685	18,744	257	$ 67.96	$ 1.46
Subtotal (Medical)	$ 972,119,224	20,973,812	388,017			$ 222.40
CC4C LHD Payments	$ 4,299,649	953,649	N/A	2,618	$ 4.51	$ 0.98
OBCM LHD Payments	$ 4,573,489	934,336	N/A	2,565	$ 4.89	$ 1.05
Medical Home Payments	$ 9,387,301	3,576,510	N/A	9,819	$ 2.62	$ 2.15
Subtotal (LHD/Medical Home Payments)	$ 18,260,439	5,464,495	N/A			$ 4.18
Total (Medical + LHD/Medical Home)	$ 990,379,663	26,438,307	N/A			$ 226.58

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.4 SFY 2016 Region 4 Exhibits

Exhibit 19

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	276,093
Average Monthly Members/Deliveries:	23,008
Eligibles:	28,128

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 37,959,143	38,694	3,662	1,682	$ 981.01	$ 137.49
Inpatient — BH	$ 1,813,577	2,641	308	115	$ 686.66	$ 6.57
Outpatient Hospital	$ 25,967,271	54,081	12,082	2,351	$ 480.16	$ 94.05
Emergency Room	$ 15,184,312	30,722	11,967	1,335	$ 494.24	$ 55.00
Physician	$ 27,909,412	197,542	20,543	8,586	$ 141.28	$ 101.09
FQHC/RHC	$ 1,881,022	16,613	4,925	722	$ 113.22	$ 6.81
Other Clinic	$ 3,356,768	8,013	4,605	348	$ 418.90	$ 12.16
Other Practitioner	$ 171,847	2,181	980	95	$ 78.81	$ 0.62
Therapies	$ 1,375,705	12,029	699	523	$ 114.37	$ 4.98
Prescribed Drugs	$ 109,662,363	689,234	20,314	29,957	$ 159.11	$ 397.19
Other BH Services	$ 4,933,598	103,409	6,006	4,495	$ 47.71	$ 17.87
LTSS Services	$ 16,826,783	3,578,620	2,320	155,540	$ 163.31	$ 60.95
Durable Medical Equipment	$ 8,219,124	3,257,667	6,448	141,590	$ 2.52	$ 29.77
Limited Dental Services	$ 11,397	460	167	20	$ 24.77	$ 0.04
Optical	$ 279,585	3,943	2,444	171	$ 70.90	$ 1.01
Lab and X-Ray	$ 2,637,137	153,089	9,579	6,654	$ 17.23	$ 9.55
Transportation	$ 2,602,438	43,163	4,053	1,876	$ 60.29	$ 9.43
Subtotal (Medical)	$ 260,791,483	8,192,102	24,058			$ 944.58
CC4C LHD Payments	$ 1,963	435	N/A	19	$ 4.51	$ 0.01
OBCM LHD Payments	$ 213,426	43,470	N/A	1,889	$ 4.91	$ 0.77
Medical Home Payments	$ 1,087,407	227,397	N/A	9,884	$ 4.78	$ 3.94
Subtotal (LHD/Medical Home Payments)	$ 1,302,796	271,302	N/A			$ 4.72
Total (Medical + LHD/Medical Home)	$ 262,094,279	8,463,404	N/A			$ 949.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 20

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	176,685
Average Monthly Members/Deliveries:	14,724
Eligibles:	28,904

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 30,442,859	55,574	12,844	3,774	$ 547.79	$ 172.30
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,453,859	9,719	5,050	660	$ 149.59	$ 8.23
Emergency Room	$ 3,766,594	15,453	8,789	1,049	$ 243.75	$ 21.32
Physician	$ 13,570,959	148,528	23,981	10,088	$ 91.37	$ 76.81
FQHC/RHC	$ 1,293,410	12,386	2,990	841	$ 104.42	$ 7.32
Other Clinic	$ 6,331,693	65,558	21,845	4,453	$ 96.58	$ 35.84
Other Practitioner	$ 3,800	83	16	6	$ 45.75	$ 0.02
Therapies	$ 125,205	1,308	265	89	$ 95.72	$ 0.71
Prescribed Drugs	$ 2,466,439	46,285	13,261	3,144	$ 53.29	$ 13.96
Other BH Services	$ 6,358	192	23	13	$ 33.11	$ 0.04
LTSS Services	$ 100,995	6,928	23	471	$ 14.58	$ 0.57
Durable Medical Equipment	$ 513,155	81,363	1,870	5,526	$ 6.31	$ 2.90
Limited Dental Services	$ 367,652	14,825	6,261	1,007	$ 24.80	$ 2.08
Optical	$ 2,400	28	27	2	$ 85.71	$ 0.01
Lab and X-Ray	$ 105,238	7,805	3,444	530	$ 13.48	$ 0.60
Transportation	$ 184,550	1,819	844	124	$ 101.45	$ 1.04
Subtotal (Medical)	$ 60,735,166	467,853	26,562			$ 343.75
CC4C LHD Payments	$ 785,335	173,753	N/A	11,801	$ 4.52	$ 4.44
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 306,684	125,508	N/A	8,524	$ 2.44	$ 1.74
Subtotal (LHD/Medical Home Payments)	$ 1,092,019	299,261	N/A			$ 6.18
Total (Medical + LHD/Medical Home)	$ 61,827,185	767,114	N/A			$ 349.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 21

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,561,546
Average Monthly Members/Deliveries:	213,462
Eligibles:	255,071

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,021,676	8,698	2,056	41	$ 1,152.19	$ 3.91
Inpatient — BH	$ 2,369,461	3,695	422	17	$ 641.27	$ 0.93
Outpatient Hospital	$ 20,225,810	65,510	36,361	307	$ 308.75	$ 7.90
Emergency Room	$ 31,244,482	104,503	65,122	490	$ 298.98	$ 12.20
Physician	$ 48,721,156	610,010	163,973	2,858	$ 79.87	$ 19.02
FQHC/RHC	$ 5,550,833	53,532	23,023	251	$ 103.69	$ 2.17
Other Clinic	$ 14,120,485	140,583	112,040	659	$ 100.44	$ 5.51
Other Practitioner	$ 247,312	3,035	1,305	14	$ 81.48	$ 0.10
Therapies	$ 13,737,346	121,207	8,020	568	$ 113.34	$ 5.36
Prescribed Drugs	$ 76,171,672	775,889	135,031	3,635	$ 98.17	$ 29.74
Other BH Services	$ 14,658,536	182,631	16,403	856	$ 80.26	$ 5.72
LTSS Services	$ 267,248	33,717	99	158	$ 101.23	$ 0.10
Durable Medical Equipment	$ 4,673,169	1,632,429	15,827	7,647	$ 2.86	$ 1.82
Limited Dental Services	$ 880,838	35,641	13,953	167	$ 24.71	$ 0.34
Optical	$ 2,779,619	33,491	30,350	157	$ 83.00	$ 1.09
Lab and X-Ray	$ 3,152,389	216,303	39,998	1,013	$ 14.57	$ 1.23
Transportation	$ 813,013	9,735	4,894	46	$ 83.51	$ 0.32
Subtotal (Medical)	$ 249,635,045	4,030,610	203,876			$ 97.45
CC4C LHD Payments	$ 2,736,815	607,444	N/A	2,846	$ 4.51	$ 1.07
OBCM LHD Payments	$ 1,412,063	288,135	N/A	1,350	$ 4.90	$ 0.55
Medical Home Payments	$ 5,442,294	2,215,381	N/A	10,378	$ 2.46	$ 2.12
Subtotal (LHD/Medical Home Payments)	$ 9,591,172	3,110,960	N/A			$ 3.74
Total (Medical + LHD/Medical Home)	$ 259,226,217	7,141,570	N/A			$ 101.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 22

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	493,513
Average Monthly Members/Deliveries:	41,126
Eligibles:	64,794

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,652,638	9,808	2,027	238	$ 1,086.07	$ 21.59
Inpatient — BH	$ 737,019	1,015	209	25	$ 726.22	$ 1.49
Outpatient Hospital	$ 14,583,002	43,489	20,390	1,057	$ 335.32	$ 29.55
Emergency Room	$ 22,102,801	48,951	24,142	1,190	$ 451.53	$ 44.79
Physician	$ 21,578,124	184,335	38,681	4,482	$ 117.06	$ 43.72
FQHC/RHC	$ 1,707,792	15,848	6,223	385	$ 107.76	$ 3.46
Other Clinic	$ 4,156,204	25,403	17,805	618	$ 163.61	$ 8.42
Other Practitioner	$ 148,026	1,972	891	48	$ 75.05	$ 0.30
Therapies	$ 1,393	29	27	1	$ 47.96	$ 0.00
Prescribed Drugs	$ 39,655,962	478,426	35,233	11,633	$ 82.89	$ 80.35
Other BH Services	$ 4,085,791	52,573	5,804	1,278	$ 77.72	$ 8.28
LTSS Services	$ 862,968	160,316	309	3,898	$ 163.02	$ 1.75
Durable Medical Equipment	$ 2,133,831	1,049,049	4,612	25,508	$ 2.03	$ 4.32
Limited Dental Services	$ 77	4	3	0	$ 19.13	$ 0.00
Optical	$ 164,480	2,376	1,440	58	$ 69.23	$ 0.33
Lab and X-Ray	$ 6,366,443	330,133	23,901	8,027	$ 19.28	$ 12.90
Transportation	$ 736,771	9,568	3,414	233	$ 77.00	$ 1.49
Subtotal (Medical)	$ 129,673,324	2,413,297	49,345			$ 262.76
CC4C LHD Payments	$ 112	25	N/A	1	$ 4.47	$ 0.00
OBCM LHD Payments	$ 1,798,462	367,823	N/A	8,944	$ 4.89	$ 3.64
Medical Home Payments	$ 756,687	312,935	N/A	7,609	$ 2.42	$ 1.53
Subtotal (LHD/Medical Home Payments)	$ 2,555,261	680,783	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 132,228,585	3,094,080	N/A			$ 267.93

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 23

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,895
Average Monthly Members/Deliveries:	825
Eligibles:	10,183

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,460,479	27,881	9,627	33,814	$ 697.97	$ 1,966.78
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,959,874	27,345	3,723	33,163	$ 144.81	$ 400.21
Emergency Room	$ 4,249,729	11,649	1,470	14,128	$ 364.81	$ 429.50
Physician	$ 15,371,357	69,061	9,741	83,756	$ 222.58	$ 1,553.51
FQHC/RHC	$ 551,826	4,299	314	5,214	$ 128.36	$ 55.77
Other Clinic	$ 2,223,071	12,893	3,070	15,636	$ 172.43	$ 224.68
Other Practitioner	$ 120	3	16	4	$ 39.84	$ 0.01
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 889	14	199	17	$ 63.47	$ 0.09
LTSS Services	$ 24,929	6,100	19	7,398	$ 4.09	$ 2.52
Durable Medical Equipment	$ 21,990	722	260	876	$ 30.45	$ 2.22
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 114	2	19	2	$ 57.06	$ 0.01
Lab and X-Ray	$ 427,670	18,051	2,271	21,892	$ 23.69	$ 43.22
Transportation	$ 129,702	1,361	629	1,650	$ 95.32	$ 13.11
Subtotal (Medical)	$ 46,421,750	179,382	10,110			$ 4,691.63
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 46,421,750	179,382	N/A			$ 4,691.63

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 24

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,507,837
Average Monthly Members/Deliveries:	292,320
Eligibles:	387,080

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 108,536,794	140,656	30,216	481	$ 771.65	$ 30.94
Inpatient — BH	$ 4,920,057	7,351	939	25	$ 669.31	$ 1.40
Outpatient Hospital	$ 66,189,817	200,143	77,606	685	$ 330.71	$ 18.87
Emergency Room	$ 76,547,919	211,278	111,490	723	$ 362.31	$ 21.82
Physician	$ 127,151,009	1,209,477	256,919	4,138	$ 105.13	$ 36.25
FQHC/RHC	$ 10,984,883	102,679	37,475	351	$ 106.98	$ 3.13
Other Clinic	$ 30,188,223	252,450	159,365	864	$ 119.58	$ 8.61
Other Practitioner	$ 571,105	7,274	3,208	25	$ 78.51	$ 0.16
Therapies	$ 15,239,649	134,573	9,011	460	$ 113.24	$ 4.34
Prescribed Drugs	$ 227,956,436	1,989,834	209,164	6,807	$ 114.56	$ 64.98
Other BH Services	$ 23,685,173	338,819	28,435	1,159	$ 69.91	$ 6.75
LTSS Services	$ 18,082,923	3,785,682	2,770	12,950	$ 164.79	$ 5.16
Durable Medical Equipment	$ 15,561,269	6,021,230	29,017	20,598	$ 2.58	$ 4.44
Limited Dental Services	$ 1,259,963	50,931	20,384	174	$ 24.74	$ 0.36
Optical	$ 3,226,198	39,840	34,280	136	$ 80.98	$ 0.92
Lab and X-Ray	$ 12,688,878	725,381	79,193	2,481	$ 17.49	$ 3.62
Transportation	$ 4,466,473	65,646	13,834	225	$ 68.04	$ 1.27
Subtotal (Medical)	$ 747,256,769	15,283,244	313,396			$ 213.02
CC4C LHD Payments	$ 3,524,224	781,657	N/A	2,674	$ 4.51	$ 1.00
OBCM LHD Payments	$ 3,423,952	699,428	N/A	2,393	$ 4.90	$ 0.98
Medical Home Payments	$ 7,593,072	2,881,221	N/A	9,856	$ 2.64	$ 2.16
Subtotal (LHD/Medical Home Payments)	$ 14,541,248	4,362,306	N/A			$ 4.15
Total (Medical + LHD/Medical Home)	$ 761,798,016	19,645,550	N/A			$ 217.17

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.5 SFY 2016 Region 5 Exhibits

Exhibit 25

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	312,103
Average Monthly Members/Deliveries:	26,009
Eligibles:	31,124

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 42,980,100	47,378	4,516	1,822	$ 907.18	$ 137.71
Inpatient — BH	$ 1,383,726	2,116	372	81	$ 653.89	$ 4.43
Outpatient Hospital	$ 26,374,888	53,612	13,698	2,061	$ 491.96	$ 84.51
Emergency Room	$ 17,104,032	39,021	14,405	1,500	$ 438.33	$ 54.80
Physician	$ 35,678,291	252,643	23,588	9,714	$ 141.22	$ 114.32
FQHC/RHC	$ 2,016,353	20,506	4,975	788	$ 98.33	$ 6.46
Other Clinic	$ 3,243,299	7,287	4,596	280	$ 445.05	$ 10.39
Other Practitioner	$ 271,106	3,666	1,283	141	$ 73.96	$ 0.87
Therapies	$ 2,029,014	18,785	958	722	$ 108.02	$ 6.50
Prescribed Drugs	$ 116,567,756	872,775	23,493	33,557	$ 133.56	$ 373.49
Other BH Services	$ 4,728,085	66,653	6,058	2,563	$ 70.94	$ 15.15
LTSS Services	$ 20,646,580	4,522,069	2,937	173,869	$ 161.39	$ 66.15
Durable Medical Equipment	$ 9,173,715	3,694,744	7,288	142,059	$ 2.48	$ 29.39
Limited Dental Services	$ 8,320	336	129	13	$ 24.75	$ 0.03
Optical	$ 496,667	7,642	3,602	294	$ 65.00	$ 1.59
Lab and X-Ray	$ 3,915,422	217,209	11,915	8,351	$ 18.03	$ 12.55
Transportation	$ 2,060,412	28,966	5,435	1,114	$ 71.13	$ 6.60
Subtotal (Medical)	$ 288,677,766	9,855,407	26,943			$ 924.95
CC4C LHD Payments	$ 2,257	500	N/A	19	$ 4.51	$ 0.01
OBCM LHD Payments	$ 245,000	49,899	N/A	1,919	$ 4.91	$ 0.78
Medical Home Payments	$ 1,237,466	259,007	N/A	9,959	$ 4.78	$ 3.96
Subtotal (LHD/Medical Home Payments)	$ 1,484,723	309,406	N/A			$ 4.76
Total (Medical + LHD/Medical Home)	$ 290,162,489	10,164,813	N/A			$ 929.70

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 26

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	140,711
Average Monthly Members/Deliveries:	11,726
Eligibles:	23,094

Category of Service		Incurred Claims	Utilization	Users	Utilization Per 1,000		Unit Cost		PMPM/ Payment
Inpatient — PH	$	24,601,998	46,618	10,363	3,976	$	527.74	$	174.84
Inpatient — BH	$	-	-	-	-	$	-	$	-
Outpatient Hospital	$	998,951	8,397	4,281	716	$	118.97	$	7.10
Emergency Room	$	2,754,046	14,025	7,748	1,196	$	196.37	$	19.57
Physician	$	11,455,591	119,505	19,799	10,192	$	95.86	$	81.41
FQHC/RHC	$	460,136	4,621	1,079	394	$	99.58	$	3.27
Other Clinic	$	5,219,250	51,899	18,109	4,426	$	100.57	$	37.09
Other Practitioner	$	3,873	52	16	4	$	74.42	$	0.03
Therapies	$	81,601	971	178	83	$	84.06	$	0.58
Prescribed Drugs	$	2,046,215	50,954	12,371	4,345	$	40.16	$	14.54
Other BH Services	$	2,552	138	7	12	$	18.49	$	0.02
LTSS Services	$	54,472	1,997	65	170	$	27.27	$	0.39
Durable Medical Equipment	$	480,535	109,985	1,766	9,380	$	4.37	$	3.42
Limited Dental Services	$	343,593	13,872	5,738	1,183	$	24.77	$	2.44
Optical	$	12,352	157	123	13	$	78.65	$	0.09
Lab and X-Ray	$	113,524	5,526	2,322	471	$	20.54	$	0.81
Transportation	$	185,427	1,324	785	113	$	140.05	$	1.32
Subtotal (Medical)	$	48,814,117	430,040	21,241				$	346.91
CC4C LHD Payments	$	628,182	138,989	N/A	11,853	$	4.52	$	4.46
OBCM LHD Payments	$	-	-	N/A	-	$	-	$	-
Medical Home Payments	$	254,644	104,969	N/A	8,952	$	2.43	$	1.81
Subtotal (LHD/Medical Home Payments)	$	882,826	243,958	N/A				$	6.27
Total (Medical + LHD/Medical Home)	$	49,696,943	673,998	N/A				$	353.19

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 27

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,122,571
Average Monthly Members/Deliveries:	176,881
Eligibles:	207,787

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,713,159	9,013	2,273	51	$ 1,077.73	$ 4.58
Inpatient — BH	$ 1,394,564	2,214	311	13	$ 629.78	$ 0.66
Outpatient Hospital	$ 15,722,919	59,014	33,568	334	$ 266.43	$ 7.41
Emergency Room	$ 26,005,939	105,950	63,131	599	$ 245.46	$ 12.25
Physician	$ 42,463,907	575,829	142,263	3,255	$ 73.74	$ 20.01
FQHC/RHC	$ 2,875,787	31,068	12,475	176	$ 92.56	$ 1.35
Other Clinic	$ 12,267,363	116,685	93,129	660	$ 105.13	$ 5.78
Other Practitioner	$ 245,584	3,374	1,227	19	$ 72.79	$ 0.12
Therapies	$ 12,480,599	115,042	7,036	650	$ 108.49	$ 5.88
Prescribed Drugs	$ 75,677,720	850,321	125,255	4,807	$ 89.00	$ 35.65
Other BH Services	$ 11,344,267	155,995	14,877	882	$ 72.72	$ 5.34
LTSS Services	$ 190,433	37,810	126	214	$ 93.59	$ 0.09
Durable Medical Equipment	$ 3,042,897	1,188,599	10,573	6,720	$ 2.56	$ 1.43
Limited Dental Services	$ 951,522	38,629	14,324	218	$ 24.63	$ 0.45
Optical	$ 2,928,708	36,044	30,515	204	$ 81.25	$ 1.38
Lab and X-Ray	$ 2,659,638	151,971	29,719	859	$ 17.50	$ 1.25
Transportation	$ 903,051	9,793	5,159	55	$ 92.21	$ 0.43
Subtotal (Medical)	$ 220,868,056	3,487,350	169,878			$ 104.06
CC4C LHD Payments	$ 2,230,710	495,131	N/A	2,799	$ 4.51	$ 1.05
OBCM LHD Payments	$ 1,316,151	268,567	N/A	1,518	$ 4.90	$ 0.62
Medical Home Payments	$ 4,510,956	1,848,289	N/A	10,449	$ 2.44	$ 2.13
Subtotal (LHD/Medical Home Payments)	$ 8,057,817	2,611,987	N/A			$ 3.80
Total (Medical + LHD/Medical Home)	$ 228,925,873	6,099,337	N/A			$ 107.85

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 28

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	533,376
Average Monthly Members/Deliveries:	44,448
Eligibles:	63,876

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 13,190,539	13,170	2,766	296	$ 1,001.58	$ 24.73
Inpatient — BH	$ 870,327	1,242	303	28	$ 700.58	$ 1.63
Outpatient Hospital	$ 15,827,870	46,231	21,128	1,040	$ 342.36	$ 29.67
Emergency Room	$ 22,626,252	58,408	26,693	1,314	$ 387.38	$ 42.42
Physician	$ 29,900,583	247,480	41,517	5,568	$ 120.82	$ 56.06
FQHC/RHC	$ 2,057,504	21,229	6,844	478	$ 96.92	$ 3.86
Other Clinic	$ 3,793,640	18,112	14,944	407	$ 209.46	$ 7.11
Other Practitioner	$ 197,667	2,653	1,044	60	$ 74.52	$ 0.37
Therapies	$ 3,636	64	56	1	$ 56.71	$ 0.01
Prescribed Drugs	$ 52,581,046	650,801	39,900	14,642	$ 80.79	$ 98.58
Other BH Services	$ 3,906,403	60,112	6,310	1,352	$ 64.99	$ 7.32
LTSS Services	$ 1,145,454	216,046	375	4,861	$ 156.03	$ 2.15
Durable Medical Equipment	$ 2,453,672	1,116,800	5,338	25,126	$ 2.20	$ 4.60
Limited Dental Services	$ 15	1	1	0	$ 15.10	$ 0.00
Optical	$ 295,388	4,579	2,208	103	$ 64.51	$ 0.55
Lab and X-Ray	$ 8,172,080	403,936	26,022	9,088	$ 20.23	$ 15.32
Transportation	$ 861,529	9,719	4,740	219	$ 88.65	$ 1.62
Subtotal (Medical)	$ 157,883,606	2,870,584	50,297			$ 296.01
CC4C LHD Payments	$ 322	75	N/A	2	$ 4.29	$ 0.00
OBCM LHD Payments	$ 1,938,417	396,455	N/A	8,920	$ 4.89	$ 3.63
Medical Home Payments	$ 892,039	369,982	N/A	8,324	$ 2.41	$ 1.67
Subtotal (LHD/Medical Home Payments)	$ 2,830,777	766,512	N/A			$ 5.31
Total (Medical + LHD/Medical Home)	$ 160,714,383	3,637,096	N/A			$ 301.32

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 29

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	8,788
Average Monthly Members/Deliveries:	732
Eligibles:	8,964

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,036,806	26,193	8,539	35,767	$ 688.61	$ 2,052.45
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,131,933	27,019	3,709	36,895	$ 115.92	$ 356.39
Emergency Room	$ 3,128,692	9,950	1,145	13,587	$ 314.45	$ 356.02
Physician	$ 15,632,406	63,245	8,681	86,362	$ 247.17	$ 1,778.85
FQHC/RHC	$ 465,819	3,216	299	4,392	$ 144.84	$ 53.01
Other Clinic	$ 970,427	6,891	1,764	9,410	$ 140.82	$ 110.43
Other Practitioner	$ 39	1	14	1	$ 38.73	$ 0.00
Therapies	$ 61	1	1	1	$ 61.21	$ 0.01
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 219	4	185	5	$ 54.68	$ 0.02
LTSS Services	$ 29,229	5,508	15	7,522	$ 5.31	$ 3.33
Durable Medical Equipment	$ 31,789	644	604	880	$ 49.35	$ 3.62
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 194	3	20	4	$ 64.58	$ 0.02
Lab and X-Ray	$ 345,324	14,963	1,806	20,433	$ 23.08	$ 39.30
Transportation	$ 176,420	1,690	648	2,308	$ 104.37	$ 20.08
Subtotal (Medical)	$ 41,949,358	159,330	8,927			$ 4,773.52
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 41,949,358	159,330	N/A			$ 4,773.52

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 30

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,108,760
Average Monthly Members/Deliveries:	259,063
Eligibles:	334,845

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 108,522,603	142,371	28,457	550	$ 762.25	$ 34.91
Inpatient — BH	$ 3,648,617	5,573	987	22	$ 654.72	$ 1.17
Outpatient Hospital	$ 62,056,562	194,273	76,384	750	$ 319.43	$ 19.96
Emergency Room	$ 71,618,962	227,354	113,122	878	$ 315.01	$ 23.04
Physician	$ 135,130,778	1,258,702	235,848	4,859	$ 107.36	$ 43.47
FQHC/RHC	$ 7,875,598	80,640	25,672	311	$ 97.66	$ 2.53
Other Clinic	$ 25,493,979	200,875	132,542	775	$ 126.91	$ 8.20
Other Practitioner	$ 718,268	9,745	3,584	38	$ 73.70	$ 0.23
Therapies	$ 14,594,911	134,862	8,229	521	$ 108.22	$ 4.69
Prescribed Drugs	$ 246,872,736	2,424,851	206,747	9,360	$ 101.81	$ 79.41
Other BH Services	$ 19,981,526	282,902	27,437	1,092	$ 70.63	$ 6.43
LTSS Services	$ 22,066,168	4,783,431	3,519	18,464	$ 158.33	$ 7.10
Durable Medical Equipment	$ 15,182,608	6,110,772	25,569	23,588	$ 2.48	$ 4.88
Limited Dental Services	$ 1,303,450	52,838	20,192	204	$ 24.67	$ 0.42
Optical	$ 3,733,310	48,424	36,468	187	$ 77.10	$ 1.20
Lab and X-Ray	$ 15,205,989	793,605	71,784	3,063	$ 19.16	$ 4.89
Transportation	$ 4,186,839	51,493	16,767	199	$ 81.31	$ 1.35
Subtotal (Medical)	$ 758,192,903	16,802,710	276,945			$ 243.89
CC4C LHD Payments	$ 2,861,471	634,695	N/A	2,450	$ 4.51	$ 0.92
OBCM LHD Payments	$ 3,499,567	714,921	N/A	2,760	$ 4.90	$ 1.13
Medical Home Payments	$ 6,895,105	2,582,247	N/A	9,968	$ 2.67	$ 2.22
Subtotal (LHD/Medical Home Payments)	$ 13,256,142	3,931,863	N/A			$ 4.26
Total (Medical + LHD/Medical Home)	$ 771,449,045	20,734,573	N/A			$ 248.15

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.1.6 SFY 2016 Region 6 Exhibits

Exhibit 31

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	271,768
Average Monthly Members/Deliveries:	22,647
Eligibles:	27,187

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,746,462	33,582	3,497	1,483	$ 1,004.89	$ 124.17
Inpatient — BH	$ 2,041,020	2,925	381	129	$ 697.69	$ 7.51
Outpatient Hospital	$ 18,007,561	35,785	10,613	1,580	$ 503.22	$ 66.26
Emergency Room	$ 15,518,336	32,035	12,348	1,414	$ 484.42	$ 57.10
Physician	$ 27,413,637	188,235	20,024	8,312	$ 145.63	$ 100.87
FQHC/RHC	$ 1,987,124	19,232	5,328	849	$ 103.32	$ 7.31
Other Clinic	$ 3,558,962	7,844	4,459	346	$ 453.73	$ 13.10
Other Practitioner	$ 231,660	3,202	1,216	141	$ 72.35	$ 0.85
Therapies	$ 1,416,161	12,220	613	540	$ 115.89	$ 5.21
Prescribed Drugs	$ 95,090,588	696,518	20,453	30,755	$ 136.52	$ 349.90
Other BH Services	$ 3,391,052	58,654	5,772	2,590	$ 57.81	$ 12.48
LTSS Services	$ 17,109,712	3,489,771	2,090	154,092	$ 164.84	$ 62.96
Durable Medical Equipment	$ 9,274,550	3,136,402	6,108	138,489	$ 2.96	$ 34.13
Limited Dental Services	$ 6,713	274	99	12	$ 24.49	$ 0.02
Optical	$ 338,362	4,874	3,082	215	$ 69.43	$ 1.25
Lab and X-Ray	$ 2,617,835	149,366	10,766	6,595	$ 17.53	$ 9.63
Transportation	$ 2,639,256	41,632	4,335	1,838	$ 63.39	$ 9.71
Subtotal (Medical)	$ 234,388,990	7,912,551	23,632			$ 862.46
CC4C LHD Payments	$ 1,581	350	N/A	15	$ 4.52	$ 0.01
OBCM LHD Payments	$ 214,584	43,705	N/A	1,930	$ 4.91	$ 0.79
Medical Home Payments	$ 1,093,735	229,616	N/A	10,139	$ 4.76	$ 4.02
Subtotal (LHD/Medical Home Payments)	$ 1,309,900	273,671	N/A			$ 4.82
Total (Medical + LHD/Medical Home)	$ 235,698,890	8,186,222	N/A			$ 867.28

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 32

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	114,678
Average Monthly Members/Deliveries:	9,556
Eligibles:	18,758

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,176,688	34,213	8,324	3,580	$ 560.51	$ 167.22
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 932,170	5,729	3,373	600	$ 162.71	$ 8.13
Emergency Room	$ 2,602,548	10,661	5,956	1,116	$ 244.11	$ 22.69
Physician	$ 8,026,720	88,860	15,709	9,298	$ 90.33	$ 69.99
FQHC/RHC	$ 667,309	6,408	1,484	671	$ 104.13	$ 5.82
Other Clinic	$ 4,640,715	41,615	14,369	4,355	$ 111.51	$ 40.47
Other Practitioner	$ 1,567	25	15	3	$ 62.62	$ 0.01
Therapies	$ 102,872	903	145	94	$ 113.97	$ 0.90
Prescribed Drugs	$ 1,547,167	33,986	9,379	3,556	$ 45.52	$ 13.49
Other BH Services	$ 5,516	339	9	35	$ 16.27	$ 0.05
LTSS Services	$ 9,048	547	9	57	$ 16.54	$ 0.08
Durable Medical Equipment	$ 209,818	22,958	1,066	2,402	$ 9.14	$ 1.83
Limited Dental Services	$ 308,066	12,428	5,098	1,301	$ 24.79	$ 2.69
Optical	$ 6,295	73	68	8	$ 86.20	$ 0.05
Lab and X-Ray	$ 52,726	3,312	1,615	347	$ 15.92	$ 0.46
Transportation	$ 252,244	1,990	724	208	$ 126.76	$ 2.20
Subtotal (Medical)	$ 38,541,467	264,049	17,306			$ 336.08
CC4C LHD Payments	$ 510,941	113,049	N/A	11,830	$ 4.52	$ 4.46
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 212,887	87,084	N/A	9,113	$ 2.44	$ 1.86
Subtotal (LHD/Medical Home Payments)	$ 723,828	200,133	N/A			$ 6.31
Total (Medical + LHD/Medical Home)	$ 39,265,296	464,182	N/A			$ 342.40

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 33

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,683,919
Average Monthly Members/Deliveries:	140,327
Eligibles:	166,388

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,145,189	5,875	1,281	42	$ 1,216.16	$ 4.24
Inpatient — BH	$ 1,367,229	2,342	289	17	$ 583.88	$ 0.81
Outpatient Hospital	$ 11,778,648	35,556	21,302	253	$ 331.27	$ 6.99
Emergency Room	$ 22,751,995	82,296	49,499	586	$ 276.47	$ 13.51
Physician	$ 28,818,468	417,336	110,112	2,974	$ 69.05	$ 17.11
FQHC/RHC	$ 3,289,015	32,669	13,162	233	$ 100.68	$ 1.95
Other Clinic	$ 10,505,924	96,433	76,729	687	$ 108.95	$ 6.24
Other Practitioner	$ 185,005	2,491	950	18	$ 74.28	$ 0.11
Therapies	$ 5,294,784	46,445	3,658	331	$ 114.00	$ 3.14
Prescribed Drugs	$ 60,404,898	636,860	95,451	4,538	$ 94.85	$ 35.87
Other BH Services	$ 7,096,542	103,600	12,382	738	$ 68.50	$ 4.21
LTSS Services	$ 456,631	54,259	61	387	$ 97.08	$ 0.27
Durable Medical Equipment	$ 2,638,242	986,319	8,081	7,029	$ 2.67	$ 1.57
Limited Dental Services	$ 826,732	33,501	12,044	239	$ 24.68	$ 0.49
Optical	$ 2,235,342	26,873	24,723	192	$ 83.18	$ 1.33
Lab and X-Ray	$ 1,968,925	115,805	22,208	825	$ 17.00	$ 1.17
Transportation	$ 867,571	10,676	3,929	76	$ 81.26	$ 0.52
Subtotal (Medical)	$ 167,631,139	2,689,334	135,612			$ 99.55
CC4C LHD Payments	$ 1,789,238	397,139	N/A	2,830	$ 4.51	$ 1.06
OBCM LHD Payments	$ 1,014,494	207,016	N/A	1,475	$ 4.90	$ 0.60
Medical Home Payments	$ 3,673,284	1,501,853	N/A	10,703	$ 2.45	$ 2.18
Subtotal (LHD/Medical Home Payments)	$ 6,477,016	2,106,008	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 174,108,155	4,795,342	N/A			$ 103.39

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 34

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	401,299
Average Monthly Members/Deliveries:	33,442
Eligibles:	49,451

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,613,378	7,721	1,659	231	$ 1,245.02	$ 23.96
Inpatient — BH	$ 1,007,650	1,374	246	41	$ 733.50	$ 2.51
Outpatient Hospital	$ 10,378,550	26,984	14,510	807	$ 384.62	$ 25.86
Emergency Room	$ 19,093,129	47,274	21,335	1,414	$ 403.88	$ 47.58
Physician	$ 16,536,882	149,024	30,089	4,456	$ 110.97	$ 41.21
FQHC/RHC	$ 1,716,029	17,262	6,018	516	$ 99.41	$ 4.28
Other Clinic	$ 3,838,973	21,268	13,785	636	$ 180.51	$ 9.57
Other Practitioner	$ 182,124	2,510	1,001	75	$ 72.57	$ 0.45
Therapies	$ 120	2	2	0	$ 59.72	$ 0.00
Prescribed Drugs	$ 35,015,197	424,751	29,947	12,701	$ 82.44	$ 87.25
Other BH Services	$ 2,732,287	41,433	5,428	1,239	$ 65.95	$ 6.81
LTSS Services	$ 637,940	112,513	214	3,364	$ 108.78	$ 1.59
Durable Medical Equipment	$ 1,830,965	817,160	3,597	24,435	$ 2.24	$ 4.56
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 155,921	2,256	1,481	67	$ 69.12	$ 0.39
Lab and X-Ray	$ 5,238,306	254,812	19,930	7,620	$ 20.56	$ 13.05
Transportation	$ 693,643	8,812	3,043	264	$ 78.72	$ 1.73
Subtotal (Medical)	$ 108,671,094	1,935,154	38,739			$ 270.80
CC4C LHD Payments	$ 507	118	N/A	4	$ 4.30	$ 0.00
OBCM LHD Payments	$ 1,491,982	305,139	N/A	9,125	$ 4.89	$ 3.72
Medical Home Payments	$ 694,052	291,057	N/A	8,703	$ 2.38	$ 1.73
Subtotal (LHD/Medical Home Payments)	$ 2,186,541	596,314	N/A			$ 5.45
Total (Medical + LHD/Medical Home)	$ 110,857,635	2,531,468	N/A			$ 276.25

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 35

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	7,457
Average Monthly Members/Deliveries:	621
Eligibles:	7,632

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,473,680	20,211	7,284	32,522	$ 765.61	$ 2,074.93
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,810,873	13,975	2,735	22,487	$ 129.58	$ 242.83
Emergency Room	$ 2,903,617	10,194	1,413	16,403	$ 284.84	$ 389.36
Physician	$ 12,212,921	48,927	7,194	78,729	$ 249.62	$ 1,637.68
FQHC/RHC	$ 1,006,079	6,656	525	10,710	$ 151.16	$ 134.91
Other Clinic	$ 1,630,980	12,154	2,393	19,557	$ 134.20	$ 218.70
Other Practitioner	$ 271	4	12	6	$ 67.77	$ 0.04
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 88	1	177	2	$ 88.00	$ 0.01
LTSS Services	$ 20,591	2,134	9	3,434	$ 9.65	$ 2.76
Durable Medical Equipment	$ 25,608	339	163	546	$ 75.53	$ 3.43
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 576	6	14	10	$ 96.02	$ 0.08
Lab and X-Ray	$ 315,511	12,163	1,964	19,572	$ 25.94	$ 42.31
Transportation	$ 151,602	1,426	566	2,295	$ 106.30	$ 20.33
Subtotal (Medical)	$ 35,552,399	128,189	7,582			$ 4,767.37
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 35,552,399	128,189	N/A			$ 4,767.37

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 36

Time Period/Region Selections:	
Time Period:	SFY 2016
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	2,471,664
Average Monthly Members/Deliveries:	205,972
Eligibles:	269,416

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 85,155,397	101,603	22,045	493	$ 838.12	$ 34.45
Inpatient — BH	$ 4,415,899	6,641	918	32	$ 664.97	$ 1.79
Outpatient Hospital	$ 42,907,801	118,028	52,533	573	$ 363.54	$ 17.36
Emergency Room	$ 62,869,623	182,459	90,551	886	$ 344.57	$ 25.44
Physician	$ 93,008,627	892,381	183,128	4,333	$ 104.23	$ 37.63
FQHC/RHC	$ 8,665,556	82,227	26,517	399	$ 105.39	$ 3.51
Other Clinic	$ 24,175,554	179,313	111,735	871	$ 134.82	$ 9.78
Other Practitioner	$ 600,627	8,231	3,194	40	$ 72.97	$ 0.24
Therapies	$ 6,813,937	59,570	4,418	289	$ 114.39	$ 2.76
Prescribed Drugs	$ 192,057,850	1,792,115	159,980	8,701	$ 107.17	$ 77.70
Other BH Services	$ 13,225,485	204,027	23,768	991	$ 64.82	$ 5.35
LTSS Services	$ 18,233,922	3,659,223	2,383	17,766	$ 160.19	$ 7.38
Durable Medical Equipment	$ 13,979,184	4,963,178	19,015	24,096	$ 2.82	$ 5.66
Limited Dental Services	$ 1,141,510	46,203	17,241	224	$ 24.71	$ 0.46
Optical	$ 2,736,497	34,081	29,368	165	$ 80.29	$ 1.11
Lab and X-Ray	$ 10,193,303	535,458	56,483	2,600	$ 19.04	$ 4.12
Transportation	$ 4,604,316	64,536	12,597	313	$ 71.34	$ 1.86
Subtotal (Medical)	$ 584,785,089	12,929,276	222,587			$ 236.60
CC4C LHD Payments	$ 2,302,267	510,656	N/A	2,479	$ 4.51	$ 0.93
OBCM LHD Payments	$ 2,721,061	555,860	N/A	2,699	$ 4.90	$ 1.10
Medical Home Payments	$ 5,673,958	2,109,610	N/A	10,242	$ 2.69	$ 2.30
Subtotal (LHD/Medical Home Payments)	$ 10,697,286	3,176,126	N/A			$ 4.33
Total (Medical + LHD/Medical Home)	$ 595,482,375	16,105,402	N/A			$ 240.92

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2 SFY 2017 Exhibits

Cost and utilization information for the July 1, 2016 through June 30, 2017 (SFY 2017) time period is illustrated in Section 7.2.

7.2.1 SFY 2017 Region 1 Exhibits

Exhibit 37

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	146,847
Average Monthly Members/Deliveries:	12,237
Eligibles:	14,853

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,994,504	18,663	2,226	1,525	$ 1,017.76	$ 129.35
Inpatient — BH	$ 1,338,873	1,901	275	155	$ 704.19	$ 9.12
Outpatient Hospital	$ 18,296,270	40,731	8,523	3,328	$ 449.20	$ 124.59
Emergency Room	$ 9,346,567	18,051	6,512	1,475	$ 517.80	$ 63.65
Physician	$ 15,556,490	115,987	11,575	9,478	$ 134.12	$ 105.94
FQHC/RHC	$ 2,218,513	17,279	3,821	1,412	$ 128.40	$ 15.11
Other Clinic	$ 1,166,583	3,710	2,170	303	$ 314.47	$ 7.94
Other Practitioner	$ 180,776	2,318	653	189	$ 78.00	$ 1.23
Therapies	$ 486,461	4,406	263	360	$ 110.40	$ 3.31
Prescribed Drugs	$ 61,440,392	491,070	11,706	40,129	$ 125.12	$ 418.40
Other BH Services	$ 2,094,097	37,746	2,879	3,085	$ 55.48	$ 14.26
LTSS Services	$ 7,210,950	850,972	1,068	69,539	$ 189.60	$ 49.11
Durable Medical Equipment	$ 5,723,376	2,063,918	3,815	168,658	$ 2.77	$ 38.97
Limited Dental Services	$ 3,342	137	50	11	$ 24.43	$ 0.02
Optical	$ 132,996	1,897	1,174	155	$ 70.11	$ 0.91
Lab and X-Ray	$ 1,088,692	37,872	4,843	3,095	$ 28.75	$ 7.41
Transportation	$ 1,676,927	27,938	2,706	2,283	$ 60.02	$ 11.42
Subtotal (Medical)	$ 146,955,808	3,734,595	13,178			$ 1,000.74
CC4C LHD Payments	$ 397	88	N/A	7	$ 4.54	$ 0.00
OBCM LHD Payments	$ 101,345	20,523	N/A	1,677	$ 4.94	$ 0.69
Medical Home Payments	$ 621,927	133,474	N/A	10,907	$ 4.66	$ 4.24
Subtotal (LHD/Medical Home Payments)	$ 723,669	154,084	N/A			$ 4.93
Total (Medical + LHD/Medical Home)	$ 147,679,478	3,888,679	N/A			$ 1,005.67

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 38

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	78,257
Average Monthly Members/Deliveries:	6,521
Eligibles:	12,641

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,525,719	24,261	5,804	3,720	$ 639.95	$ 198.39
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,728,925	11,443	3,805	1,755	$ 151.10	$ 22.09
Emergency Room	$ 1,316,140	5,521	3,212	847	$ 238.40	$ 16.82
Physician	$ 6,695,472	73,367	10,474	11,250	$ 91.26	$ 85.56
FQHC/RHC	$ 779,884	5,972	1,367	916	$ 130.59	$ 9.97
Other Clinic	$ 2,464,658	27,935	9,257	4,284	$ 88.23	$ 31.49
Other Practitioner	$ 2,393	60	24	9	$ 39.69	$ 0.03
Therapies	$ 85,974	915	187	140	$ 93.91	$ 1.10
Prescribed Drugs	$ 1,101,993	23,586	6,177	3,617	$ 46.72	$ 14.08
Other BH Services	$ 5,128	257	11	39	$ 19.93	$ 0.07
LTSS Services	$ 163,499	1,914	246	293	$ 85.44	$ 2.09
Durable Medical Equipment	$ 822,414	182,332	1,251	27,959	$ 4.51	$ 10.51
Limited Dental Services	$ 122,046	4,930	2,027	756	$ 24.75	$ 1.56
Optical	$ 2,257	29	19	4	$ 77.33	$ 0.03
Lab and X-Ray	$ 43,797	2,096	646	321	$ 20.89	$ 0.56
Transportation	$ 109,478	1,300	389	199	$ 84.19	$ 1.40
Subtotal (Medical)	$ 30,969,776	365,919	11,576			$ 395.75
CC4C LHD Payments	$ 323,152	70,918	N/A	10,875	$ 4.56	$ 4.13
OBCM LHD Payments	$ 15	3	N/A	0	$ 4.96	$ 0.00
Medical Home Payments	$ 163,036	66,160	N/A	10,145	$ 2.46	$ 2.08
Subtotal (LHD/Medical Home Payments)	$ 486,203	137,081	N/A			$ 6.21
Total (Medical + LHD/Medical Home)	$ 31,455,979	503,000	N/A			$ 401.96

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 39

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,220,080
Average Monthly Members/Deliveries:	101,673
Eligibles:	116,531

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 5,297,873	4,396	991	43	$ 1,205.11	$ 4.34
Inpatient — BH	$ 1,431,364	1,575	214	15	$ 909.02	$ 1.17
Outpatient Hospital	$ 22,147,849	93,938	34,648	924	$ 235.77	$ 18.15
Emergency Room	$ 15,014,302	49,887	29,704	491	$ 300.97	$ 12.31
Physician	$ 27,760,868	383,658	83,775	3,773	$ 72.36	$ 22.75
FQHC/RHC	$ 5,694,160	41,304	13,839	406	$ 137.86	$ 4.67
Other Clinic	$ 6,516,181	65,219	53,472	641	$ 99.91	$ 5.34
Other Practitioner	$ 215,180	4,152	1,149	41	$ 51.83	$ 0.18
Therapies	$ 4,634,703	46,289	3,434	455	$ 100.13	$ 3.80
Prescribed Drugs	$ 49,955,652	501,953	72,628	4,937	$ 99.52	$ 40.94
Other BH Services	$ 8,956,123	119,215	9,894	1,173	$ 75.13	$ 7.34
LTSS Services	$ 327,992	29,662	53	292	$ 25.08	$ 0.27
Durable Medical Equipment	$ 3,334,257	999,037	6,621	9,826	$ 3.34	$ 2.73
Limited Dental Services	$ 382,494	15,519	5,648	153	$ 24.65	$ 0.31
Optical	$ 1,175,104	14,300	12,815	141	$ 82.17	$ 0.96
Lab and X-Ray	$ 732,355	36,994	9,426	364	$ 19.80	$ 0.60
Transportation	$ 631,403	8,983	2,230	88	$ 70.29	$ 0.52
Subtotal (Medical)	$ 154,207,860	2,416,081	98,966			$ 126.39
CC4C LHD Payments	$ 1,179,912	260,803	N/A	2,565	$ 4.52	$ 0.97
OBCM LHD Payments	$ 658,366	133,787	N/A	1,316	$ 4.92	$ 0.54
Medical Home Payments	$ 2,796,550	1,143,143	N/A	11,243	$ 2.45	$ 2.29
Subtotal (LHD/Medical Home Payments)	$ 4,634,828	1,537,733	N/A			$ 3.80
Total (Medical + LHD/Medical Home)	$ 158,842,688	3,953,814	N/A			$ 130.19

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 40

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	270,425
Average Monthly Members/Deliveries:	22,535
Eligibles:	33,192

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 7,923,909	6,445	1,290	286	$ 1,229.50	$ 29.30
Inpatient — BH	$ 798,181	1,015	203	45	$ 786.59	$ 2.95
Outpatient Hospital	$ 14,339,387	45,065	14,113	2,000	$ 318.19	$ 53.03
Emergency Room	$ 11,885,273	26,596	12,069	1,180	$ 446.88	$ 43.95
Physician	$ 11,407,559	109,837	20,943	4,874	$ 103.86	$ 42.18
FQHC/RHC	$ 2,082,077	16,108	5,354	715	$ 129.26	$ 7.70
Other Clinic	$ 2,241,069	7,958	7,512	353	$ 281.61	$ 8.29
Other Practitioner	$ 128,946	2,276	722	101	$ 56.66	$ 0.48
Therapies	$ 5,759	96	61	4	$ 60.20	$ 0.02
Prescribed Drugs	$ 23,691,831	318,126	20,038	14,117	$ 74.47	$ 87.61
Other BH Services	$ 1,977,560	27,475	3,698	1,219	$ 71.98	$ 7.31
LTSS Services	$ 317,349	18,616	150	826	$ 172.95	$ 1.17
Durable Medical Equipment	$ 1,592,017	686,886	2,671	30,480	$ 2.32	$ 5.89
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 95,213	1,380	843	61	$ 68.99	$ 0.35
Lab and X-Ray	$ 2,284,452	65,669	9,654	2,914	$ 34.79	$ 8.45
Transportation	$ 517,694	7,405	1,797	329	$ 69.91	$ 1.91
Subtotal (Medical)	$ 81,288,275	1,340,954	26,354			$ 300.59
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 853,983	173,769	N/A	7,711	$ 4.91	$ 3.16
Medical Home Payments	$ 456,639	192,396	N/A	8,537	$ 2.37	$ 1.69
Subtotal (LHD/Medical Home Payments)	$ 1,310,621	366,164	N/A			$ 4.85
Total (Medical + LHD/Medical Home)	$ 82,598,896	1,707,119	N/A			$ 305.44

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 41

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	5,230
Average Monthly Members/Deliveries:	436
Eligibles:	5,361

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,196,571	14,204	4,806	32,587	$ 788.30	$ 2,140.69
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,988,804	15,334	2,412	35,180	$ 129.70	$ 380.24
Emergency Room	$ 1,719,165	5,102	683	11,706	$ 336.95	$ 328.69
Physician	$ 8,069,159	44,448	4,938	101,978	$ 181.54	$ 1,542.75
FQHC/RHC	$ 1,101,462	7,373	602	16,917	$ 149.38	$ 210.59
Other Clinic	$ 1,075,068	8,221	1,217	18,861	$ 130.77	$ 205.54
Other Practitioner	$ 616	6	19	14	$ 98.69	$ 0.12
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 87	1	144	2	$ 87.29	$ 0.02
LTSS Services	$ 7,547	987	5	2,264	$ 7.65	$ 1.44
Durable Medical Equipment	$ 45,075	590	179	1,354	$ 76.40	$ 8.62
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 127	1	3	2	$ 121.79	$ 0.02
Lab and X-Ray	$ 199,971	7,563	533	17,353	$ 26.44	$ 38.23
Transportation	$ 66,700	645	263	1,480	$ 103.41	$ 12.75
Subtotal (Medical)	$ 25,470,353	104,476	5,323			$ 4,869.71
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 25,470,353	104,476	N/A			$ 4,869.71

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 42

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 1

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	1,715,609
Average Monthly Members/Deliveries:	142,967
Eligibles:	182,578

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 58,938,575	67,968	15,117	475	$ 867.15	$ 34.35
Inpatient — BH	$ 3,568,417	4,491	697	31	$ 794.63	$ 2.08
Outpatient Hospital	$ 58,501,235	206,511	63,501	1,444	$ 283.28	$ 34.10
Emergency Room	$ 39,281,447	105,157	52,180	736	$ 373.55	$ 22.90
Physician	$ 69,489,547	727,298	131,705	5,087	$ 95.54	$ 40.50
FQHC/RHC	$ 11,876,095	88,035	24,983	616	$ 134.90	$ 6.92
Other Clinic	$ 13,463,559	113,043	73,628	791	$ 119.10	$ 7.85
Other Practitioner	$ 527,911	8,812	2,567	62	$ 59.91	$ 0.31
Therapies	$ 5,212,896	51,706	3,946	362	$ 100.82	$ 3.04
Prescribed Drugs	$ 136,189,868	1,334,735	113,718	9,336	$ 102.04	$ 79.38
Other BH Services	$ 13,032,996	184,695	16,626	1,292	$ 70.56	$ 7.60
LTSS Services	$ 8,027,337	902,150	1,522	6,310	$ 189.51	$ 4.68
Durable Medical Equipment	$ 11,517,139	3,932,762	14,537	27,508	$ 2.93	$ 6.71
Limited Dental Services	$ 507,883	20,586	7,725	144	$ 24.67	$ 0.30
Optical	$ 1,405,697	17,607	14,854	123	$ 79.84	$ 0.82
Lab and X-Ray	$ 4,349,267	150,195	25,102	1,051	$ 28.96	$ 2.54
Transportation	$ 3,002,202	46,271	7,385	324	$ 64.88	$ 1.75
Subtotal (Medical)	$ 438,892,071	7,962,025	155,271			$ 255.82
CC4C LHD Payments	$ 1,503,461	331,809	N/A	2,321	$ 4.53	$ 0.88
OBCM LHD Payments	$ 1,613,708	328,082	N/A	2,295	$ 4.92	$ 0.94
Medical Home Payments	$ 4,038,152	1,535,172	N/A	10,738	$ 2.63	$ 2.35
Subtotal (LHD/Medical Home Payments)	$ 7,155,321	2,195,063	N/A			$ 4.17
Total (Medical + LHD/Medical Home)	$ 446,047,392	10,157,087	N/A			$ 259.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.2 SFY 2017 Region 2 Exhibits

Exhibit 43

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	263,136
Average Monthly Members/Deliveries:	21,928
Eligibles:	25,937

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,083,387	33,435	3,631	1,525	$ 989.49	$ 125.73
Inpatient — BH	$ 1,581,726	2,275	441	104	$ 695.42	$ 6.01
Outpatient Hospital	$ 31,459,577	62,331	12,516	2,843	$ 504.72	$ 119.56
Emergency Room	$ 16,949,675	32,514	11,717	1,483	$ 521.31	$ 64.41
Physician	$ 26,481,959	204,381	20,426	9,321	$ 129.57	$ 100.64
FQHC/RHC	$ 526,521	4,249	1,282	194	$ 123.91	$ 2.00
Other Clinic	$ 2,287,971	6,835	4,055	312	$ 334.72	$ 8.70
Other Practitioner	$ 208,798	2,803	1,077	128	$ 74.48	$ 0.79
Therapies	$ 819,074	7,765	458	354	$ 105.48	$ 3.11
Prescribed Drugs	$ 103,369,743	765,152	20,070	34,894	$ 135.10	$ 392.84
Other BH Services	$ 4,094,563	62,861	5,480	2,867	$ 65.14	$ 15.56
LTSS Services	$ 17,626,213	3,058,087	2,099	139,461	$ 169.55	$ 66.99
Durable Medical Equipment	$ 10,831,764	3,708,218	6,231	169,109	$ 2.92	$ 41.16
Limited Dental Services	$ 10,381	412	143	19	$ 25.21	$ 0.04
Optical	$ 248,853	3,518	2,010	160	$ 70.75	$ 0.95
Lab and X-Ray	$ 2,735,269	109,014	10,867	4,971	$ 25.09	$ 10.39
Transportation	$ 3,308,251	37,263	4,850	1,699	$ 88.78	$ 12.57
Subtotal (Medical)	$ 255,623,725	8,101,112	22,727			$ 971.45
CC4C LHD Payments	$ 1,114	245	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 196,065	39,704	N/A	1,811	$ 4.94	$ 0.75
Medical Home Payments	$ 1,139,481	243,996	N/A	11,127	$ 4.67	$ 4.33
Subtotal (LHD/Medical Home Payments)	$ 1,336,660	283,945	N/A			$ 5.08
Total (Medical + LHD/Medical Home)	$ 256,960,385	8,385,058	N/A			$ 976.53

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 44

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	144,528
Average Monthly Members/Deliveries:	12,044
Eligibles:	23,173

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 26,576,128	47,242	11,050	3,922	$ 562.55	$ 183.88
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,106,834	13,525	5,393	1,123	$ 155.78	$ 14.58
Emergency Room	$ 3,182,994	11,942	6,874	991	$ 266.55	$ 22.02
Physician	$ 12,150,122	133,359	19,705	11,073	$ 91.11	$ 84.07
FQHC/RHC	$ 641,465	5,569	1,225	462	$ 115.19	$ 4.44
Other Clinic	$ 5,142,516	53,297	17,927	4,425	$ 96.49	$ 35.58
Other Practitioner	$ 1,191	37	12	3	$ 32.17	$ 0.01
Therapies	$ 112,191	1,144	157	95	$ 98.08	$ 0.78
Prescribed Drugs	$ 1,946,504	41,817	11,502	3,472	$ 46.55	$ 13.47
Other BH Services	$ 8,618	376	62	31	$ 22.89	$ 0.06
LTSS Services	$ 35,172	546	65	45	$ 64.47	$ 0.24
Durable Medical Equipment	$ 1,128,812	39,504	1,701	3,280	$ 28.57	$ 7.81
Limited Dental Services	$ 312,710	12,578	5,100	1,044	$ 24.86	$ 2.16
Optical	$ 3,409	35	30	3	$ 97.60	$ 0.02
Lab and X-Ray	$ 118,304	6,993	2,524	581	$ 16.92	$ 0.82
Transportation	$ 135,618	1,503	721	125	$ 90.22	$ 0.94
Subtotal (Medical)	$ 53,602,588	369,466	21,347			$ 370.88
CC4C LHD Payments	$ 595,268	130,636	N/A	10,847	$ 4.56	$ 4.12
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 302,478	122,332	N/A	10,157	$ 2.47	$ 2.09
Subtotal (LHD/Medical Home Payments)	$ 897,746	252,967	N/A			$ 6.21
Total (Medical + LHD/Medical Home)	$ 54,500,334	622,433	N/A			$ 377.09

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 45

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,297,179
Average Monthly Members/Deliveries:	191,432
Eligibles:	216,277

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,752,091	8,205	1,852	43	$ 1,310.38	$ 4.68
Inpatient — BH	$ 2,114,694	3,235	524	17	$ 653.76	$ 0.92
Outpatient Hospital	$ 24,844,015	105,826	44,807	553	$ 234.76	$ 10.82
Emergency Room	$ 31,493,396	97,184	58,948	508	$ 324.06	$ 13.71
Physician	$ 45,315,943	655,747	155,015	3,425	$ 69.11	$ 19.73
FQHC/RHC	$ 2,928,078	25,853	11,590	135	$ 113.26	$ 1.27
Other Clinic	$ 13,436,188	131,296	103,554	686	$ 102.33	$ 5.85
Other Practitioner	$ 234,925	2,965	1,369	15	$ 79.23	$ 0.10
Therapies	$ 6,837,795	59,661	3,997	312	$ 114.61	$ 2.98
Prescribed Drugs	$ 84,692,324	875,933	131,257	4,576	$ 96.69	$ 36.87
Other BH Services	$ 10,839,718	140,832	13,430	736	$ 76.97	$ 4.72
LTSS Services	$ 174,936	26,924	85	141	$ 6.50	$ 0.08
Durable Medical Equipment	$ 5,217,783	2,011,476	11,540	10,508	$ 2.59	$ 2.27
Limited Dental Services	$ 1,005,121	40,739	13,961	213	$ 24.67	$ 0.44
Optical	$ 2,395,843	28,838	23,135	151	$ 83.08	$ 1.04
Lab and X-Ray	$ 3,364,513	178,466	42,564	932	$ 18.85	$ 1.46
Transportation	$ 958,910	10,649	4,449	56	$ 90.05	$ 0.42
Subtotal (Medical)	$ 246,606,272	4,403,829	180,636			$ 107.35
CC4C LHD Payments	$ 2,230,258	492,968	N/A	2,575	$ 4.52	$ 0.97
OBCM LHD Payments	$ 1,263,793	256,816	N/A	1,342	$ 4.92	$ 0.55
Medical Home Payments	$ 5,345,660	2,179,810	N/A	11,387	$ 2.45	$ 2.33
Subtotal (LHD/Medical Home Payments)	$ 8,839,710	2,929,593	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 255,445,982	7,333,422	N/A			$ 111.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 46

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	468,569
Average Monthly Members/Deliveries:	39,047
Eligibles:	56,420

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,971,337	11,199	2,262	287	$ 1,068.94	$ 25.55
Inpatient — BH	$ 1,014,168	1,495	382	38	$ 678.22	$ 2.16
Outpatient Hospital	$ 17,998,181	51,707	19,704	1,324	$ 348.08	$ 38.41
Emergency Room	$ 20,552,237	44,736	22,136	1,146	$ 459.42	$ 43.86
Physician	$ 22,478,323	208,375	37,935	5,336	$ 107.87	$ 47.97
FQHC/RHC	$ 324,957	2,701	1,193	69	$ 120.31	$ 0.69
Other Clinic	$ 3,651,840	14,503	12,615	371	$ 251.80	$ 7.79
Other Practitioner	$ 176,221	2,613	1,043	67	$ 67.45	$ 0.38
Therapies	$ 6,918	125	98	3	$ 55.20	$ 0.01
Prescribed Drugs	$ 51,201,429	542,420	34,564	13,891	$ 94.39	$ 109.27
Other BH Services	$ 3,523,543	45,048	5,294	1,154	$ 78.22	$ 7.52
LTSS Services	$ 1,109,248	163,970	298	4,199	$ 172.43	$ 2.37
Durable Medical Equipment	$ 2,716,156	1,264,152	4,234	32,375	$ 2.15	$ 5.80
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 250,399	3,797	1,565	97	$ 65.95	$ 0.53
Lab and X-Ray	$ 6,453,854	227,736	23,592	5,832	$ 28.34	$ 13.77
Transportation	$ 1,146,516	12,345	3,507	316	$ 92.88	$ 2.45
Subtotal (Medical)	$ 144,575,328	2,596,921	44,687			$ 308.55
CC4C LHD Payments	$ 18	4	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 1,579,767	321,452	N/A	8,232	$ 4.91	$ 3.37
Medical Home Payments	$ 795,630	336,586	N/A	8,620	$ 2.36	$ 1.70
Subtotal (LHD/Medical Home Payments)	$ 2,375,415	658,041	N/A			$ 5.07
Total (Medical + LHD/Medical Home)	$ 146,950,743	3,254,963	N/A			$ 313.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 47

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,264
Average Monthly Members/Deliveries:	772
Eligibles:	9,406

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 18,484,926	26,525	8,734	34,361	$ 696.87	$ 1,995.43
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,001,893	31,395	3,775	40,669	$ 127.47	$ 432.00
Emergency Room	$ 4,737,924	13,907	1,445	18,016	$ 340.67	$ 511.46
Physician	$ 16,582,118	75,117	9,064	97,306	$ 220.75	$ 1,790.03
FQHC/RHC	$ 64,871	517	38	670	$ 125.40	$ 7.00
Other Clinic	$ 1,041,576	7,139	2,368	9,247	$ 145.91	$ 112.44
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 215	5	174	7	$ 42.19	$ 0.02
LTSS Services	$ 23,955	4,764	7	6,172	$ 5.03	$ 2.59
Durable Medical Equipment	$ 16,373	619	256	802	$ 26.45	$ 1.77
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 247	3	20	4	$ 80.26	$ 0.03
Lab and X-Ray	$ 367,249	18,967	2,042	24,570	$ 19.36	$ 39.64
Transportation	$ 97,926	982	487	1,272	$ 99.69	$ 10.57
Subtotal (Medical)	$ 45,419,272	179,942	9,364			$ 4,902.97
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 45,419,272	179,942	N/A			$ 4,902.97

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 48

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 2

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,173,411
Average Monthly Members/Deliveries:	264,451
Eligibles:	331,213

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 100,867,870	126,607	27,529	479	$ 796.70	$ 31.79
Inpatient — BH	$ 4,710,589	7,005	1,349	26	$ 672.51	$ 1.48
Outpatient Hospital	$ 80,410,499	264,783	86,195	1,001	$ 303.68	$ 25.34
Emergency Room	$ 76,916,227	200,282	101,120	757	$ 384.04	$ 24.24
Physician	$ 123,008,465	1,276,979	242,145	4,829	$ 96.33	$ 38.76
FQHC/RHC	$ 4,485,892	38,890	15,328	147	$ 115.35	$ 1.41
Other Clinic	$ 25,560,091	213,070	140,519	806	$ 119.96	$ 8.05
Other Practitioner	$ 621,135	8,418	3,509	32	$ 73.79	$ 0.20
Therapies	$ 7,775,978	68,695	4,710	260	$ 113.20	$ 2.45
Prescribed Drugs	$ 241,209,999	2,225,322	203,600	8,415	$ 108.39	$ 76.01
Other BH Services	$ 18,466,657	249,122	24,440	942	$ 74.13	$ 5.82
LTSS Services	$ 18,969,525	3,254,292	2,554	12,306	$ 170.88	$ 5.98
Durable Medical Equipment	$ 19,910,887	7,023,969	23,962	26,561	$ 2.83	$ 6.27
Limited Dental Services	$ 1,328,212	53,729	19,204	203	$ 24.72	$ 0.42
Optical	$ 2,898,750	36,190	26,760	137	$ 80.10	$ 0.91
Lab and X-Ray	$ 13,039,190	541,176	81,589	2,046	$ 24.09	$ 4.11
Transportation	$ 5,647,221	62,742	14,014	237	$ 90.01	$ 1.78
Subtotal (Medical)	$ 745,827,186	15,651,270	278,326			$ 235.02
CC4C LHD Payments	$ 2,826,658	623,853	N/A	2,359	$ 4.53	$ 0.89
OBCM LHD Payments	$ 3,039,624	617,972	N/A	2,337	$ 4.92	$ 0.96
Medical Home Payments	$ 7,583,248	2,882,723	N/A	10,901	$ 2.63	$ 2.39
Subtotal (LHD/Medical Home Payments)	$ 13,449,531	4,124,547	N/A			$ 4.24
Total (Medical + LHD/Medical Home)	$ 759,276,717	19,775,818	N/A			$ 239.26

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.3 SFY 2017 Region 3 Exhibits

Exhibit 49

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	328,525
Average Monthly Members/Deliveries:	27,377
Eligibles:	32,778

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 41,598,028	42,685	4,608	1,559	$ 974.53	$ 126.62
Inpatient — BH	$ 2,290,834	4,096	454	150	$ 559.29	$ 6.97
Outpatient Hospital	$ 35,546,505	73,931	15,775	2,700	$ 480.81	$ 108.20
Emergency Room	$ 22,891,149	45,627	15,006	1,667	$ 501.70	$ 69.68
Physician	$ 37,974,265	282,103	25,581	10,304	$ 134.61	$ 115.59
FQHC/RHC	$ 1,081,821	9,709	2,908	355	$ 111.43	$ 3.29
Other Clinic	$ 3,723,798	8,149	4,961	298	$ 456.95	$ 11.33
Other Practitioner	$ 284,035	3,766	1,323	138	$ 75.42	$ 0.86
Therapies	$ 1,780,683	16,327	1,037	596	$ 109.07	$ 5.42
Prescribed Drugs	$ 153,170,308	942,292	24,965	34,419	$ 162.55	$ 466.24
Other BH Services	$ 5,135,458	104,727	6,843	3,825	$ 49.04	$ 15.63
LTSS Services	$ 31,801,162	6,153,530	3,492	224,769	$ 168.18	$ 96.80
Durable Medical Equipment	$ 15,590,300	4,925,689	7,927	179,920	$ 3.17	$ 47.46
Limited Dental Services	$ 9,796	386	145	14	$ 25.41	$ 0.03
Optical	$ 219,763	3,083	1,816	113	$ 71.28	$ 0.67
Lab and X-Ray	$ 3,124,896	123,251	11,636	4,502	$ 25.35	$ 9.51
Transportation	$ 3,542,680	61,309	6,189	2,239	$ 57.78	$ 10.78
Subtotal (Medical)	$ 359,765,481	12,800,659	28,564			$ 1,095.09
CC4C LHD Payments	$ 1,416	312	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 238,983	48,396	N/A	1,768	$ 4.94	$ 0.73
Medical Home Payments	$ 1,453,939	302,679	N/A	11,056	$ 4.80	$ 4.43
Subtotal (LHD/Medical Home Payments)	$ 1,694,338	351,387	N/A			$ 5.16
Total (Medical + LHD/Medical Home)	$ 361,459,819	13,152,046	N/A			$ 1,100.25

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 50

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	211,433
Average Monthly Members/Deliveries:	17,619
Eligibles:	33,933

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 39,150,106	67,642	15,412	3,839	$ 578.78	$ 185.17
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 2,291,442	13,526	7,212	768	$ 169.41	$ 10.84
Emergency Room	$ 4,503,473	18,120	10,252	1,028	$ 248.53	$ 21.30
Physician	$ 18,382,371	195,045	28,890	11,070	$ 94.25	$ 86.94
FQHC/RHC	$ 327,502	2,924	659	166	$ 112.01	$ 1.55
Other Clinic	$ 7,106,897	75,519	25,720	4,286	$ 94.11	$ 33.61
Other Practitioner	$ 16,794	446	73	25	$ 37.64	$ 0.08
Therapies	$ 238,573	2,634	361	149	$ 90.58	$ 1.13
Prescribed Drugs	$ 3,245,173	62,943	16,361	3,572	$ 51.56	$ 15.35
Other BH Services	$ 18,984	1,151	41	65	$ 16.49	$ 0.09
LTSS Services	$ 375,745	25,068	270	1,423	$ 14.99	$ 1.78
Durable Medical Equipment	$ 1,891,641	71,498	2,717	4,058	$ 26.46	$ 8.95
Limited Dental Services	$ 356,162	14,319	5,745	813	$ 24.87	$ 1.68
Optical	$ 890	9	8	0	$ 102.46	$ 0.00
Lab and X-Ray	$ 362,383	10,187	2,748	578	$ 35.57	$ 1.71
Transportation	$ 188,556	1,943	975	110	$ 97.04	$ 0.89
Subtotal (Medical)	$ 78,456,691	562,974	30,794			$ 371.07
CC4C LHD Payments	$ 867,157	190,304	N/A	10,801	$ 4.56	$ 4.10
OBCM LHD Payments	$ 5	1	N/A	0	$ 4.96	$ 0.00
Medical Home Payments	$ 418,634	169,083	N/A	9,596	$ 2.48	$ 1.98
Subtotal (LHD/Medical Home Payments)	$ 1,285,797	359,387	N/A			$ 6.08
Total (Medical + LHD/Medical Home)	$ 79,742,487	922,361	N/A			$ 377.15

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 51

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	3,243,949
Average Monthly Members/Deliveries:	270,329
Eligibles:	308,878

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 12,385,404	11,265	2,430	42	$ 1,099.48	$ 3.82
Inpatient — BH	$ 2,072,143	3,875	578	14	$ 534.69	$ 0.64
Outpatient Hospital	$ 25,456,020	95,720	53,076	354	$ 265.94	$ 7.85
Emergency Room	$ 40,944,054	138,951	82,366	514	$ 294.67	$ 12.62
Physician	$ 70,311,450	927,875	219,935	3,432	$ 75.78	$ 21.67
FQHC/RHC	$ 1,785,329	15,073	6,462	56	$ 118.45	$ 0.55
Other Clinic	$ 19,078,107	193,462	148,634	716	$ 98.61	$ 5.88
Other Practitioner	$ 646,166	7,977	2,263	30	$ 81.01	$ 0.20
Therapies	$ 10,137,948	102,097	7,207	378	$ 99.30	$ 3.13
Prescribed Drugs	$ 114,284,540	1,177,481	179,354	4,356	$ 97.06	$ 35.23
Other BH Services	$ 17,461,990	231,775	20,559	857	$ 75.34	$ 5.38
LTSS Services	$ 933,047	113,486	219	420	$ 22.25	$ 0.29
Durable Medical Equipment	$ 7,018,183	2,132,100	16,249	7,887	$ 3.29	$ 2.16
Limited Dental Services	$ 1,012,572	40,951	14,558	151	$ 24.73	$ 0.31
Optical	$ 2,033,644	24,224	22,053	90	$ 83.95	$ 0.63
Lab and X-Ray	$ 5,428,344	247,962	45,200	917	$ 21.89	$ 1.67
Transportation	$ 1,228,715	17,417	6,352	64	$ 70.55	$ 0.38
Subtotal (Medical)	$ 332,217,656	5,481,690	250,681			$ 102.41
CC4C LHD Payments	$ 3,184,269	703,839	N/A	2,604	$ 4.52	$ 0.98
OBCM LHD Payments	$ 1,735,278	352,627	N/A	1,304	$ 4.92	$ 0.53
Medical Home Payments	$ 7,385,222	2,996,840	N/A	11,086	$ 2.46	$ 2.28
Subtotal (LHD/Medical Home Payments)	$ 12,304,769	4,053,305	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 344,522,425	9,534,995	N/A			$ 106.20

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 52

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	711,903
Average Monthly Members/Deliveries:	59,325
Eligibles:	84,698

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 15,322,830	13,791	2,684	232	$ 1,111.10	$ 21.52
Inpatient — BH	$ 1,236,429	2,212	382	37	$ 558.94	$ 1.74
Outpatient Hospital	$ 22,025,205	69,568	27,879	1,173	$ 316.60	$ 30.94
Emergency Room	$ 32,641,030	73,873	33,311	1,245	$ 441.85	$ 45.85
Physician	$ 32,474,178	295,608	54,292	4,983	$ 109.86	$ 45.62
FQHC/RHC	$ 964,134	8,969	3,531	151	$ 107.49	$ 1.35
Other Clinic	$ 4,865,419	21,997	18,253	371	$ 221.19	$ 6.83
Other Practitioner	$ 263,606	4,308	1,494	73	$ 61.19	$ 0.37
Therapies	$ 25,581	452	401	8	$ 56.63	$ 0.04
Prescribed Drugs	$ 64,644,468	733,296	50,217	12,361	$ 88.16	$ 90.81
Other BH Services	$ 4,875,878	75,615	7,176	1,275	$ 64.48	$ 6.85
LTSS Services	$ 1,977,810	332,526	502	5,605	$ 160.13	$ 2.78
Durable Medical Equipment	$ 4,169,468	1,749,357	5,681	29,488	$ 2.38	$ 5.86
Limited Dental Services	$ 30	2	1	0	$ 15.06	$ 0.00
Optical	$ 145,795	2,102	1,167	35	$ 69.35	$ 0.20
Lab and X-Ray	$ 8,241,625	270,613	27,708	4,562	$ 30.46	$ 11.58
Transportation	$ 1,275,756	17,486	5,143	295	$ 72.96	$ 1.79
Subtotal (Medical)	$ 195,149,244	3,671,775	65,333			$ 274.12
CC4C LHD Payments	$ 5	1	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 2,376,978	483,668	N/A	8,153	$ 4.91	$ 3.34
Medical Home Payments	$ 1,252,574	514,790	N/A	8,677	$ 2.43	$ 1.76
Subtotal (LHD/Medical Home Payments)	$ 3,629,556	998,459	N/A			$ 5.10
Total (Medical + LHD/Medical Home)	$ 198,778,800	4,670,234	N/A			$ 279.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 53

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	13,078
Average Monthly Members/Deliveries:	1,090
Eligibles:	13,259

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 26,477,511	36,076	11,977	33,103	$ 733.93	$ 2,024.61
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,228,461	23,951	4,613	21,977	$ 134.80	$ 246.87
Emergency Room	$ 6,100,174	16,495	2,258	15,136	$ 369.81	$ 466.45
Physician	$ 21,653,244	93,486	12,698	85,781	$ 231.62	$ 1,655.72
FQHC/RHC	$ 100,569	767	42	704	$ 131.16	$ 7.69
Other Clinic	$ 3,065,443	15,434	2,973	14,162	$ 198.62	$ 234.40
Other Practitioner	$ 1,775	40	27	37	$ 44.05	$ 0.14
Therapies	$ 387	4	2	4	$ 89.84	$ 0.03
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 46,500	57,529	20	52,788	$ 0.81	$ 3.56
Durable Medical Equipment	$ 26,774	1,037	351	952	$ 25.81	$ 2.05
Limited Dental Services	$ 51	2	-	2	$ 24.71	$ 0.00
Optical	$ 144	2	15	2	$ 69.74	$ 0.01
Lab and X-Ray	$ 619,157	21,757	1,957	19,964	$ 28.46	$ 47.34
Transportation	$ 127,393	1,396	668	1,281	$ 91.28	$ 9.74
Subtotal (Medical)	$ 61,447,583	267,977	13,221			$ 4,698.62
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 61,447,583	267,977	N/A			$ 4,698.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 54

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 3

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	4,495,811
Average Monthly Members/Deliveries:	374,651
Eligibles:	473,546

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 134,933,879	171,459	37,111	458	$ 786.98	$ 30.01
Inpatient — BH	$ 5,599,406	10,183	1,416	27	$ 549.85	$ 1.25
Outpatient Hospital	$ 88,547,633	276,696	108,555	739	$ 320.02	$ 19.70
Emergency Room	$ 107,079,880	293,067	143,193	782	$ 365.38	$ 23.82
Physician	$ 180,795,507	1,794,117	341,396	4,789	$ 100.77	$ 40.21
FQHC/RHC	$ 4,259,355	37,441	13,602	100	$ 113.76	$ 0.95
Other Clinic	$ 37,839,664	314,561	200,541	840	$ 120.29	$ 8.42
Other Practitioner	$ 1,212,375	16,537	5,180	44	$ 73.31	$ 0.27
Therapies	$ 12,183,172	121,514	9,008	324	$ 100.26	$ 2.71
Prescribed Drugs	$ 335,344,488	2,916,011	278,989	7,783	$ 115.00	$ 74.59
Other BH Services	$ 27,492,311	413,268	34,870	1,103	$ 66.52	$ 6.12
LTSS Services	$ 35,134,265	6,682,139	4,503	17,836	$ 167.51	$ 7.81
Durable Medical Equipment	$ 28,696,365	8,879,681	32,925	23,701	$ 3.23	$ 6.38
Limited Dental Services	$ 1,378,611	55,659	20,449	149	$ 24.77	$ 0.31
Optical	$ 2,400,237	29,421	25,059	79	$ 81.58	$ 0.53
Lab and X-Ray	$ 17,776,406	673,770	89,249	1,798	$ 26.38	$ 3.95
Transportation	$ 6,363,100	99,551	19,327	266	$ 63.92	$ 1.42
Subtotal (Medical)	$ 1,027,036,654	22,785,075	388,116			$ 228.44
CC4C LHD Payments	$ 4,052,847	894,455	N/A	2,387	$ 4.53	$ 0.90
OBCM LHD Payments	$ 4,351,244	884,692	N/A	2,361	$ 4.92	$ 0.97
Medical Home Payments	$ 10,510,370	3,983,391	N/A	10,632	$ 2.64	$ 2.34
Subtotal (LHD/Medical Home Payments)	$ 18,914,461	5,762,538	N/A			$ 4.21
Total (Medical + LHD/Medical Home)	$ 1,045,951,115	28,547,613	N/A			$ 232.65

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.4 SFY 2017 Region 4 Exhibits

Exhibit 55

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	278,511
Average Monthly Members/Deliveries:	23,209
Eligibles:	27,445

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 38,729,867	39,670	3,610	1,709	$ 976.30	$ 139.06
Inpatient — BH	$ 2,067,638	2,586	304	111	$ 799.57	$ 7.42
Outpatient Hospital	$ 27,936,179	54,068	11,740	2,330	$ 516.68	$ 100.31
Emergency Room	$ 17,085,084	33,138	12,223	1,428	$ 515.57	$ 61.34
Physician	$ 28,552,620	204,806	20,445	8,824	$ 139.41	$ 102.52
FQHC/RHC	$ 2,013,794	17,215	4,840	742	$ 116.98	$ 7.23
Other Clinic	$ 4,031,634	8,133	4,302	350	$ 495.74	$ 14.48
Other Practitioner	$ 174,698	2,215	917	95	$ 78.86	$ 0.63
Therapies	$ 1,820,760	15,897	929	685	$ 114.53	$ 6.54
Prescribed Drugs	$ 121,607,990	703,312	20,431	30,303	$ 172.91	$ 436.64
Other BH Services	$ 5,974,538	101,786	5,806	4,386	$ 58.70	$ 21.45
LTSS Services	$ 17,890,751	3,563,752	2,243	153,549	$ 171.36	$ 64.24
Durable Medical Equipment	$ 10,148,598	3,845,988	6,547	165,710	$ 2.64	$ 36.44
Limited Dental Services	$ 9,625	390	144	17	$ 24.66	$ 0.03
Optical	$ 283,386	4,041	2,392	174	$ 70.14	$ 1.02
Lab and X-Ray	$ 2,448,064	105,268	9,564	4,536	$ 23.26	$ 8.79
Transportation	$ 2,707,501	46,364	4,592	1,998	$ 58.40	$ 9.72
Subtotal (Medical)	$ 283,482,727	8,748,629	23,855			$ 1,017.85
CC4C LHD Payments	$ 1,087	240	N/A	10	$ 4.54	$ 0.00
OBCM LHD Payments	$ 194,270	39,341	N/A	1,695	$ 4.94	$ 0.70
Medical Home Payments	$ 1,234,620	256,154	N/A	11,037	$ 4.82	$ 4.43
Subtotal (LHD/Medical Home Payments)	$ 1,429,978	295,734	N/A			$ 5.13
Total (Medical + LHD/Medical Home)	$ 284,912,705	9,044,364	N/A			$ 1,022.99

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 56

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	171,144
Average Monthly Members/Deliveries:	14,262
Eligibles:	27,550

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,192,884	59,628	12,717	4,181	$ 556.67	$ 193.95
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,558,689	10,016	4,852	702	$ 155.62	$ 9.11
Emergency Room	$ 4,032,465	15,019	8,330	1,053	$ 268.50	$ 23.56
Physician	$ 16,249,014	159,947	22,675	11,215	$ 101.59	$ 94.94
FQHC/RHC	$ 1,331,168	12,586	2,728	883	$ 105.76	$ 7.78
Other Clinic	$ 5,670,995	60,423	19,861	4,237	$ 93.85	$ 33.14
Other Practitioner	$ 3,714	80	24	6	$ 46.54	$ 0.02
Therapies	$ 146,961	1,450	319	102	$ 101.37	$ 0.86
Prescribed Drugs	$ 2,326,991	42,297	12,393	2,966	$ 55.01	$ 13.60
Other BH Services	$ 16,882	377	68	26	$ 44.81	$ 0.10
LTSS Services	$ 138,232	9,368	22	657	$ 14.76	$ 0.81
Durable Medical Equipment	$ 592,898	108,736	1,677	7,624	$ 5.45	$ 3.46
Limited Dental Services	$ 328,860	13,198	5,322	925	$ 24.92	$ 1.92
Optical	$ 4,012	46	39	3	$ 86.63	$ 0.02
Lab and X-Ray	$ 150,471	6,704	2,203	470	$ 22.44	$ 0.88
Transportation	$ 205,431	2,190	904	154	$ 93.79	$ 1.20
Subtotal (Medical)	$ 65,949,665	502,066	25,034			$ 385.35
CC4C LHD Payments	$ 703,766	154,446	N/A	10,829	$ 4.56	$ 4.11
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 340,825	138,895	N/A	9,739	$ 2.45	$ 1.99
Subtotal (LHD/Medical Home Payments)	$ 1,044,591	293,341	N/A			$ 6.10
Total (Medical + LHD/Medical Home)	$ 66,994,257	795,408	N/A			$ 391.45

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 57

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,661,605
Average Monthly Members/Deliveries:	221,800
Eligibles:	254,570

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 10,743,316	9,464	2,049	43	$ 1,135.22	$ 4.04
Inpatient — BH	$ 3,347,145	4,904	512	22	$ 682.59	$ 1.26
Outpatient Hospital	$ 21,664,568	68,578	36,951	309	$ 315.91	$ 8.14
Emergency Room	$ 35,537,128	110,945	67,270	500	$ 320.31	$ 13.35
Physician	$ 51,877,982	642,506	167,275	2,897	$ 80.74	$ 19.49
FQHC/RHC	$ 5,883,863	56,555	23,375	255	$ 104.04	$ 2.21
Other Clinic	$ 14,767,935	146,571	107,852	661	$ 100.76	$ 5.55
Other Practitioner	$ 254,872	3,144	1,356	14	$ 81.08	$ 0.10
Therapies	$ 15,642,186	140,175	9,534	632	$ 111.59	$ 5.88
Prescribed Drugs	$ 83,094,773	793,826	138,203	3,579	$ 104.68	$ 31.22
Other BH Services	$ 16,490,885	201,086	16,840	907	$ 82.01	$ 6.20
LTSS Services	$ 506,994	55,059	88	248	$ 100.42	$ 0.19
Durable Medical Equipment	$ 5,323,569	1,843,198	16,064	8,310	$ 2.89	$ 2.00
Limited Dental Services	$ 1,006,920	40,769	14,218	184	$ 24.70	$ 0.38
Optical	$ 2,858,250	35,190	29,914	159	$ 81.22	$ 1.07
Lab and X-Ray	$ 3,539,940	221,569	41,038	999	$ 15.98	$ 1.33
Transportation	$ 928,882	12,288	5,462	55	$ 75.59	$ 0.35
Subtotal (Medical)	$ 273,469,208	4,385,825	207,373			$ 102.75
CC4C LHD Payments	$ 2,601,271	574,975	N/A	2,592	$ 4.52	$ 0.98
OBCM LHD Payments	$ 1,373,290	279,067	N/A	1,258	$ 4.92	$ 0.52
Medical Home Payments	$ 6,100,387	2,481,210	N/A	11,187	$ 2.46	$ 2.29
Subtotal (LHD/Medical Home Payments)	$ 10,074,948	3,335,253	N/A			$ 3.79
Total (Medical + LHD/Medical Home)	$ 283,544,156	7,721,078	N/A			$ 106.53

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 58

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	509,487
Average Monthly Members/Deliveries:	42,457
Eligibles:	63,865

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,795,791	11,082	2,048	261	$ 1,064.42	$ 23.15
Inpatient — BH	$ 776,246	979	206	23	$ 792.51	$ 1.52
Outpatient Hospital	$ 16,897,404	45,563	19,957	1,073	$ 370.86	$ 33.17
Emergency Room	$ 24,056,553	49,941	24,093	1,176	$ 481.70	$ 47.22
Physician	$ 21,895,235	193,964	39,057	4,568	$ 112.88	$ 42.98
FQHC/RHC	$ 1,859,431	16,940	6,144	399	$ 109.77	$ 3.65
Other Clinic	$ 4,116,851	23,515	17,253	554	$ 175.07	$ 8.08
Other Practitioner	$ 155,717	2,046	856	48	$ 76.12	$ 0.31
Therapies	$ 14,062	252	187	6	$ 55.91	$ 0.03
Prescribed Drugs	$ 43,540,709	481,193	35,552	11,334	$ 90.48	$ 85.46
Other BH Services	$ 4,241,961	53,394	5,626	1,258	$ 79.45	$ 8.33
LTSS Services	$ 962,875	164,580	311	3,876	$ 161.73	$ 1.89
Durable Medical Equipment	$ 2,316,258	1,165,421	4,649	27,449	$ 1.99	$ 4.55
Limited Dental Services	$ 16	1	1	0	$ 15.11	$ 0.00
Optical	$ 182,097	2,654	1,541	63	$ 68.61	$ 0.36
Lab and X-Ray	$ 5,662,928	223,143	23,527	5,256	$ 25.38	$ 11.11
Transportation	$ 848,431	11,709	3,769	276	$ 72.46	$ 1.67
Subtotal (Medical)	$ 139,322,565	2,446,376	49,408			$ 273.46
CC4C LHD Payments	$ 59	13	N/A	0	$ 4.52	$ 0.00
OBCM LHD Payments	$ 1,726,213	351,250	N/A	8,273	$ 4.91	$ 3.39
Medical Home Payments	$ 852,336	350,290	N/A	8,250	$ 2.43	$ 1.67
Subtotal (LHD/Medical Home Payments)	$ 2,578,607	701,554	N/A			$ 5.06
Total (Medical + LHD/Medical Home)	$ 141,901,172	3,147,930	N/A			$ 278.52

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 59

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	9,785
Average Monthly Members/Deliveries:	815
Eligibles:	9,978

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 20,698,110	27,700	9,171	33,970	$ 747.23	$ 2,115.28
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 4,185,698	26,015	3,533	31,904	$ 160.90	$ 427.77
Emergency Room	$ 5,781,685	14,018	1,737	17,191	$ 412.46	$ 590.87
Physician	$ 15,890,268	73,835	9,536	90,548	$ 215.21	$ 1,623.93
FQHC/RHC	$ 540,150	4,280	311	5,248	$ 126.21	$ 55.20
Other Clinic	$ 2,723,339	16,916	3,107	20,746	$ 160.99	$ 278.32
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 1,015	17	192	21	$ 58.47	$ 0.10
LTSS Services	$ 16,604	3,655	20	4,482	$ 4.54	$ 1.70
Durable Medical Equipment	$ 11,888	184	280	226	$ 64.53	$ 1.21
Limited Dental Services	$ 106	4	-	5	$ 25.18	$ 0.01
Optical	$ -	-	-	-	$ -	$ -
Lab and X-Ray	$ 742,268	27,079	2,088	33,208	$ 27.41	$ 75.86
Transportation	$ 137,693	1,535	653	1,883	$ 89.70	$ 14.07
Subtotal (Medical)	$ 50,728,824	195,238	9,909			$ 5,184.32
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 50,728,824	195,238	N/A			$ 5,184.32

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 60

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 4

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,620,746
Average Monthly Members/Deliveries:	301,729
Eligibles:	383,408

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 115,159,968	147,543	29,595	489	$ 780.52	$ 31.81
Inpatient — BH	$ 6,191,029	8,469	1,025	28	$ 731.02	$ 1.71
Outpatient Hospital	$ 72,242,539	204,240	77,033	677	$ 353.71	$ 19.95
Emergency Room	$ 86,492,915	223,060	113,653	739	$ 387.76	$ 23.89
Physician	$ 134,465,119	1,275,058	258,988	4,226	$ 105.46	$ 37.14
FQHC/RHC	$ 11,628,405	107,575	37,398	357	$ 108.10	$ 3.21
Other Clinic	$ 31,310,754	255,559	152,375	847	$ 122.52	$ 8.65
Other Practitioner	$ 589,000	7,484	3,161	25	$ 78.70	$ 0.16
Therapies	$ 17,623,969	157,773	10,969	523	$ 111.70	$ 4.87
Prescribed Drugs	$ 250,570,463	2,020,628	211,979	6,697	$ 124.01	$ 69.20
Other BH Services	$ 26,725,280	356,659	28,532	1,182	$ 74.93	$ 7.38
LTSS Services	$ 19,515,455	3,796,414	2,684	12,582	$ 170.40	$ 5.39
Durable Medical Equipment	$ 18,393,211	6,963,527	29,217	23,079	$ 2.64	$ 5.08
Limited Dental Services	$ 1,345,527	54,363	19,685	180	$ 24.75	$ 0.37
Optical	$ 3,327,746	41,931	33,903	139	$ 79.36	$ 0.92
Lab and X-Ray	$ 12,543,671	583,764	78,420	1,935	$ 21.49	$ 3.46
Transportation	$ 4,827,938	74,087	15,380	246	$ 65.17	$ 1.33
Subtotal (Medical)	$ 812,952,989	16,278,134	315,007			$ 224.53
CC4C LHD Payments	$ 3,306,184	729,674	N/A	2,418	$ 4.53	$ 0.91
OBCM LHD Payments	$ 3,293,773	669,658	N/A	2,219	$ 4.92	$ 0.91
Medical Home Payments	$ 8,528,168	3,226,550	N/A	10,694	$ 2.64	$ 2.36
Subtotal (LHD/Medical Home Payments)	$ 15,128,124	4,625,882	N/A			$ 4.18
Total (Medical + LHD/Medical Home)	$ 828,081,113	20,904,016	N/A			$ 228.70

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.5 SFY 2017 Region 5 Exhibits

Exhibit 61

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	309,639
Average Monthly Members/Deliveries:	25,803
Eligibles:	30,210

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 40,612,383	42,084	4,313	1,631	$ 965.03	$ 131.16
Inpatient — BH	$ 1,864,503	2,693	379	104	$ 692.36	$ 6.02
Outpatient Hospital	$ 27,508,819	52,609	13,244	2,039	$ 522.90	$ 88.84
Emergency Room	$ 18,961,621	39,224	14,102	1,520	$ 483.42	$ 61.24
Physician	$ 33,875,195	248,340	23,159	9,624	$ 136.41	$ 109.40
FQHC/RHC	$ 1,866,205	18,500	4,747	717	$ 100.87	$ 6.03
Other Clinic	$ 3,299,232	7,614	4,659	295	$ 433.34	$ 10.66
Other Practitioner	$ 276,665	3,624	1,216	140	$ 76.35	$ 0.89
Therapies	$ 2,451,168	22,859	1,171	886	$ 107.23	$ 7.92
Prescribed Drugs	$ 118,183,541	870,596	23,351	33,740	$ 135.75	$ 381.68
Other BH Services	$ 5,304,737	74,299	6,109	2,879	$ 71.40	$ 17.13
LTSS Services	$ 19,007,888	3,980,340	2,569	154,257	$ 183.98	$ 61.39
Durable Medical Equipment	$ 10,628,755	3,778,000	7,348	146,416	$ 2.81	$ 34.33
Limited Dental Services	$ 11,350	458	167	18	$ 24.78	$ 0.04
Optical	$ 495,088	7,574	3,415	294	$ 65.36	$ 1.60
Lab and X-Ray	$ 3,483,305	128,141	11,730	4,966	$ 27.18	$ 11.25
Transportation	$ 2,165,704	29,698	5,503	1,151	$ 72.93	$ 6.99
Subtotal (Medical)	$ 289,996,157	9,306,652	26,375			$ 936.56
CC4C LHD Payments	$ 1,393	307	N/A	12	$ 4.54	$ 0.00
OBCM LHD Payments	$ 227,324	46,035	N/A	1,784	$ 4.94	$ 0.73
Medical Home Payments	$ 1,375,299	288,824	N/A	11,193	$ 4.76	$ 4.44
Subtotal (LHD/Medical Home Payments)	$ 1,604,016	335,165	N/A			$ 5.18
Total (Medical + LHD/Medical Home)	$ 291,600,174	9,641,817	N/A			$ 941.74

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 62

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	135,338
Average Monthly Members/Deliveries:	11,278
Eligibles:	21,970

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 27,527,584	50,762	10,306	4,501	$ 542.29	$ 203.40
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,082,010	8,301	4,063	736	$ 130.34	$ 7.99
Emergency Room	$ 2,916,943	13,428	7,304	1,191	$ 217.22	$ 21.55
Physician	$ 13,689,167	130,796	18,720	11,597	$ 104.66	$ 101.15
FQHC/RHC	$ 423,789	4,260	1,008	378	$ 99.48	$ 3.13
Other Clinic	$ 4,623,649	50,617	16,743	4,488	$ 91.35	$ 34.16
Other Practitioner	$ 3,178	45	12	4	$ 70.51	$ 0.02
Therapies	$ 131,091	1,633	250	145	$ 80.29	$ 0.97
Prescribed Drugs	$ 2,203,710	47,463	11,603	4,208	$ 46.43	$ 16.28
Other BH Services	$ 23,757	977	26	87	$ 24.32	$ 0.18
LTSS Services	$ 47,343	2,743	50	243	$ 17.26	$ 0.35
Durable Medical Equipment	$ 538,442	154,897	1,631	13,734	$ 3.48	$ 3.98
Limited Dental Services	$ 304,063	12,224	4,974	1,084	$ 24.87	$ 2.25
Optical	$ 10,944	140	100	12	$ 77.89	$ 0.08
Lab and X-Ray	$ 121,307	4,449	1,298	395	$ 27.26	$ 0.90
Transportation	$ 239,493	1,459	776	129	$ 164.11	$ 1.77
Subtotal (Medical)	$ 53,886,470	484,195	20,079			$ 398.16
CC4C LHD Payments	$ 557,110	122,261	N/A	10,841	$ 4.56	$ 4.12
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 273,894	111,246	N/A	9,864	$ 2.46	$ 2.02
Subtotal (LHD/Medical Home Payments)	$ 831,004	233,508	N/A			$ 6.14
Total (Medical + LHD/Medical Home)	$ 54,717,474	717,703	N/A			$ 404.30

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 63

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	2,183,299
Average Monthly Members/Deliveries:	181,942
Eligibles:	206,833

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 11,636,909	9,854	2,270	54	$ 1,180.90	$ 5.33
Inpatient — BH	$ 1,883,430	2,838	340	16	$ 663.67	$ 0.86
Outpatient Hospital	$ 16,688,669	58,785	32,333	323	$ 283.90	$ 7.64
Emergency Room	$ 29,730,660	109,861	63,656	604	$ 270.62	$ 13.62
Physician	$ 45,810,665	605,763	143,958	3,329	$ 75.62	$ 20.98
FQHC/RHC	$ 2,962,837	31,615	12,412	174	$ 93.72	$ 1.36
Other Clinic	$ 12,237,362	122,028	93,960	671	$ 100.28	$ 5.60
Other Practitioner	$ 201,271	2,305	1,041	13	$ 87.33	$ 0.09
Therapies	$ 13,751,741	132,724	7,670	729	$ 103.61	$ 6.30
Prescribed Drugs	$ 79,259,858	859,738	126,619	4,725	$ 92.19	$ 36.30
Other BH Services	$ 12,831,228	165,675	15,127	911	$ 77.45	$ 5.88
LTSS Services	$ 285,805	35,577	118	196	$ 98.42	$ 0.13
Durable Medical Equipment	$ 3,747,091	1,494,775	10,436	8,216	$ 2.51	$ 1.72
Limited Dental Services	$ 1,003,780	40,617	14,034	223	$ 24.71	$ 0.46
Optical	$ 2,925,673	35,965	29,624	198	$ 81.35	$ 1.34
Lab and X-Ray	$ 2,800,306	128,611	28,381	707	$ 21.77	$ 1.28
Transportation	$ 1,028,192	10,494	5,365	58	$ 97.98	$ 0.47
Subtotal (Medical)	$ 238,785,477	3,847,224	170,371			$ 109.37
CC4C LHD Payments	$ 2,096,343	463,368	N/A	2,547	$ 4.52	$ 0.96
OBCM LHD Payments	$ 1,250,632	254,142	N/A	1,397	$ 4.92	$ 0.57
Medical Home Payments	$ 5,066,409	2,066,633	N/A	11,359	$ 2.45	$ 2.32
Subtotal (LHD/Medical Home Payments)	$ 8,413,384	2,784,143	N/A			$ 3.85
Total (Medical + LHD/Medical Home)	$ 247,198,861	6,631,367	N/A			$ 113.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 64

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	540,587
Average Monthly Members/Deliveries:	45,049
Eligibles:	63,298

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 13,865,660	13,012	2,651	289	$ 1,065.61	$ 25.65
Inpatient — BH	$ 1,245,868	1,728	355	38	$ 721.16	$ 2.30
Outpatient Hospital	$ 16,250,251	47,359	20,793	1,051	$ 343.13	$ 30.06
Emergency Room	$ 25,088,335	57,415	26,535	1,275	$ 436.97	$ 46.41
Physician	$ 28,709,294	250,471	41,412	5,560	$ 114.62	$ 53.11
FQHC/RHC	$ 1,869,126	19,086	6,283	424	$ 97.93	$ 3.46
Other Clinic	$ 3,739,911	16,035	14,756	356	$ 233.23	$ 6.92
Other Practitioner	$ 179,258	2,442	967	54	$ 73.42	$ 0.33
Therapies	$ 18,778	331	248	7	$ 56.65	$ 0.03
Prescribed Drugs	$ 54,429,473	643,955	39,716	14,295	$ 84.52	$ 100.69
Other BH Services	$ 4,372,906	57,473	6,681	1,276	$ 76.09	$ 8.09
LTSS Services	$ 1,112,868	223,543	335	4,962	$ 167.29	$ 2.06
Durable Medical Equipment	$ 2,901,484	1,157,933	5,315	25,704	$ 2.51	$ 5.37
Limited Dental Services	$ -	-	-	-	$ -	$ -
Optical	$ 292,396	4,521	2,118	100	$ 64.67	$ 0.54
Lab and X-Ray	$ 7,635,268	249,732	24,812	5,544	$ 30.57	$ 14.12
Transportation	$ 990,173	10,918	4,868	242	$ 90.69	$ 1.83
Subtotal (Medical)	$ 162,701,048	2,755,954	49,986			$ 300.97
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 1,832,484	372,875	N/A	8,277	$ 4.91	$ 3.39
Medical Home Payments	$ 1,006,669	418,439	N/A	9,289	$ 2.41	$ 1.86
Subtotal (LHD/Medical Home Payments)	$ 2,839,153	791,313	N/A			$ 5.25
Total (Medical + LHD/Medical Home)	$ 165,540,201	3,547,268	N/A			$ 306.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 65

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	8,871
Average Monthly Members/Deliveries:	739
Eligibles:	9,011

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 19,682,422	26,759	8,406	36,196	$ 735.55	$ 2,218.66
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 3,239,525	25,977	3,633	35,138	$ 124.71	$ 365.17
Emergency Room	$ 4,679,384	12,736	1,161	17,228	$ 367.41	$ 527.47
Physician	$ 16,393,306	67,776	8,711	91,679	$ 241.87	$ 1,847.90
FQHC/RHC	$ 413,497	2,799	264	3,787	$ 147.71	$ 46.61
Other Clinic	$ 1,096,469	8,583	1,573	11,610	$ 127.74	$ 123.60
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ 362	7	2	10	$ 50.11	$ 0.04
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ 105	2	232	3	$ 51.19	$ 0.01
LTSS Services	$ 23,398	5,171	23	6,994	$ 4.53	$ 2.64
Durable Medical Equipment	$ 38,881	817	698	1,105	$ 47.59	$ 4.38
Limited Dental Services	$ 54	2	-	3	$ 24.88	$ 0.01
Optical	$ 81	1	14	1	$ 80.59	$ 0.01
Lab and X-Ray	$ 501,977	17,910	1,679	24,227	$ 28.03	$ 56.58
Transportation	$ 169,899	1,510	677	2,042	$ 112.53	$ 19.15
Subtotal (Medical)	$ 46,239,360	170,050	8,964			$ 5,212.24
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 46,239,360	170,050	N/A			$ 5,212.24

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 66

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 5

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	3,168,863
Average Monthly Members/Deliveries:	264,072
Eligibles:	331,322

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 113,324,958	142,471	27,946	540	$ 795.43	$ 35.76
Inpatient — BH	$ 4,993,801	7,258	1,075	27	$ 688.00	$ 1.58
Outpatient Hospital	$ 64,769,273	193,030	74,066	731	$ 335.54	$ 20.44
Emergency Room	$ 81,376,943	232,664	112,758	881	$ 349.76	$ 25.68
Physician	$ 138,477,627	1,303,147	235,960	4,935	$ 106.26	$ 43.70
FQHC/RHC	$ 7,535,453	76,261	24,714	289	$ 98.81	$ 2.38
Other Clinic	$ 24,996,624	204,877	131,691	776	$ 122.01	$ 7.89
Other Practitioner	$ 660,373	8,415	3,243	32	$ 78.47	$ 0.21
Therapies	$ 16,353,139	157,554	9,341	597	$ 103.79	$ 5.16
Prescribed Drugs	$ 254,076,583	2,421,752	207,026	9,171	$ 104.91	$ 80.18
Other BH Services	$ 22,532,732	298,425	28,175	1,130	$ 75.51	$ 7.11
LTSS Services	$ 20,477,302	4,247,373	3,095	16,084	$ 181.97	$ 6.46
Durable Medical Equipment	$ 17,854,652	6,586,422	25,428	24,942	$ 2.71	$ 5.63
Limited Dental Services	$ 1,319,246	53,301	19,175	202	$ 24.75	$ 0.42
Optical	$ 3,724,182	48,202	35,271	183	$ 77.26	$ 1.18
Lab and X-Ray	$ 14,542,162	528,844	67,900	2,003	$ 27.50	$ 4.59
Transportation	$ 4,593,461	54,078	17,189	205	$ 84.94	$ 1.45
Subtotal (Medical)	$ 791,608,513	16,564,075	275,352			$ 249.81
CC4C LHD Payments	$ 2,654,845	585,936	N/A	2,219	$ 4.53	$ 0.84
OBCM LHD Payments	$ 3,310,441	673,051	N/A	2,549	$ 4.92	$ 1.04
Medical Home Payments	$ 7,722,271	2,885,143	N/A	10,926	$ 2.68	$ 2.44
Subtotal (LHD/Medical Home Payments)	$ 13,687,557	4,144,130	N/A			$ 4.32
Total (Medical + LHD/Medical Home)	$ 805,296,070	20,708,205	N/A			$ 254.13

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

7.2.6 SFY 2017 Region 6 Exhibits

Exhibit 67

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Aged, Blind, Disabled
Age:	All Ages

Member Months/Deliveries:	267,136
Average Monthly Members/Deliveries:	22,261
Eligibles:	26,250

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 33,908,853	34,770	3,445	1,562	$ 975.23	$ 126.93
Inpatient — BH	$ 2,181,274	2,921	372	131	$ 746.83	$ 8.17
Outpatient Hospital	$ 20,092,525	35,463	10,317	1,593	$ 566.57	$ 75.21
Emergency Room	$ 16,221,364	32,182	12,109	1,446	$ 504.05	$ 60.72
Physician	$ 27,327,152	191,382	19,642	8,597	$ 142.79	$ 102.30
FQHC/RHC	$ 2,032,962	19,316	5,292	868	$ 105.25	$ 7.61
Other Clinic	$ 3,642,048	7,529	4,317	338	$ 483.75	$ 13.63
Other Practitioner	$ 250,262	3,395	1,203	153	$ 73.71	$ 0.94
Therapies	$ 1,278,108	11,240	660	505	$ 113.71	$ 4.78
Prescribed Drugs	$ 96,667,525	702,485	20,214	31,556	$ 137.61	$ 361.87
Other BH Services	$ 3,109,256	53,752	5,567	2,415	$ 57.85	$ 11.64
LTSS Services	$ 17,007,737	3,253,079	2,030	146,132	$ 182.17	$ 63.67
Durable Medical Equipment	$ 9,592,168	3,371,875	6,021	151,468	$ 2.84	$ 35.91
Limited Dental Services	$ 9,836	397	128	18	$ 24.76	$ 0.04
Optical	$ 362,636	5,181	3,151	233	$ 70.00	$ 1.36
Lab and X-Ray	$ 2,491,765	109,950	10,797	4,939	$ 22.66	$ 9.33
Transportation	$ 2,475,349	41,715	4,783	1,874	$ 59.34	$ 9.27
Subtotal (Medical)	$ 238,650,822	7,876,632	22,943			$ 893.37
CC4C LHD Payments	$ 1,091	240	N/A	11	$ 4.54	$ 0.00
OBCM LHD Payments	$ 193,836	39,253	N/A	1,763	$ 4.94	$ 0.73
Medical Home Payments	$ 1,210,762	252,617	N/A	11,348	$ 4.79	$ 4.53
Subtotal (LHD/Medical Home Payments)	$ 1,405,688	292,110	N/A			$ 5.26
Total (Medical + LHD/Medical Home)	$ 240,056,510	8,168,742	N/A			$ 898.63

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 68

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Newborn (<1)

Member Months/Deliveries:	108,992
Average Monthly Members/Deliveries:	9,083
Eligibles:	17,762

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 20,773,693	36,954	8,077	4,069	$ 562.14	$ 190.60
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,062,514	5,906	3,306	650	$ 179.90	$ 9.75
Emergency Room	$ 2,578,938	10,276	5,565	1,131	$ 250.97	$ 23.66
Physician	$ 9,710,719	96,348	14,546	10,608	$ 100.79	$ 89.10
FQHC/RHC	$ 645,160	6,198	1,382	682	$ 104.10	$ 5.92
Other Clinic	$ 4,202,945	39,555	13,116	4,355	$ 106.26	$ 38.56
Other Practitioner	$ 2,043	48	15	5	$ 42.88	$ 0.02
Therapies	$ 101,548	976	169	108	$ 103.99	$ 0.93
Prescribed Drugs	$ 1,631,998	31,402	8,681	3,457	$ 51.97	$ 14.97
Other BH Services	$ 11,417	625	8	69	$ 18.27	$ 0.10
LTSS Services	$ 70,376	1,048	7	115	$ 67.16	$ 0.65
Durable Medical Equipment	$ 298,073	53,417	1,044	5,881	$ 5.58	$ 2.73
Limited Dental Services	$ 271,630	10,897	4,303	1,200	$ 24.93	$ 2.49
Optical	$ 7,233	89	69	10	$ 81.68	$ 0.07
Lab and X-Ray	$ 64,975	3,118	978	343	$ 20.84	$ 0.60
Transportation	$ 273,848	2,284	772	251	$ 119.91	$ 2.51
Subtotal (Medical)	$ 41,707,110	299,140	16,085			$ 382.66
CC4C LHD Payments	$ 448,412	98,407	N/A	10,835	$ 4.56	$ 4.11
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ 219,774	89,579	N/A	9,863	$ 2.45	$ 2.02
Subtotal (LHD/Medical Home Payments)	$ 668,186	187,986	N/A			$ 6.13
Total (Medical + LHD/Medical Home)	$ 42,375,296	487,126	N/A			$ 388.79

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 69

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Child (1-20)

Member Months/Deliveries:	1,733,723
Average Monthly Members/Deliveries:	144,477
Eligibles:	164,827

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 6,922,858	5,524	1,238	38	$ 1,253.21	$ 3.99
Inpatient — BH	$ 1,361,232	2,319	265	16	$ 586.97	$ 0.79
Outpatient Hospital	$ 12,996,332	37,526	21,281	260	$ 346.33	$ 7.50
Emergency Room	$ 23,892,199	84,304	49,404	584	$ 283.40	$ 13.78
Physician	$ 31,089,086	437,138	110,576	3,026	$ 71.12	$ 17.93
FQHC/RHC	$ 3,316,828	32,743	12,981	227	$ 101.30	$ 1.91
Other Clinic	$ 10,472,431	99,358	76,957	688	$ 105.40	$ 6.04
Other Practitioner	$ 178,352	2,450	927	17	$ 72.81	$ 0.10
Therapies	$ 5,944,391	51,738	4,338	358	$ 114.89	$ 3.43
Prescribed Drugs	$ 64,058,923	645,147	95,278	4,465	$ 99.29	$ 36.95
Other BH Services	$ 7,845,836	104,811	12,584	725	$ 74.86	$ 4.53
LTSS Services	$ 257,952	20,979	44	145	$ 100.85	$ 0.15
Durable Medical Equipment	$ 2,911,911	1,079,420	8,057	7,471	$ 2.70	$ 1.68
Limited Dental Services	$ 909,824	36,814	12,054	255	$ 24.71	$ 0.52
Optical	$ 2,336,482	28,135	25,400	195	$ 83.05	$ 1.35
Lab and X-Ray	$ 2,092,395	110,151	21,902	762	$ 19.00	$ 1.21
Transportation	$ 875,144	11,298	4,147	78	$ 77.46	$ 0.50
Subtotal (Medical)	$ 177,462,176	2,789,854	135,358			$ 102.36
CC4C LHD Payments	$ 1,691,277	373,833	N/A	2,587	$ 4.52	$ 0.98
OBCM LHD Payments	$ 974,781	198,086	N/A	1,371	$ 4.92	$ 0.56
Medical Home Payments	$ 4,024,743	1,642,587	N/A	11,369	$ 2.45	$ 2.32
Subtotal (LHD/Medical Home Payments)	$ 6,690,801	2,214,507	N/A			$ 3.86
Total (Medical + LHD/Medical Home)	$ 184,152,977	5,004,360	N/A			$ 106.22

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 70

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	TANF and Other Related Children/Adults
Age:	Adult (21+)

Member Months/Deliveries:	407,775
Average Monthly Members/Deliveries:	33,981
Eligibles:	48,504

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 9,328,294	8,085	1,625	238	$ 1,153.71	$ 22.88
Inpatient — BH	$ 954,536	1,153	221	34	$ 827.64	$ 2.34
Outpatient Hospital	$ 11,099,675	28,181	14,061	829	$ 393.87	$ 27.22
Emergency Room	$ 19,013,960	45,809	21,066	1,348	$ 415.07	$ 46.63
Physician	$ 17,249,518	152,651	29,685	4,492	$ 113.00	$ 42.30
FQHC/RHC	$ 1,737,885	17,224	5,889	507	$ 100.90	$ 4.26
Other Clinic	$ 3,231,879	16,812	13,144	495	$ 192.23	$ 7.93
Other Practitioner	$ 157,965	2,285	929	67	$ 69.12	$ 0.39
Therapies	$ 4,959	101	83	3	$ 49.00	$ 0.01
Prescribed Drugs	$ 37,976,488	425,052	29,509	12,508	$ 89.35	$ 93.13
Other BH Services	$ 2,785,498	41,492	5,344	1,221	$ 67.13	$ 6.83
LTSS Services	$ 569,700	106,364	206	3,130	$ 173.22	$ 1.40
Durable Medical Equipment	$ 2,089,279	921,812	3,731	27,127	$ 2.27	$ 5.12
Limited Dental Services	$ 15	1	1	0	$ 15.11	$ 0.00
Optical	$ 148,446	2,118	1,394	62	$ 70.10	$ 0.36
Lab and X-Ray	$ 4,928,565	183,312	19,404	5,395	$ 26.89	$ 12.09
Transportation	$ 721,889	9,660	3,164	284	$ 74.73	$ 1.77
Subtotal (Medical)	$ 111,998,551	1,962,113	38,188			$ 274.66
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ 1,409,970	286,901	N/A	8,443	$ 4.91	$ 3.46
Medical Home Payments	$ 756,316	316,367	N/A	9,310	$ 2.39	$ 1.85
Subtotal (LHD/Medical Home Payments)	$ 2,166,286	603,268	N/A			$ 5.31
Total (Medical + LHD/Medical Home)	$ 114,164,837	2,565,381	N/A			$ 279.97

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 71

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	Maternity Event
Age:	All Ages

Member Months/Deliveries:	7,245
Average Monthly Members/Deliveries:	604
Eligibles:	7,365

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 16,577,058	20,705	6,964	34,296	$ 800.63	$ 2,288.19
Inpatient — BH	$ -	-	-	-	$ -	$ -
Outpatient Hospital	$ 1,824,891	12,591	2,691	20,856	$ 144.93	$ 251.90
Emergency Room	$ 3,213,442	10,590	1,369	17,542	$ 303.44	$ 443.56
Physician	$ 12,376,813	51,708	6,877	85,649	$ 239.36	$ 1,708.42
FQHC/RHC	$ 980,384	6,217	527	10,298	$ 157.69	$ 135.33
Other Clinic	$ 2,051,707	15,842	1,978	26,241	$ 129.51	$ 283.21
Other Practitioner	$ -	-	-	-	$ -	$ -
Therapies	$ -	-	-	-	$ -	$ -
Prescribed Drugs	$ -	-	-	-	$ -	$ -
Other BH Services	$ -	-	-	-	$ -	$ -
LTSS Services	$ 31,081	2,216	7	3,671	$ 14.02	$ 4.29
Durable Medical Equipment	$ 7,087	119	195	197	$ 59.53	$ 0.98
Limited Dental Services	$ 50	2	-	3	$ 24.79	$ 0.01
Optical	$ 81	1	14	2	$ 80.59	$ 0.01
Lab and X-Ray	$ 399,774	15,469	1,961	25,623	$ 25.84	$ 55.18
Transportation	$ 155,300	1,367	576	2,264	$ 113.62	$ 21.44
Subtotal (Medical)	$ 37,617,668	136,828	7,316			$ 5,192.51
CC4C LHD Payments	$ -	-	N/A	-	$ -	$ -
OBCM LHD Payments	$ -	-	N/A	-	$ -	$ -
Medical Home Payments	$ -	-	N/A	-	$ -	$ -
Subtotal (LHD/Medical Home Payments)	$ -	-	N/A			$ -
Total (Medical + LHD/Medical Home)	$ 37,617,668	136,828	N/A			$ 5,192.51

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

Exhibit 72

Time Period/Region Selections:	
Time Period:	SFY 2017
Region:	Region 6

Population Selections:	
Program Type:	Standard Plan (Non-Duals)
Category of Aid:	All Population Groups
Age:	All Ages

Member Months/Deliveries:	2,517,626
Average Monthly Members/Deliveries:	209,802
Eligibles:	264,708

Category of Service	Incurred Claims	Utilization	Users	Utilization Per 1,000	Unit Cost	PMPM/ Payment
Inpatient — PH	$ 87,510,757	106,039	21,349	505	$ 825.27	$ 34.76
Inpatient — BH	$ 4,497,042	6,393	859	30	$ 703.42	$ 1.79
Outpatient Hospital	$ 47,075,937	119,668	51,656	570	$ 393.39	$ 18.70
Emergency Room	$ 64,919,904	183,161	89,513	873	$ 354.44	$ 25.79
Physician	$ 97,753,287	929,228	181,326	4,429	$ 105.20	$ 38.83
FQHC/RHC	$ 8,713,219	81,697	26,071	389	$ 106.65	$ 3.46
Other Clinic	$ 23,601,011	179,096	109,512	854	$ 131.78	$ 9.37
Other Practitioner	$ 588,622	8,178	3,075	39	$ 71.98	$ 0.23
Therapies	$ 7,329,005	64,056	5,250	305	$ 114.42	$ 2.91
Prescribed Drugs	$ 200,334,934	1,804,087	158,208	8,599	$ 111.05	$ 79.57
Other BH Services	$ 13,752,008	200,679	23,688	957	$ 68.53	$ 5.46
LTSS Services	$ 17,936,846	3,383,686	2,294	16,128	$ 181.75	$ 7.12
Durable Medical Equipment	$ 14,898,518	5,426,643	19,048	25,866	$ 2.75	$ 5.92
Limited Dental Services	$ 1,191,355	48,111	16,486	229	$ 24.76	$ 0.47
Optical	$ 2,854,879	35,523	30,028	169	$ 80.37	$ 1.13
Lab and X-Ray	$ 9,977,474	422,000	55,042	2,011	$ 23.64	$ 3.96
Transportation	$ 4,501,528	66,324	13,442	316	$ 67.87	$ 1.79
Subtotal (Medical)	$ 607,436,327	13,064,567	219,576			$ 241.27
CC4C LHD Payments	$ 2,140,779	472,481	N/A	2,252	$ 4.53	$ 0.85
OBCM LHD Payments	$ 2,578,587	524,240	N/A	2,499	$ 4.92	$ 1.02
Medical Home Payments	$ 6,211,595	2,301,150	N/A	10,968	$ 2.70	$ 2.47
Subtotal (LHD/Medical Home Payments)	$ 10,930,961	3,297,871	N/A			$ 4.34
Total (Medical + LHD/Medical Home)	$ 618,367,288	16,362,437	N/A			$ 245.62

Note: Please refer to Section 5 for more information on the detailed services captured under each COS in the exhibit above.

8 CAPITATION RATE DEVELOPMENT

The rate-setting methodology is based on generally accepted actuarial principles and best practices and approaches from other state Medicaid managed care programs. The rate-setting process and related documentation comply with CMS regulations outlined in 42 CFR 438.4 and were developed in accordance with applicable law and regulations, including the ASOPs. The process was developed in a way that supports the financial-related objectives of the new program to:

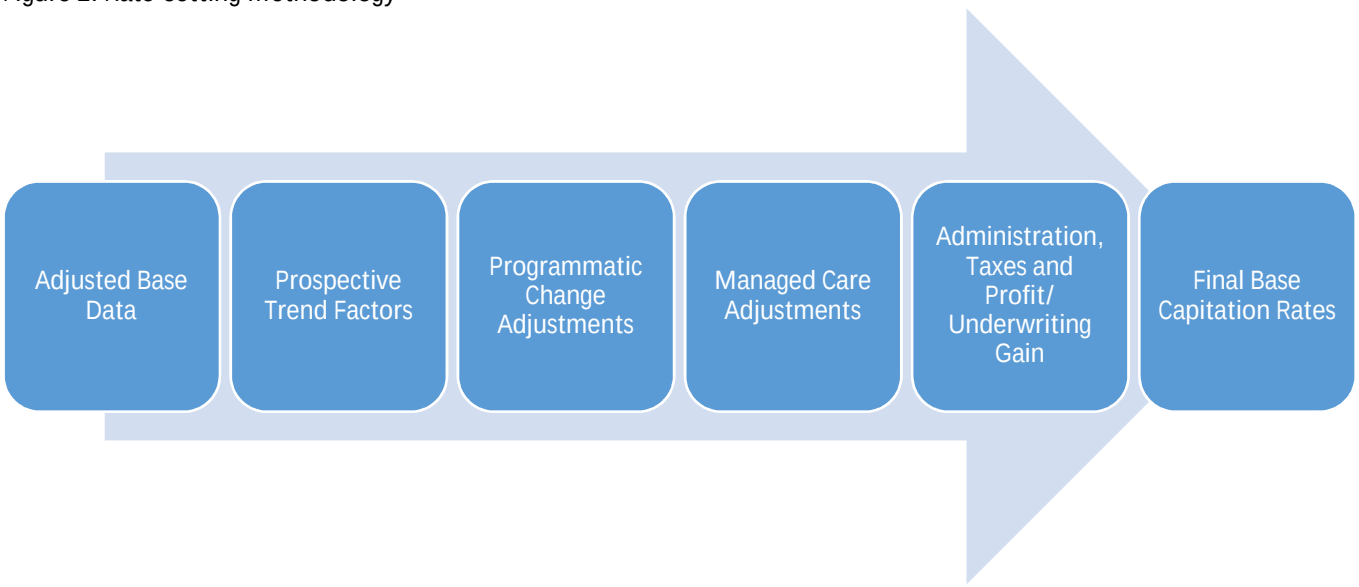
- Advance high-value care, and
- Establish a sustainable program with predictable costs.

The capitation rates are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care program designed for the State Medicaid and NC Health Choice populations. Under managed care, the capitation payments will be made by DHHS to the PHPs who will administer the contractually-required services to the populations covered under the program. Capitation payments differ from FFS payments where DHHS pays providers for each service rendered. Under capitation payments, a monthly payment for each member is made to a PHP to cover a defined set of services. Under managed care, PHPs will contract and reimburse providers for services rendered to their enrollees.

The rate-setting process is the means for determining the PMPM capitation payments DHHS will pay to the PHPs for each beneficiary enrolled in the program, regardless of the amount of future services that beneficiary receives. Generally, this process involves summarizing historical claims and eligibility data that represent the covered populations and services (Sections 2 through 7) and projecting future medical claims costs on a PMPM basis into the rating period. Consideration for administrative allowances and profit/underwriting gain or risk margin will be added to the expected medical costs to arrive at the base capitation rates for each rate cell.

The overall rate-setting approach is based on the foundational steps outlined below. Mercer has refined the approach to best match the proposed Medicaid managed care program design and North Carolina's health care landscape.

Figure 2: Rate-Setting Methodology



9 BASE DATA DEVELOPMENT

Capitation rates were developed starting with a 20.0%/80.0% blend of SFY 2016 and SFY 2017 base data experience, respectively (with the exception of pharmacy as described below). Prior to blending the base data experience into a single base year, Mercer trended SFY 2016 data forward one year so that the SFY 2016 and SFY 2017 experience was on the same basis.

Mercer reviewed SFY 2015 through SFY 2017 historical experience to develop retrospective trend assumptions, which are used to trend SFY 2016 to SFY 2017 prior to blending. Retrospective trend assumptions were developed by major COS groupings, and were developed in aggregate across all regions and COA. This approach helps create a more credible level of data, smooth data anomalies and mitigate volatility for smaller COS within a rate cell. Since retrospective trend was developed and applied on an aggregate basis this allows for annual regional, COA and/or detailed COS variances to be mitigated by trending SFY 2016 to SFY 2017 and blending the two years of experience.

The table below provides an outline of how the detailed COS included in the base data summaries (Section 7) are aggregated for trend analyses (same COS groupings used for prospective trend in Section 10) along with the retrospective trend factors used to trend SFY 2016 onto a SFY 2017 time period basis.

Table 14: Retrospective Trend Factors for SFY 2016 to SFY 2017 by COS

Aggregate COS	Detailed COS	Trend Factors for SFY 2016 to SFY 2017
Inpatient Hospital	Inpatient Hospital — PH Inpatient Hospital — BH	2.0%
Outpatient Hospital	Outpatient Hospital	2.0%
Emergency Room	Emergency Room	2.0%
Physician	Physician FQHC/RHC Other Clinic Other Practitioner Therapies	2.5%
Prescribed Drugs	Prescribed Drugs	Not Applicable
Other BH Services	Other BH Services	6.5%
LTSS Services	LTSS Services	2.0%
Other Acute Care	Durable Medical Equipment Limited Dental Services Optical Lab and X-Ray	2.0%
Transportation	Transportation	0.0%

After trending SFY 2016 to a common SFY 2017 time period, Mercer smoothed the claims data by blending the multiple years of available data into a single base year (SFY 2017), placing higher credibility on the most recent year. The goal of this process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates. For all populations and services, except for pharmacy, 20.0% weight was given to SFY 2016 and 80.0% weight was given to SFY 2017. For pharmacy, effective January 1, 2016, DHHS implemented a new reimbursement methodology based on Actual Acquisition Cost (AAC). Given this change is not fully reflected in the SFY 2016 base data, Mercer placed 100.0% weight on the SFY 2017 experience.

Please note the base data development will be refreshed to include data through SFY 2018 in advance of managed care implementation and final capitation rate development.

10 TREND ASSUMPTIONS

Medical trend is the projection of utilization and unit cost changes over time. A trend factor is necessary to estimate the expenses of providing health care services in the SFY 2020 rating period. Per 42 CFR 438.5(b)(2) of the CMS Managed Care Final Rule (Final Rule), in setting actuarially sound rates, the actuary must "develop and apply trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles."

10.1 Trend Development Methodology

Mercer reviewed historical FFS and BH LME/MCO claims and enrollment data during the SFY 2015, SFY 2016 and SFY 2017 time periods for the proposed Standard Plan population. The data was analyzed on a rolling average basis (12-months, 9-months, 3-months and single month) to evaluate changes in historical cost and utilization patterns while smoothing the influence of significant outliers and seasonality. Regression models were also created to fit the historical data to a linear equation by region and service category. The slope of the fitted line from the historical data informed prospective trend assumptions. As a secondary source, Mercer reviewed actuarial reports from CMS Office of the Actuary, Consumer Price Indices and trend information from other state Medicaid programs.

Unit cost and utilization trend factors were developed to form an overall PMPM trend for each of the major COS. Similar service categories were aggregated and reviewed on a statewide and regional basis. Rate cell specific variations were also evaluated and informed further delineation where warranted for certain COS; assumptions vary by rate cell for Inpatient and Prescription Drugs which make up over 40.0% of the total Standard Plan base expenditures. Since each rate cell has a different distribution of services, the trend assumption percentages translate to a different PMPM impact by rate cell. The trend assumptions were applied from the midpoint of the credibility-blended SFY 2017 base data period to the midpoint of the SFY 2020 rating period, a total of 36 months.

10.2 Overall Trend Assumptions

Mercer developed an annual trend assumption of approximately 3.0% to project the SFY 2017 base data to the SFY 2020 rate period. The impact varies by COS and is captured in the table below. Specific details about unique service considerations are provided below the trend tables.

Table 15: Overall Annual Trend Projections by Major Service Category

COS	Unit Cost Trend	Utilization Trend	Total PMPM Trend	SFY 2017 Base PMPM[13]
Inpatient Hospital	0.5%	0.7%	1.2%	$34.25
Outpatient Hospital	0.5%	1.4%	1.9%	$22.02
Emergency Room	0.5%	1.5%	2.0%	$24.40
Physician[14]	0.5%	1.7%	2.2%	$54.57
Prescription Drugs	5.2%	0.4%	5.7%	$75.85
Other BH Services	1.0%	1.6%	2.7%	$6.53
LTSS Services	0.5%	0.2%	0.7%	$6.42
Other Acute Care	0.5%	1.1%	1.6%	$11.08

[13] Overall base data PMPM provided for reference to scale of overall COS relative to the total across all services.

[14] Physician trend projections were applied to the primary and specialty care physician, FQHCs/RHCs, Therapies and Other Clinics and Practitioners service lines. Other acute care trend projections were applied to the Durable Medical Equipment, Optical and Lab and X-ray service lines.

COS	Unit Cost Trend	Utilization Trend	Total PMPM Trend	SFY 2017 Base PMPM[13]
Transportation	0.5%	-0.5%	0.0%	$1.55
Medical Home/LHD Payments	0.0%	0.0%	0.0%	$4.24
Total Standard Plan	2.0%	1.0%	3.0%	$240.91

Note: The transportation COS is comprised of both Ambulance and NEMT cost and utilization; negative prospective utilization trend is a result of historical decreases observed for the Ambulance COS.

The table below shows the trend factors by region. The impact of trend is generally consistent across the regions; differences are driven by the variation in the utilization of services within each region.

Table 16: Overall Annual Trend Projections by PHP Region

Region	Unit Cost Trend	Utilization Trend	Total PMPM Trend
Region 1	1.9%	1.2%	3.1%
Region 2	2.0%	1.0%	3.0%
Region 3	2.2%	0.8%	3.0%
Region 4	2.2%	1.1%	3.3%
Region 5	1.9%	1.0%	2.8%
Region 6	2.1%	1.0%	3.1%
Total Standard Plan	2.0%	1.0%	3.0%

The sections below provide additional commentary for service categories with trend differences by rate cell or observations within the base data. For detailed trend assumptions by rate cell, see the Capitation Rate Development Exhibits included in Section 14 of this Draft Rate Book.

10.2.1 Inpatient Hospital

Mercer evaluated the inpatient hospital service trends by rate cell to assess whether trend should be varied across the rate cells. Historical experience for this service line is comprised of over 90.0% physical health services. This service line captures approximately 15.0% of the total Standard Plan expenditures. Historical trends have been highest for the TANF — Adult (21+) and Maternity Event rate cells, resulting in the higher trend projections for these rate cells. Conversely, historical trends have been lowest for the ABD population, resulting in lower trend projections. Trend projections for the TANF — Newborn (<1) and TANF — Child (1-20) populations fall between these levels. Variation was included by rate cell for the Inpatient Hospital service line. The same assumptions were applied across all regions.

Specific to Inpatient Hospital — PH services, DHHS is requiring PHPs to reimburse hospitals per the DHHS-determined DRG base rates, Medicaid FFS case weights and outlier methodologies. DHHS will increase the DRG base rate annually by the Medicare Inpatient Hospital Prospective Payment System (PPS) market basket update less the productivity adjustment, as published in the Medicare Hospital Inpatient PPS and Long Term Acute Care Hospital PPS Final Rule. This trend index will be reviewed as a part of annual rate development, and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements (Section 11.1).

10.2.2 Prescription Drugs

Prescription drugs have the highest prospective trend assumptions in the capitation rates. Recent publications pertaining to the National Drug Trend and Pipeline suggest overall trends across specialty and traditional drug classes are expected to increase in the coming years. Further, prescription drug growth is expected to accelerate between 2017 – 2019 due to price growth and fewer brand name drugs losing patent protection.

It is important to note pharmacy trends require special consideration in rate-setting. Recently, pharmacy trends have been higher than other services covered under Medicaid programs driven by large trends in specialty medications. Mercer has performed a trend analysis that reviews projections for specialty and traditional pharmacy trends by rate cell to account for the varying impact of prescription drugs for each population. Some of the underlying reasons for the higher specialty trends include: expanded indications, direct to consumer advertising and new drugs entering the market faster due to breakthrough therapy approvals granted by the Food and Drug Administration (FDA).

Pipeline drugs, which are drugs that are still under development or discovery, may not be reflected in the historical claims data, but are known to impact utilization and cost beyond the base data period. These types of drugs were evaluated and accounted for in the pharmacy trend development. There may also be significant growth in other drug classes such as diabetes (traditional), asthma (traditional), rheumatoid arthritis (specialty), oncology (specialty), HIV (specialty) and other new and emerging therapeutic drugs. Some recent examples of emerging drugs that have impacted expected pharmacy costs are treatments for hypercholesterolemia, cystic fibrosis and hepatitis C. Pharmacy-specific trend models utilize this information along with historical utilization data to develop pharmacy trends for each rate cell.

Please note the trend assumptions will be re-evaluated when more recent base data experience becomes available in advance of managed care implementation and final capitation rate development. Pharmacy trends will be specifically reviewed to account for industry emerging trends, along with State-specific changes that may impact pharmacy trends (e.g., 2017 Opioid policy changes).

11 PROGRAM DESIGN CONSIDERATIONS

Mercer has adjusted the data for known programmatic design elements that are anticipated to impact the projected claims expenditures. Mercer has utilized information in the claims data as well as information provided by DHHS to assess the impact of known programmatic changes to the capitation rates. Note that these programmatic changes currently assume no changes to proposed covered benefits, and any changes (e.g., changes to address the opioid crisis) will be evaluated and accounted for in the final capitation rate development process.

11.1 Hospital Reimbursement Methodology

DHHS has historically reimbursed hospitals using a mix of claims payments and supplemental payments. In the initial contract years, rate floors will apply for PHP payments to hospitals that incorporate a portion of these supplemental payments into hospital base rates. For additional information on hospital reimbursement methodology, see Appendix G.

For purposes of the draft rates, the hospital reimbursement adjustment has been modeled based on the historical supplemental payment levels. To account for the historical supplemental payments made to hospitals outside of the claims system, Mercer utilized supplemental payment information for the federal fiscal year (FFY) 2016 time period to calculate a rate adjustment. Mercer evaluated the supplemental payments for Inpatient Hospital and Outpatient Hospital services, including Emergency Room services, by provider number (National Provider Identifier [NPI]). Mercer then distributed these payments across the Standard Plan population by region and by rate cell based on the population-specific claim costs by hospital captured in the FFS data.

DHHS will make GME payments directly to eligible hospitals, and thus PHPs will not be required to reimburse hospitals for GME. The hospital reimbursement methodology adjustment reflects the reclassification of historical supplemental payments as GME per the hospital reimbursement methodology; the total amount of historical supplemental payments reclassified as GME in the draft rates is around $140 million for all populations (including those excluded from PHPs). This $140 million is in addition to the $85 million removed from historical FFS claims expenditures, reflecting the GME add-on currently included in the hospital base rates (see Section 6.4 of this Draft Rate Book). In total, $225 million in GME, representing the base rate add-on and portion of supplemental payments attributable to GME, was removed from the draft capitation rates.

The tables below represents the total regional supplemental payment amounts across all populations and then the amount allocated to the Standard Plan population and the overall impact by COA to the Standard Plan capitation rates. As mentioned above, the figures below reflect adjusted historical supplemental payment information for the GME reclassification.

Table 17: Calculated Historical Supplemental Payments by Region

	Inpatient Hospital		Outpatient Hospital (Includes Emergency Room)	
Region	Total Supplemental Payments for All Populations	Supplemental Payments for the Standard Plan Population	Total Supplemental Payments for All Populations	Supplemental Payments for the Standard Plan Population
Region 1	$146.9M	$112.8M	$32.0M	$24.2M
Region 2	$256.1M	$204.4M	$61.9M	$49.2M
Region 3	$339.3M	$267.8M	$92.9M	$73.8M
Region 4	$255.7M	$190.9M	$53.8M	$41.4M
Region 5	$251.0M	$196.7M	$51.4M	$41.5M
Region 6	$118.1M	$91.4M	$31.1M	$24.9M
Total	$1,367.1M	$1,064.0M	$323.1M	$255.0M

Table 18: Impact of Hospital Reimbursement Requirements by COA

COA	PMPM/Payment Impact	Percent Impact
ABD	$241.95	21.9%
TANF, Newborn (<1)	$306.44	76.6%
TANF, Children (1-20)	$12.85	10.7%
TANF, Adults (21+)	$66.42	20.5%
Maternity Event	$3,756.83	73.0%
Total Standard Plan	$64.81	24.7%

Final capitation rates will reflect the final hospital base rates developed using the methodology described in Appendix G. Note as part of the hospital reimbursement design, DHHS will apply the new reimbursement rates to the NC Health Choice population. The capitation rate adjustment outlined above does not reflect this impact for the NC Health Choice population. DHHS is also requiring PHPs to make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center. DHHS will reimburse PHPs for these additional payments outside of the prospective PMPM and maternity event capitated payments. The historical supplemental payments for UNC and Vidant are included in the supplemental payments incorporated into the draft rates. The final rates will be adjusted downward to account for the directed payments to UNC Health Care and Vidant Medical Center that will be removed from the risk pool.

11.2 Maternity Enhanced Rate

Under the current FFS program, providers offering coverage to beneficiaries enrolled in the PMH are reimbursed at an enhanced rate for vaginal deliveries (approximately 85.0% of total vaginal births). Under managed care, DHHS is requiring that PHPs reimburse all providers at the enhanced payment rate on all vaginal deliveries. Given that a portion of the historical FFS deliveries occurred outside of the PMH, Mercer evaluated an adjustment to ensure all vaginal deliveries in the base experience reflected the enhanced rate consistent with future PHP reimbursement requirements. To calculate this adjustment, Mercer identified the vaginal deliveries with a unit cost corresponding to the fee schedule rate and repriced at the enhanced vaginal delivery unit cost represented in the data. Claims and utilization data for this adjustment was based on the Calendar Year 2016 time period to ensure adequate runout in order to capture all deliveries within a year. This adjustment represented an overall 0.3%, or approximately $784,000 overall, upward adjustment to the Maternity Event rate cell (0.8% upward adjustment to the Physician COS).

11.3 Long-Term Nursing Home Stay Beneficiaries

The base data currently excludes beneficiaries with long-term nursing home stays (90 days or greater) from the Standard Plan population. Under the proposed program design, PHPs are responsible for short-term nursing home stays along with the first 90 days of a long-term nursing home stay for new admissions to the nursing home (after which they would be dis-enrolled from the PHP). Beneficiaries accessing services in State-owned neuro-medical centers or State-owned veteran homes will be excluded from PHP coverage upon entry to one of those facilities. Since the summarized base experience does not include long-term nursing home stay beneficiaries, Mercer modeled an assumption to calculate an upward adjustment to account for the additional cost and membership associated with new nursing home admissions during the first 90 days of a long-term nursing home stay. Mercer applied this adjustment on a PMPM basis to account for both the additional costs and MMs associated with these beneficiaries. Note that this adjustment is subject to change pending final approach to the long-term nursing home stay population.

Table 19: Impact of Initial 90 Days of Long-term Nursing Home Stays

COA	PMPM/Payment Impact
ABD	0.8%
TANF, Newborn (<1)	0.0%
TANF, Children (1-20)	0.0%
TANF, Adults (21+)	0.0%
Maternity Event	0.0%
Total Standard Plan	0.3%

11.4 Other Provider Reimbursement Considerations

11.4.1 Provider Rate Floors

DHHS will establish rate floors set at FFS levels as allowed by 438.6(c)(1)(iii)(A) for in-network physicians, physician extenders, hospitals and nursing facilities. The rate floor for in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) will be set at 100.0% of the Medicaid FFS rate. For a period of time to be defined by DHHS, PHPs shall be required to reimburse nursing facilities (excluding those owned and operated by the State) at a rate that is no less than the Medicaid FFS rate in effect six months prior to the start of the capitation rating year. As such, the capitation rates assume the current FFS levels will be maintained as the payment level for these providers.

11.4.2 LME/MCO Services Reimbursement

The current proposed Standard Plan program design includes service offerings for a subset of BH services historically covered through the LME/MCOs (see Section 5, Table 4 for a listing of these services). However, proposed program design dictates that services historically covered by LME/MCOs should not be subject to a rate floor requirement. While most LME/MCOs adhere to the State per diem fee schedule published for State-Operated ICF/IIDs, the LME/MCOs generally negotiate rates for other services. As such, the base encounter experience reflects provider-negotiated rates for LME/MCO BH services covered under the Standard Plan. No adjustments, other than trend, have been made in capitation rate development to alter the historical LME/MCO provider rates.

11.4.3 FQHC/RHC Providers

DHHS is currently working with FQHCs/RHCs on appropriate reimbursement rates under the PHP contracts. For purposes of draft rate development, similar reimbursement levels as FFS for these providers have been assumed, with anticipated wrap payments as required. The historical cost settlements for FQHCs/RHCs were $10,039,949 and $17,211,997 for SFY 2015 and SFY 2016, respectively. Final rates will reflect PHP requirements related to FQHC/RHC reimbursement.

11.4.4 Historical Cost Settlements

DHHS has historically cost settled certain providers in the FFS program. Interim payments are made based on a defined fee schedule and providers subsequently settled to actual cost. While cost settlements cannot continue in a managed care environment, DHHS is working with CMS to get approval for converting current cost settlements for certain providers to directed payments per 42 CFR 438.6(c). These are additional payments made by PHPs to certain providers for a particular service, for which DHHS would reimburse PHPs outside of the prospective PMPM and maternity event capitated rates based on utilization of that particular service. As such, the capitation rates assume continuation of reimbursement consistent with current fee schedules. Any changes to this approach will be reflected in final rates.

Table 20: Historical Cost Settlement Amounts for Proposed Additional Payments Outside of the Prospective PMPM and Maternity Event Capitated Rates

Provider Type	SFY 2015 Settlement Amount	SFY 2016 Settlement Amount
Public Ambulance	$58,665,724	$60,800,909
LHDs	$66,453,787	Not Available
Certain faculty physicians affiliated with the University of North Carolina and East Carolina University schools of medicine	$85,954,097	$82,465,468

11.5 Additional Programmatic Considerations

There are additional programmatic considerations that must be evaluated as final rates are developed for the SFY 2020 time period. These items include but are not limited to:

- Any revisions in BH I/DD Tailored Plan eligibility criteria from that assumed herein, including known changes in recent legislation not reflected in these draft rates.
- Beneficiaries shifting between the Standard Plan and BH I/DD Tailored Plan (outlined in Appendix F).
- Potential impact of extended coverage for services delivered in an IMD on the Standard Plan population. DHHS is still in negotiations with CMS on this provision. To date, Mercer's analysis has indicated that this provision will have minimal impact to the Standard Plan member costs, as the majority of individuals utilizing these services are expected to meet BH I/DD Tailored Plan criteria. As such, no adjustment has been included in the draft RFP rates, but Mercer will continue to evaluate for final rate development.
- Potential impact of SUD service array expansion. The State is working on updates to the SUD service array. Changes are under development and may require updates to the State Plan. No adjustment is currently reflected in the draft rates, but as the State Plan amendments are submitted and the changes determined the final rates will consider implications of updates to the SUD service array.
- Future fee schedule changes that impact rate floors prior to July 2019 go-live date will need to be monitored and evaluated for incorporation into the final rates.
- Other changes in covered benefits and provider reimbursement requirements will be reflected in the final rates.

12 MANAGED CARE ASSUMPTIONS

Managed care adjustments are intended to capture expected future changes in the utilization of certain services as a result of care management initiatives by the PHPs. Mercer conducted a managed care opportunity analysis as part of the rate development process. The following components were analyzed as part of the managed care opportunity assessment and were specifically evaluated in the development of the Standard Plan capitation rate development:

- Comparison of North Carolina FFS statistics to other state managed care experience
- Research regarding other state program initial managed care expectations and experience operating under managed care
- Pharmacy considerations under managed care
- Low Acuity Non-Emergent (LANE) analysis related to avoidable visits to the Emergency Room in NC Medicaid data
- Potentially Preventable Admissions (PPA) analysis in NC Medicaid data for Inpatient Hospital visits
- Analysis of Inpatient Hospital readmissions

More detail on each analysis is included in the remainder of this section.

12.1 Overall Managed Care Findings

Mercer applied managed care assumptions in the Contract year 1 capitation rate development for the Standard Plan population. These assumptions were developed based on a review of current program experience coupled with other data sources which includes specific data analyses such as clinical efficiency analyses, pharmacy clinical edits analysis and potential PHP rebate analysis. Assumed reductions in provider services spend are offset by non-benefit expenses incorporated into PHP capitation rates as outlined in Section 13.

Mercer assumes it will take approximately three years for each population under managed care to realize the full extent of expected savings. Furthermore, Mercer assumes approximately 75.0% of managed care savings to be realized in year 1 given a period of continuity of care and an implementation period for plans to realize results from their care management strategies and utilization management procedures. Mercer also expects the pharmacy clinical edits savings adjustment to ramp up to account for a potential continuity of care period where patients continue with the same prescribed drugs as when they were under FFS for a period of time. In the instance the year 1 rating period is not twelve months, Mercer will reevaluate the appropriateness of the 75.0% assumption.

The table below illustrates the overall impact of the year 1 managed care assumptions by rate cell. Overall, these amount to approximately a -8.4% impact to the cost of Standard Plan medical benefits. Regional variations are driven by varying assumptions for the Outpatient Hospital COS since observed utilization varied greatly by region; all other assumptions by COS were applied consistently by region.

Table 21: Year 1 Standard Plan Savings Factors to Medical Costs

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	-11.8%	-11.3%	-10.3%	-10.2%	-10.4%	-9.4%
TANF, Newborn (<1)	-12.9%	-12.5%	-12.6%	-12.2%	-12.5%	-11.6%
TANF, Children (1-20)	-7.2%	-5.9%	-5.8%	-5.9%	-5.9%	-5.2%
TANF, Adults (21+)	-10.9%	-8.3%	-8.4%	-8.4%	-8.1%	-7.4%
Maternity Event	-2.6%	-2.6%	-2.2%	-2.7%	-2.4%	-2.0%

Assumptions above are based on a review of current programmatic experience. The appropriateness of these factors will be re-evaluated as the base experience is updated upon calculation of final capitation rates for Contract Year 1.

12.2 Non-Pharmacy Benefits

This section gives an overview of the available information utilized in development of the managed care factors for non-pharmacy benefits. Section 12.3 overviews the specific analyses used to develop pharmacy-specific opportunity assumptions.

Mercer reviewed a number of data sources in order to arrive at reasonable managed care expectations for the Standard Plan population. These reviews largely focused on a comparison to other state Medicaid managed care experience along with results of managed care efficiency analyses run on the current program experience. Additionally, a review of other state Medicaid managed care assumptions helped inform expectations for other medical services not compared in Section 12.2.1.

In general, PHPs are expected to impact the current levels of medical cost and utilization through care management. The overall managed care savings may be achieved through a reduction to utilization of high-cost and high-intensity services as a result of activities such as, but not limited to:

1. Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the Emergency Room or hospitalization.
2. Reducing non-emergent use of the Emergency room through member education and viable alternatives (e.g., extended hours for doctor's offices, after-hours urgent care clinics, or even nurse advice lines).
3. Hospital discharge planning to ensure a smooth transition from facility-based care to community resources, and minimize readmissions.

Mercer also reviewed the historical utilization of physician services in the FFS program. It is important to note that the Physician service line for rate setting purposes was summarized to include both the attending physician claims for Outpatient Hospital visits as well as primary care and specialist physician office visits. Mercer considered each component of physician utilization to arrive at the overall managed care assumption by rate cell. For the portion of the utilization associated with the attending physician for Outpatient Hospital claims, Mercer assumed the same level of utilization savings as was assumed for the Outpatient Hospital facility claims. For office visits, Mercer evaluated the impact on utilization for both primary care and specialty Physician visits. Mercer assumed decreases on Physician specialty visits, assuming PHPs would increase provider network management to better manage services provided by specialists and specialty facilities. For primary care office visits, Mercer assumed increased utilization as a result of PHP preventative care efforts coupled with beneficiaries being diverted from more high-cost and high-intensity services.

Note that Maternity Event managed care expectations were developed based on the TANF Adult (21+) rate cell observations given the majority of beneficiaries receiving maternity care also fall in the TANF Adult (21+) rate cell. However, the factors were tailored to target non-Physician services outside of the month of delivery. Moreover, the factor noted in the table above reflects a prorated factor adjusted for the portion of the Maternity Event payment attributable to costs outside of the month of delivery. The expectation is that through care management, the PHPs should be able to reduce hospital and Emergency Room utilization during the prenatal and postpartum periods of the maternity episode.

12.2.1 Other State Medicaid Experience

Mercer collected information from ten state Medicaid programs to serve as a comparison to North Carolina data and provide context regarding potential savings under managed care. Based on Mercer's review of the North Carolina experience compared to other state Medicaid programs, Mercer observes TANF and Other Related Children and Adult PMPM costs for North Carolina are generally in the range of other state Medicaid programs.

However, the utilization per 1,000 members statistics for some services (e.g., Inpatient Hospital — PH) are on the higher end of the range for other state Medicaid programs. For the ABD population, costs and utilization are above other state Medicaid program experience; even without prescription drug considerations, most other services fall towards the top of the PMPM and utilization per 1,000 range.

It is important to note that in North Carolina a number of services and populations are already receiving some coordinated care and management through (1) the CCNC/CA program, which is an enhanced Primary Care Case Management model and (2) the BH managed care program run by the LME/MCOs. Since DHHS already operates under a "managed" FFS model with CCNC/CA and has BH managed care, DHHS may observe less managed care savings opportunities due to the implementation of capitated managed care as compared to other states, given that the effect of some care management is already being realized.

12.2.2 Efficiency Analysis

Mercer completed efficiency analyses that further evaluated potential savings to support the general managed care assumptions related to Inpatient Hospital and Emergency Room services. The analyses detailed below include analysis of inpatient claims for PPA and Inpatient Hospital readmission analysis along with LANE analysis related to avoidable visits to the Emergency Room.

PPA Analysis

Mercer performed a PPA analysis to identify opportunities for managed care impact on inpatient admissions that could be achieved through PHP management of PPAs. Mercer's PPA analysis identifies inpatient admissions that could have been avoided through high quality outpatient care and/or reflects conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. The PPA analysis can help identify potential reductions of health care inefficiencies in the inpatient hospital setting and support DHHS' desire for a more value focused purchasing strategy.

In total, Mercer found that around 3.0% for TANF and 10.0% for ABD of Inpatient Hospital spend is related to Pediatric Quality Indicators/Prevention Quality Indicators (PDI/PQI) flagged conditions. After a series of exclusions for high-risk beneficiaries and enrollment duration considerations around the time to reasonably manage care, the refined proportion of PPA dollars drops to approximately 2.0% for TANF and 7.0% for ABD as a percentage of Inpatient Hospital spend. Note that results of the full PPA efficiency adjustment analysis from other state Medicaid programs generally impact Inpatient by 2.0% to 7.0%; state variations are generally a result of different underlying populations.

Inpatient Readmission Analysis

Like PPA admissions, hospital readmissions represent health care expenditures that could possibly be avoided through high-quality outpatient care and post-discharge transition planning. Mercer's readmission analysis focused on hospital admissions within 30 days of a previous discharge for the same recipient at any facility and for any diagnosis-related group. A readmission within 30 days can be a result of a breakdown in discharge planning or outpatient care subsequent to the original admission.

The observed experience based on the raw Inpatient readmission analysis is approximately 5.5% readmission rate for TANF and above 20.0% readmission rate for ABD beneficiaries. Note that results of other state Inpatient readmission analyses equate to approximately a 7.0% to 10.0% inpatient readmission rate.

LANE Analysis

Mercer performed a LANE analysis as part of the managed care opportunities analysis to support the managed care assumptions related to Emergency Room utilization. The LANE analysis identifies instances when Medicaid eligibles may not have needed to make a trip to the Emergency Room if they had received effective outreach, care coordination and/or access to preventative care. The management of the identified LANE visits is an

effective cost-containment strategy that can help reduce health care inefficiencies in the Emergency Room setting; and therefore, supports DHHS' desire for a more value-focused purchasing strategy.

The overall results illustrate that on average LANE dollars represented approximately 50.0% of total Emergency Room costs. When looking specifically at less intensive LANE visits (as defined by attending physician code of 99281-99283), Mercer observes that these constitute approximately 9.0% for TANF and 4.0% for ABD of total Emergency Room, variable by population. Results of the full LANE efficiency adjustment analysis from other state Medicaid programs generally range from 5.0% to 10.0%; state variations are generally a result of different underlying populations and different state methodology assumptions.

12.2.3 Other Medical Services

Mercer reviewed other state Medicaid experience to also understand the level of potential savings on other COS. In general, Mercer noted that other states applied savings adjustments and/or realized savings on Durable Medical Equipment. Mercer assumed all Standard Plan rate cells (other than the Maternity Event payment) would generate savings.

Savings on State Plan LTSS services including personal care is expected to take time to materialize through longer term management of patient conditions, thus a minimal savings assumption was put forth for these community LTSS services. Also, since the majority of spend for LTSS services is for the ABD population, Mercer only applied a savings factor to the ABD rate cell.

12.3 Pharmacy Benefits

Reimbursement and utilization management strategies play an important role in controlling pharmacy costs. Effective management of federal and supplemental rebates also contributes to decreasing the overall net drug costs to the Medicaid program. Along with other medical services, DHHS will move the management of the pharmacy benefit under the control of the PHPs.

Mercer performed a retrospective analysis of pharmacy claims data to identify inappropriate prescribing and/or dispensing patterns, using a customized series of clinical rules-based, pharmacy utilization management edits. These edits are developed by Mercer's managed pharmacy practice based on various states' pharmacy policies, published literature, industry standard practices, clinical appropriateness review, professional expertise and information gathered during the review of several Medicaid MCO pharmacy programs across the country. This analysis resulted in an estimated total savings opportunity of approximately -2.4%.

Additionally, under FFS, DHHS has developed a strong pharmacy benefit program, which includes a Preferred Drug List (PDL) that generates significant pharmacy rebates to DHHS on the prescription drugs administered to Medicaid beneficiaries. As a part of Medicaid Transformation efforts, the State is requiring that PHPs adhere to the State PDL. By requiring PHPs to follow the PDL, DHHS should expect to receive similar rebates on the drugs administered to PHP beneficiaries. Additionally, DHHS is mandating in the contract that the PHPs shall not negotiate rebates for drugs on the State PDL. As such, Mercer does not anticipate the PHPs will be able to negotiate further material rebates with the manufacturers under managed care, and no additional adjustment was assumed related to PHP rebate opportunities.

13 NON-BENEFIT EXPENSE CONSIDERATIONS

The final component of the capitation rates is the non-benefit expense load. This portion of the capitation rate accounts for PHP administration costs incurred to operate the Medicaid managed care program. Per 42 CFR 438.5(e) of the Final Rule, "The development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO, PIHP, or PAHP administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in §438.3(c)(1)(ii) to the populations covered under the contract." Additional guidance specific to non-benefit expense load development in Medicaid Managed Care Capitation Rate Development is included in ASOP 49 excerpt 3.2.12.

The non-benefit expense load includes consideration for general administration (including program management, administrative operations and utilization management personnel), care management personnel, non-personnel costs, profit/underwriting gain and premium taxes imposed on the PHPs. The considerations were developed to reflect the PHP contract requirements as defined by DHHS.

The non-benefit expense components (with the exception of profit/underwriting gain and premium taxes) were developed by building up the costs necessary to administer the PHP requirements as defined by DHHS. While these expenses may be expressed as a percent of premium in some exhibits, they were developed as a PMPM. The general administration and utilization management PMPM was developed on a statewide basis and does not currently vary by region. These administrative costs will be reevaluated after PHP contracts are finalized and regional information on the number of PHPs is known. The overall care management PMPM, which is largely comprised of care management staff (non-personnel related expenses for care management is captured under the general administration assumption), was also developed in aggregate on a statewide basis, and thus care management staffing assumptions did not vary by region. In addition to the care management considerations in the non-benefit load, the rates do consider required payments to LHDs and AMHs as base costs in the rate development. These considerations are discussed at the end of Section 13.3.

The tables below show the various non-benefit components summarized as a PMPM and percent of premium by COA.

Table 22: Overall Non-Benefit Expenses PMPM/Payment by COA

COA	General Administration and Utilization Management	Care Management	Profit/ Underwriting Gain	Premium Taxes	Total
ABD PMPM	$48.82	$43.79	$23.24	$27.24	$143.11
TANF, Newborn (<1) PMPM	$28.11	$22.34	$11.92	$13.97	$76.35
TANF, Child (1-20) PMPM	$10.89	$4.50	$2.49	$2.92	$20.80
TANF, Adult (21+) PMPM	$18.97	$12.87	$6.93	$8.12	$46.88
Maternity Event Payment	$70.97	$313.95	$161.92	$189.79	$736.64
Total Standard Plan	$16.37	$10.86	$5.84	$6.85	$39.92

Table 23: Overall Non-Benefit Expenses as a Percent of Premium by COA

COA	General Administration and Utilization Management	Care Management	Profit/ Underwriting Gain	Premium Taxes	Total
ABD	3.7%	3.3%	1.75%	2.01%	10.6%
TANF, Newborn (<1)	4.1%	3.3%	1.75%	2.01%	11.0%
TANF, Child (1-20)	7.6%	3.2%	1.75%	2.01%	14.3%
TANF, Adult (21+)	4.8%	3.3%	1.75%	2.01%	11.6%
Maternity Event	0.8%	3.4%	1.75%	2.01%	7.8%
Total Standard Plan	4.9%	3.3%	1.75%	2.01%	11.7%

Note: The PMPM figures in the table above were translated to a percent of total premium. In comparing these percentages to other states or industry benchmarks, please note that the total premium includes consideration for historical supplemental payments as outlined in Section 11.1.

13.1 Methodology and Data Sources

Mercer developed an administrative model that calculates the expected cost to operate a Medicaid managed care program for each rate cell. The model includes personnel costs for program management and general administrative operations as well as non-personnel costs necessary to run the program. Mercer prepared an additional model that established cost expectations for the anticipated personnel required to achieve DHHS' proposed care management requirements. The results of this modeling and its impact to the capitation rates are discussed in the subsequent sections.

The primary data source for estimating administrative staffing salaries was supplied by the Bureau of Labor Statistics (BLS) website. The Occupational Employment Statistics (OES) program estimates the number of jobs, salary and wage data by surveying employers throughout the country for more than 800 occupations. This data is available on a nationwide basis, by state and between urban and rural areas within each state. The OES survey data includes several statistical measures of salaries and wages, including the hourly and annual mean, median and various percentiles. The most recent information available is as of May 2016. The dataset was restricted to experience for the State of North Carolina. [15]

Colliers International publishes quarterly reports summarizing commercial real estate market statistics, including the average rent cost per square foot by geography. Quarterly reports are prepared for Charlotte, Raleigh-Durham and surrounding cities. The latest reports available for Raleigh-Durham, Charlotte and surrounding areas were as of the third quarter of 2017. This information supported regional cost expectations for commercial real estate needed to administer a Medicaid managed care program. [16,17]

The model output is dependent upon the assumed allocation of PHPs administering the program and their allocation across the six proposed PHP regions. Per legislation, DHHS will contract with four statewide PHPs and up to twelve regional contracts with provider-led entities (PLEs)[18]. Mercer's model currently assumes four statewide PHPs and four regional PLEs. The model allocates applicable staffing positions across regions to account for the anticipated split of responsibilities across regions for PHPs that participate in more than one

[15] https://www.bls.gov/oes/special.requests/oesm16st.zip
[16] http://www.colliers.com/-/media/files/united states/markets/north carolina/charlotte/office market reports/q3 2017 market report - office.pdf
[17] http://www.colliers.com/-/media/files/marketresearch/unitedstates/markets/raleigh/2017 reports/2017-q3-office-raleighdurham-report-colliers.pdf
[18] https://webservices.ncleg.net/ViewBillDocument/2017/7169/0/H403-PCCS10514-TR-21

region. Upon contract award, this assumption will be updated to reflect the actual number of PHPs and PLEs operating within/across regions.

13.2 Program Management and Administrative Operations Personnel

The general administration and utilization management model addresses the expected staffing needs to operate and administer a Medicaid program. The capitation rates assume each PHP will have program management staff that is further delineated by executive management, financial, clinical operations, legal (general counsel), human resources and information technology. Executive management includes the Chief Executive and Chief Operating Officers. Financial staff includes the Chief Financial Officer, accountants, financial analysts and actuarial staff. Clinical operations include a Chief Medical Officer, Pharmacy Director and BH Coordinator. Information technology staff includes the Chief Information Officer, reporting and monitoring as well as IT specialists and support.

The capitation rates also include consideration for general administrative operations staff, delineated by customer service, compliance, network, claims processing and utilization management. Operations staff reflects customer service representatives, Compliance Officer, program integrity team, provider specialists and claims processing.

Assumptions for the number of Full-Time Equivalents (FTEs) vary by staffing position across each of the PHP regions. Salaries for each personnel component were developed based on the median salary levels in the BLS data for each staff type in the State of North Carolina. In addition to the BLS salary data, Mercer included an assumption for fringe benefits and payroll taxes.

13.3 Care Management Personnel

Care management is foundational to the success of North Carolina's health care system for Medicaid and NC Health Choice beneficiaries, supporting high-quality delivery of the right care at the right place and at the right time in the right setting. DHHS' care management strategy will focus on improving the health of beneficiaries through an innovative, person-centered and well-coordinated system of care that addresses medical and nonmedical drivers of health. Beneficiaries will have access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care and contributions to health-related resources. Access to local care management will draw from the Advanced Medical Home (AMH) model and participation from the LHDs; additionally DHHS is committed to providing care management for beneficiaries to address the four priority domains of opportunities for health: housing, food, transportation, and interpersonal safety. Mercer has aligned the care management modeling, as outlined below, with the DHHS care management strategy. Please see the North Carolina's Care Management Strategy under Managed Care policy paper, released on March 9, 2018, for more insight into DHHS' care management strategy[19].

The general care management model addresses both beneficiary care management and care coordination as a part of the approach to ensure efficient, coordinated and quality care. Care coordination is more administratively focused and as such, it is available to all beneficiaries and is often administered by a non-licensed individual. Care management is a team-based, person-centered approach to effectively manage patients' medical, social and behavioral conditions.

The base care management modeling assumes that 100.0% of beneficiaries will have access to care coordination whereas care management will be focused on low to high-needs beneficiaries which are assumed to comprise around 22.0% of the Standard Plan population, which represents an increased investment in care management

[19] North Carolina's Care Management Strategy under Managed Care. March 9, 2018. https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

from the current system. Additionally, the base care management modeling includes consideration for care management FTEs based on a beneficiary to staff ratio. As mentioned, care coordinators are expected to perform tasks such as conducting care needs screening and providing linkage to community resources, which are more administratively focused. Given this, a higher member to staff ratio assumption is used for the care coordinator position. Whereas care managers are anticipated to perform more intensive beneficiary care management activities, and thus Mercer assumed a lower caseload compared to care coordinators. Mercer also assumed varied care manager caseloads depending on a range of low to high-needs priority population beneficiaries. BLS data was then leveraged to estimate the cost per FTE based on anticipated position job requirements. FTE assumptions were calculated based on the Standard Plan population average monthly membership (1.6 million).

Given DHHS' care management strategy and specific requirements outlined in the RFP, Mercer also included consideration in the care management assumption for LHD payment requirements, AMH contracting and payment requirements and additional costs for requirements related to opportunities for health initiatives.

Under managed care, DHHS is initially requiring PHPs to continue the historical payments to LHDs in the capitation rates to ensure payment levels not be disrupted under the transition to managed care. Historical payments made to LHDs for the OBCM and CC4C program are included as a service line item in the base data development. In addition to the base service costs, Mercer included consideration in the care management assumption for a small offset to PHP care management costs given LHD responsibilities along with additional PHP costs for oversight responsibilities.

DHHS has also made program design decisions to incorporate an AMH model under managed care to ease some of the transition from the historical Medical Home model. AMH practices will be designated into Tier 1, 2 or 3 practice categories. DHHS is mandating that PHPs contract with a certain number of AMH practices and also reimburse AMHs similar to the historical payments made to practices in the CA program which are included as a service line item in the base data development (Medical Home Payments). AMH Tier 3 practices will also perform beneficiary care management activities, and thus be reimbursed at an enhanced rate to account for these additional activities. Mercer worked with DHHS to estimate the anticipated number of AMH Tier 3 practices, assuming that approximately 65.0% of beneficiaries are tied to an AMH Tier 3 practice. Based on this assumption, Mercer assumed some level of additional costs to the PHPs to ensure backstop accountability for PHP members tied to an AMH Tier 3 practice and PHP oversight responsibilities and coordination with AMH Tier 3 practices. Note that the assumption around the percent of beneficiaries tied to an AMH Tier 3 practice will be revisited for final rates.

There are also a number of contract and staffing requirements related to the DHHS opportunities for health initiative considered in development of assumed care management costs, such as:

- Basic opportunities for health PHP screening requirements for all members
- Beneficiaries with high unmet social needs, regardless of medical conditions, flagged as priority population for comprehensive evaluation and potentially care management
- Specific PHP staffing requirements, such as a housing specialist

As discussed, the base data already accounts for some level of requirements associated with care management activities (OBCM LHD, CC4C LHD, Medical Home Payments). In addition to the costs captured in the base experience ($1.89 PMPM for LHD payments and $2.35 PMPM for AMH base payments), Mercer included an additional $10.86 PMPM based on the considerations and methodology outlined in Section 13.3 above, totaling $15.10 PMPM associated with medical home and care management requirements/activities.

13.4 Non-Personnel Costs

The capitation rates include consideration for the non-personnel costs associated with program management, administrative operations and care management. Non-personnel costs primarily consist of annual rent and utilities as well as the necessary equipment and supplies required to operate a business, including computers and cell phones. North Carolina commercial real estate market data from various regions throughout the state were utilized to develop cost expectations for the average annual rent cost per square foot per region. The capitation rates also capture costs for staff travel time, IT software, systems and licensing.

Finally, the capitation rates reflect the administrative costs for third-party Pharmacy Benefit Managers (PBMs) to contract with pharmacies, process/pay prescription drug claims and collect rebates for the PHPs. To calculate the impact, Mercer relied upon experience with other states due to the limited availability of data specific to North Carolina. The PBM administrative cost for other states equates to 2.0% of the projected prescription drug claim costs. For the Standard Plan, 2.0% of the base prescription drug experience levels equate to $28 million in administrative PBM costs or roughly $1.50 PMPM.

13.5 Non-Benefit Expense Load Application to Capitation Rates

Each component within program management and administrative operations personnel, care management personnel and non-personnel modeling is classified as either a fixed or variable cost. This approach recognizes that certain administrative costs will be incurred regardless of population size or magnitude of medical claims (fixed costs) while others are a function of the size of the population served or services provided to members (variable costs). The capitation rates aggregated across all rate cells illustrate a split of approximately 25.0% fixed and 75.0% variable costs for each region.

The fixed PMPM is applied uniformly to all rate cells within each region (other than the Maternity Event payment), such that each rate cell receives the same fixed PMPM. The Maternity Event payment does not include the fixed portion of the administrative expense PMPM as each pregnant woman's rate cell capitation payment (concurrent with the Maternity Event payment) for non-delivery related services will include fixed administrative costs. The remaining portion of the administrative PMPM pertains to variable costs. The total regional PMPM was converted to a rate cell specific PMPM based on distribution of claim costs; the resulting variable PMPM varies by rate cell. The statewide Standard Plan non-benefit expense PMPM prior to the application of profit/underwriting gain and premium taxes is $27.23.

13.6 Profit/Underwriting Gain and Premium Taxes

Per ASOP 49, underwriting gain (or profit) provides compensation for the risk assumed by the MCO. Underwriting gain includes consideration for cost of capital and margin for risk contingency. Risks include insurance, investment, inflation and regulatory risks as well as risk associated with social, economic and legal environments. An overall profit/underwriting gain assumption of 1.75% has been included, comprised of 1.25% for cost of capital and 0.5% for margin for risk.

Mercer has included a 2.01% consideration for PHP premium taxes in the capitation rate development, per DHHS and House Bill 156[20], which indicates legislative intent to apply the commercial insurance premium tax and regulatory surcharge applied to PHPs.

13.7 Health Insurer Provider Fee (HIPF)

The HIPF is a federal fee that applies to certain health insurers. In the context of rate-setting, the HIPF is considered a cost of doing business that is appropriate to recognize in the payments to PHPs. Currently, there is a moratorium on the HIPF for premiums earned in 2018 and uncertainty with respect to the applicability of the

[20] https://webservices.ncleg.net/ViewBillDocument/2017/7124/0/H156-PCCS40774-TR-22

HIPF in the future. As such, no adjustment has been included in the draft capitation rates for the HIPF. DHHS will reimburse PHPs for these fees and will determine the appropriate approach as more information becomes available on the applicability of the fee.

14 CAPITATION RATE DEVELOPMENT EXHIBITS

The first exhibit in this section provides an overview of the MMs and draft capitation rates by COA and region. This exhibit is followed by detailed summaries illustrating the full rate development process for each regional rate cell, from the adjusted base data (including all adjustments outlined in Section 6) to the prospective adjustments outlined in Sections 8 through 12. Additionally, the non-medical expense considerations are outlined in each summary in accordance with the methodology in Section 13 of this Rate Book.

Exhibit 73

Member Months/Deliveries by Region and Category of Aid

Rating Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide
Aged, Blind, Disabled	146,847	263,136	328,525	278,511	309,639	267,136	1,593,794
TANF and Other Related Children (<1)	78,257	144,528	211,433	171,144	135,338	108,992	849,691
TANF and Other Related Children (1-20)	1,220,080	2,297,179	3,243,949	2,661,605	2,183,299	1,733,723	13,339,835
TANF and Other Related Adults (21+)	270,425	468,569	711,903	509,487	540,587	407,775	2,908,746
Maternity Event	5,230	9,264	13,078	9,785	8,871	7,245	53,473
Total	**1,715,609**	**3,173,411**	**4,495,811**	**3,620,746**	**3,168,863**	**2,517,626**	**18,692,065**

Capitation Rates by Region and Category of Aid

Rating Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Statewide
Aged, Blind, Disabled	$ 1,373.30	$ 1,356.05	$ 1,529.02	$ 1,415.53	$ 1,278.26	$ 1,158.50	$ 1,355.46
TANF and Other Related Children (<1)	$ 749.33	$ 707.22	$ 736.81	$ 660.06	$ 736.49	$ 563.56	$ 695.20
TANF and Other Related Children (1-20)	$ 166.46	$ 148.78	$ 141.55	$ 141.70	$ 147.03	$ 136.70	$ 145.37
TANF and Other Related Adults (21+)	$ 413.55	$ 437.60	$ 394.18	$ 385.86	$ 422.14	$ 373.97	$ 403.88
Maternity Event	$ 9,555.60	$ 9,760.42	$ 9,431.17	$ 8,857.91	$ 10,192.86	$ 8,844.00	$ 9,442.29
Total	**$ 364.43**	**$ 345.46**	**$ 338.37**	**$ 322.48**	**$ 358.20**	**$ 327.48**	**$ 340.78**

14.1 Region 1 Capitation Rate Development Exhibits

Exhibit 74

Region:	**Region 1**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**146,847**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 129.73	$ 1,027.07	1,516	0.5%	0.5%	0.0%	168.6%	168.6%	0.0%	-15.8%	0.0%	-15.8%	$ 297.69	$ 2,799.99	1,276
Inpatient — BH	$ 8.94	$ 728.85	147	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.00	$ 739.83	146
Outpatient Hospital	$ 123.35	$ 444.79	3,328	3.0%	0.5%	2.5%	32.7%	32.7%	0.0%	-30.8%	0.0%	-30.8%	$ 123.72	$ 599.09	2,478
Emergency Room	$ 63.25	$ 515.04	1,474	1.5%	0.5%	1.0%	22.9%	22.9%	0.0%	-19.6%	0.0%	-19.6%	$ 65.37	$ 642.43	1,221
Physician	$ 106.11	$ 134.43	9,472	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-13.0%	0.0%	-13.0%	$ 99.42	$ 136.45	8,743
FQHC/RHC	$ 14.51	$ 128.78	1,352	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 14.33	$ 130.72	1,315
Other Clinic	$ 7.76	$ 307.37	303	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.67	$ 312.00	295
Other Practitioner	$ 1.22	$ 78.12	187	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 1.20	$ 79.29	182
Therapies	$ 3.11	$ 110.14	339	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 3.07	$ 111.80	330
Prescribed Drugs	$ 418.40	$ 125.12	40,129	5.8%	5.3%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 482.92	$ 145.87	39,727
Other BH Services	$ 14.31	$ 56.86	3,021	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 15.06	$ 58.58	3,086
LTSS Services	$ 46.57	$ 8.33	67,117	3.8%	0.5%	3.2%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 55.80	$ 9.50	70,463
Durable Medical Equipment	$ 38.17	$ 2.80	163,357	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 33.60	$ 2.85	141,651
Limited Dental Services	$ 0.02	$ 24.51	10	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.02	$ 24.88	11
Optical	$ 0.90	$ 70.12	154	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.93	$ 71.18	157
Lab and X-Ray	$ 7.87	$ 25.67	3,680	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 8.16	$ 26.05	3,760
Transportation	$ 11.32	$ 59.96	2,265	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.36	$ 60.87	2,239
Subtotal (Medical)	*$ 995.55*	*N/A*	*297,851*	*3.6%*	*2.5%*	*1.1%*	*26.0%*	*26.0%*	*0.0%*	*-11.9%*	*0.0%*	*-11.9%*	*$ 1,229.33*	*N/A*	*277,080*
CC4C LHD Payments	$ 0.00	$ 4.53	8	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	8
OBCM LHD Payments	$ 0.71	$ 4.93	1,721	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.71	$ 4.93	1,721
Medical Home Payments	$ 4.14	$ 4.66	10,668	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.14	$ 4.66	10,668
Subtotal (LHD/Medical Home Payments)	*$ 4.85*	*N/A*	*12,397*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 4.85*	*N/A*	*12,397*
Total (Medical + LHD/Medical Home)	**$ 1,000.40**	**N/A**	**310,249**	**3.6%**	**2.5%**	**1.1%**	**25.9%**	**25.9%**	**0.0%**	**-11.8%**	**0.0%**	**-11.8%**	**$ 1,234.18**	**N/A**	**289,477**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,234.18**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.46%)	$ 46.55
Care Management (3.08%)	$ 41.42
Profit/Underwriting Gain (1.75%)	$ 23.55
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,345.70**
Premium Taxes (2.01%)	$ 27.60
Total Capitation Rate:	**$ 1,373.30**

Exhibit 75

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**78,257**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 197.39	$ 642.74	3,685	1.5%	0.5%	1.0%	165.8%	165.8%	0.0%	-15.0%	0.0%	-15.0%	$ 466.31	$ 1,734.07	3,227
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 21.43	$ 152.81	1,683	3.0%	0.5%	2.5%	19.4%	19.4%	0.0%	-15.0%	0.0%	-15.0%	$ 23.77	$ 185.19	1,540
Emergency Room	$ 16.86	$ 238.04	850	1.5%	0.5%	1.0%	19.1%	19.1%	0.0%	-7.5%	0.0%	-7.5%	$ 19.43	$ 287.82	810
Physician	$ 83.51	$ 90.76	11,041	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.6%	0.0%	-7.6%	$ 83.06	$ 92.13	10,819
FQHC/RHC	$ 9.89	$ 130.32	910	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 9.85	$ 132.28	893
Other Clinic	$ 32.26	$ 90.19	4,293	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 32.14	$ 91.55	4,212
Other Practitioner	$ 0.04	$ 36.40	12	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.04	$ 36.95	12
Therapies	$ 1.04	$ 92.32	136	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.04	$ 93.72	133
Prescribed Drugs	$ 14.08	$ 46.72	3,617	-2.8%	-2.8%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 12.73	$ 42.97	3,554
Other BH Services	$ 0.06	$ 19.52	38	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.07	$ 20.12	40
LTSS Services	$ 2.10	$ 66.94	376	3.8%	0.5%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.34	$ 67.95	414
Durable Medical Equipment	$ 10.32	$ 4.47	27,705	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 9.98	$ 4.54	26,400
Limited Dental Services	$ 1.60	$ 24.85	771	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.67	$ 25.22	794
Optical	$ 0.02	$ 77.55	4	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 78.72	4
Lab and X-Ray	$ 0.55	$ 20.85	318	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.58	$ 21.17	328
Transportation	$ 1.37	$ 84.50	194	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.38	$ 85.77	194
Subtotal (Medical)	*$ 392.52*	*N/A*	*55,633*	*1.8%*	*0.4%*	*1.4%*	*84.6%*	*84.6%*	*0.0%*	*-13.0%*	*0.0%*	*-13.0%*	*$ 664.39*	*N/A*	*53,373*
CC4C LHD Payments	$ 4.20	$ 4.55	11,071	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.20	$ 4.55	11,071
OBCM LHD Payments	$ 0.00	$ 4.96	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.96	-
Medical Home Payments	$ 2.04	$ 2.46	9,964	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.04	$ 2.46	9,964
Subtotal (LHD/Medical Home Payments)	*$ 6.24*	*N/A*	*21,035*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.24*	*N/A*	*21,035*
Total (Medical + LHD/Medical Home)	**$ 398.76**	**N/A**	**76,668**	**1.7%**	**0.4%**	**1.4%**	**83.4%**	**83.4%**	**0.0%**	**-12.9%**	**0.0%**	**-12.9%**	**$ 670.63**	**N/A**	**74,408**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 670.63**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.85%)	$ 28.28
Care Management (3.06%)	$ 22.50
Profit/Underwriting Gain (1.75%)	$ 12.85
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 734.27**
Premium Taxes (2.01%)	$ 15.06
Total Capitation Rate:	**$ 749.33**

Exhibit 76

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**1,220,080**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.24	$ 1,176.35	43	1.5%	0.5%	1.0%	143.8%	143.8%	0.0%	-15.3%	0.0%	-15.3%	$ 9.16	$ 2,911.63	38
Inpatient — BH	$ 1.12	$ 906.90	15	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.17	$ 920.57	15
Outpatient Hospital	$ 17.75	$ 236.09	902	3.0%	0.5%	2.5%	24.2%	24.2%	0.0%	-15.3%	0.0%	-15.3%	$ 20.40	$ 297.57	823
Emergency Room	$ 12.34	$ 301.77	491	1.5%	0.5%	1.0%	20.0%	20.0%	0.0%	-7.8%	0.0%	-7.8%	$ 14.27	$ 367.44	466
Physician	$ 22.58	$ 72.24	3,751	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.5%	0.0%	-8.5%	$ 22.25	$ 73.33	3,641
FQHC/RHC	$ 4.51	$ 138.57	391	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 4.48	$ 140.66	382
Other Clinic	$ 5.41	$ 101.64	639	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.37	$ 103.17	625
Other Practitioner	$ 0.18	$ 52.86	41	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.18	$ 53.66	40
Therapies	$ 3.74	$ 100.47	447	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.72	$ 101.98	437
Prescribed Drugs	$ 40.94	$ 99.52	4,937	5.0%	4.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 46.23	$ 113.57	4,884
Other BH Services	$ 7.38	$ 75.98	1,166	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 7.81	$ 78.28	1,197
LTSS Services	$ 0.29	$ 11.13	312	3.8%	0.5%	3.2%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.33	$ 11.59	342
Durable Medical Equipment	$ 2.65	$ 3.38	9,420	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.56	$ 3.43	8,947
Limited Dental Services	$ 0.31	$ 24.74	151	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.32	$ 25.11	155
Optical	$ 0.96	$ 82.55	140	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.00	$ 83.79	143
Lab and X-Ray	$ 0.61	$ 19.28	380	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.64	$ 19.57	390
Transportation	$ 0.52	$ 69.87	89	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.52	$ 70.92	88
Subtotal (Medical)	*$ 125.55*	*N/A*	*23,313*	*3.2%*	*1.8%*	*1.3%*	*9.9%*	*9.9%*	*0.0%*	*-7.4%*	*0.0%*	*-7.4%*	*$ 140.40*	*N/A*	*22,615*
CC4C LHD Payments	$ 0.98	$ 4.52	2,612	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.98	$ 4.52	2,612
OBCM LHD Payments	$ 0.55	$ 4.92	1,343	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.55	$ 4.92	1,343
Medical Home Payments	$ 2.26	$ 2.44	11,108	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.26	$ 2.44	11,108
Subtotal (LHD/Medical Home Payments)	*$ 3.80*	*N/A*	*15,063*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.80*	*N/A*	*15,063*
Total (Medical + LHD/Medical Home)	**$ 129.34**	**N/A**	**38,377**	**3.1%**	**1.8%**	**1.3%**	**9.6%**	**9.6%**	**0.0%**	**-7.2%**	**0.0%**	**-7.2%**	**$ 144.20**	**N/A**	**37,678**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 144.20**
Non-Benefit Expense PMPM/Payment:	
General Administration (6.88%)	$ 11.22
Care Management (2.97%)	$ 4.84
Profit/Underwriting Gain (1.75%)	$ 2.85
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 163.11**
Premium Taxes (2.01%)	$ 3.35
Total Capitation Rate:	**$ 166.46**

Exhibit 77

Region:	**Region 1**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**270,425**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 28.85	$ 1,218.41	284	3.5%	0.5%	3.0%	152.3%	152.3%	0.0%	-12.2%	0.0%	-12.2%	$ 70.89	$ 3,119.96	273
Inpatient — BH	$ 3.04	$ 791.01	46	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 3.34	$ 802.93	50
Outpatient Hospital	$ 52.51	$ 315.66	1,996	3.0%	0.5%	2.5%	29.2%	29.2%	0.0%	-23.4%	0.0%	-23.4%	$ 56.78	$ 413.99	1,646
Emergency Room	$ 44.26	$ 442.95	1,199	1.5%	0.5%	1.0%	22.8%	22.8%	0.0%	-12.2%	0.0%	-12.2%	$ 49.93	$ 552.16	1,085
Physician	$ 42.41	$ 103.83	4,901	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-12.3%	0.0%	-12.3%	$ 40.04	$ 105.40	4,559
FQHC/RHC	$ 7.40	$ 129.51	686	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.30	$ 131.46	667
Other Clinic	$ 8.49	$ 270.90	376	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 8.38	$ 274.98	366
Other Practitioner	$ 0.48	$ 55.98	104	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.48	$ 56.82	101
Therapies	$ 0.02	$ 60.18	3	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.02	$ 61.08	3
Prescribed Drugs	$ 87.61	$ 74.47	14,117	5.3%	5.0%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 99.31	$ 86.21	13,823
Other BH Services	$ 7.37	$ 72.98	1,212	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.75	$ 75.19	1,237
LTSS Services	$ 1.20	$ 16.16	893	3.8%	0.5%	3.2%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.34	$ 16.56	974
Durable Medical Equipment	$ 5.78	$ 2.31	30,015	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.54	$ 2.35	28,323
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ -	-
Optical	$ 0.35	$ 69.10	60	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.36	$ 70.14	62
Lab and X-Ray	$ 8.80	$ 30.33	3,480	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 9.12	$ 30.79	3,553
Transportation	$ 1.90	$ 69.90	327	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.91	$ 70.95	323
Subtotal (Medical)	*$ 300.47*	*N/A*	*59,700*	*3.3%*	*1.8%*	*1.5%*	*23.0%*	*23.0%*	*0.0%*	*-11.0%*	*0.0%*	*-11.0%*	*$ 362.49*	*N/A*	*57,043*
CC4C LHD Payments	$ 0.00	$ 4.40	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.40	-
OBCM LHD Payments	$ 3.21	$ 4.91	7,845	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.21	$ 4.91	7,845
Medical Home Payments	$ 1.67	$ 2.37	8,429	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.67	$ 2.37	8,429
Subtotal (LHD/Medical Home Payments)	*$ 4.87*	*N/A*	*16,274*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 4.87*	*N/A*	*16,274*
Total (Medical + LHD/Medical Home)	**$ 305.35**	**N/A**	**75,974**	**3.2%**	**1.8%**	**1.4%**	**22.6%**	**22.6%**	**0.0%**	**-10.9%**	**0.0%**	**-10.9%**	**$ 367.37**	**N/A**	**73,317**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 367.37**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.55%)	$ 18.45
Care Management (3.04%)	$ 12.33
Profit/Underwriting Gain (1.75%)	$ 7.09
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 405.24**
Premium Taxes (2.01%)	$ 8.31
Total Capitation Rate:	**$ 413.55**

Exhibit 78

Region:	**Region 1**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**5,230**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,122.90	$ 782.43	32,558	0.5%	0.5%	0.0%	176.1%	176.1%	0.0%	-1.1%	0.0%	-1.1%	$ 5,882.81	$ 2,192.88	32,192
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 393.50	$ 129.75	36,392	3.0%	0.5%	2.5%	26.3%	26.3%	0.0%	-22.5%	0.0%	-22.5%	$ 420.96	$ 166.38	30,361
Emergency Room	$ 314.33	$ 337.39	11,180	1.5%	0.5%	1.0%	23.3%	23.3%	0.0%	-11.3%	0.0%	-11.3%	$ 359.66	$ 422.25	10,221
Physician	$ 1,545.86	$ 184.45	100,570	2.5%	0.5%	2.0%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,678.24	$ 188.75	106,694
FQHC/RHC	$ 200.94	$ 151.46	15,921	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 216.39	$ 153.74	16,890
Other Clinic	$ 201.31	$ 129.75	18,619	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 216.79	$ 131.70	19,753
Other Practitioner	$ 0.11	$ 75.77	17	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.11	$ 76.92	18
Therapies	$ -	$ -	-	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.01	$ 87.29	2	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 89.93	2
LTSS Services	$ 1.53	$ 6.69	2,735	3.8%	0.5%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.70	$ 6.80	3,009
Durable Medical Equipment	$ 8.02	$ 77.96	1,234	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 8.38	$ 79.14	1,271
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Optical	$ 0.03	$ 115.45	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 117.19	3
Lab and X-Ray	$ 36.57	$ 25.11	17,477	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 38.24	$ 25.49	18,004
Transportation	$ 12.63	$ 104.01	1,458	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 12.79	$ 105.58	1,453
Subtotal (Medical)	*$ 4,837.74*	*N/A*	*238,166*	*1.6%*	*0.5%*	*1.1%*	*78.8%*	*78.8%*	*0.0%*	*-2.6%*	*0.0%*	*-2.6%*	*$ 8,836.13*	*N/A*	*239,873*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,837.74**	**N/A**	**238,166**	**1.6%**	**0.5%**	**1.1%**	**78.8%**	**78.8%**	**0.0%**	**-2.6%**	**0.0%**	**-2.6%**	**$ 8,836.13**	**N/A**	**239,873**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,836.13**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.72%)	$ 67.03
Care Management (3.17%)	$ 296.52
Profit/Underwriting Gain (1.75%)	$ 163.86
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,363.54**
Premium Taxes (2.01%)	$ 192.07
Total Capitation Rate:	**$ 9,555.60**

14.2 Region 2 Capitation Rate Development Exhibits

Exhibit 79

Region:	**Region 2**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**263,136**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 127.01	$ 989.44	1,540	0.5%	0.5%	0.0%	167.2%	167.2%	0.0%	-15.8%	0.0%	-15.8%	$ 289.97	$ 2,683.58	1,297
Inpatient — BH	$ 6.03	$ 693.41	104	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 6.07	$ 703.87	103
Outpatient Hospital	$ 118.21	$ 502.17	2,825	3.0%	0.5%	2.5%	36.7%	36.7%	0.0%	-27.1%	0.0%	-27.1%	$ 128.74	$ 696.66	2,218
Emergency Room	$ 64.34	$ 521.01	1,482	1.5%	0.5%	1.0%	29.6%	29.6%	0.0%	-19.6%	0.0%	-19.6%	$ 70.13	$ 685.43	1,228
Physician	$ 101.06	$ 130.66	9,282	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-11.8%	0.0%	-11.8%	$ 94.62	$ 132.63	8,561
FQHC/RHC	$ 2.00	$ 123.26	195	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 1.95	$ 125.12	187
Other Clinic	$ 8.65	$ 328.01	316	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 8.41	$ 332.95	303
Other Practitioner	$ 0.79	$ 75.00	126	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.77	$ 76.13	121
Therapies	$ 3.04	$ 108.18	337	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 2.96	$ 109.81	323
Prescribed Drugs	$ 392.84	$ 135.10	34,894	6.0%	5.5%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 456.65	$ 158.64	34,543
Other BH Services	$ 15.45	$ 64.37	2,880	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 16.26	$ 66.33	2,942
LTSS Services	$ 65.78	$ 5.71	138,253	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 72.71	$ 6.52	133,906
Durable Medical Equipment	$ 40.27	$ 2.96	163,123	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 35.45	$ 3.01	141,448
Limited Dental Services	$ 0.04	$ 25.18	19	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.56	20
Optical	$ 0.93	$ 71.12	157	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.97	$ 72.20	161
Lab and X-Ray	$ 10.84	$ 23.14	5,623	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.24	$ 23.49	5,744
Transportation	$ 12.46	$ 89.20	1,676	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 12.06	$ 90.54	1,598
Subtotal (Medical)	*$ 969.74*	*N/A*	*362,832*	*3.4%*	*2.6%*	*0.8%*	*27.2%*	*27.2%*	*0.0%*	*-11.4%*	*0.0%*	*-11.4%*	*$ 1,209.00*	*N/A*	*334,703*
CC4C LHD Payments	$ 0.00	$ 4.53	13	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	13
OBCM LHD Payments	$ 0.76	$ 4.93	1,844	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.76	$ 4.93	1,844
Medical Home Payments	$ 4.26	$ 4.67	10,942	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.26	$ 4.67	10,942
Subtotal (LHD/Medical Home Payments)	*$ 5.02*	*N/A*	*12,800*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.02*	*N/A*	*12,800*
Total (Medical + LHD/Medical Home)	**$ 974.76**	**N/A**	**375,632**	**3.4%**	**2.6%**	**0.8%**	**27.0%**	**27.0%**	**0.0%**	**-11.3%**	**0.0%**	**-11.3%**	**$ 1,214.02**	**N/A**	**347,504**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,214.02**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.64%)	$ 48.35
Care Management (3.25%)	$ 43.18
Profit/Underwriting Gain (1.75%)	$ 23.25
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,328.79**
Premium Taxes (2.01%)	$ 27.26
Total Capitation Rate:	**$ 1,356.05**

Exhibit 80

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**144,528**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 178.20	$ 561.51	3,808	1.5%	0.5%	1.0%	172.5%	172.5%	0.0%	-15.0%	0.0%	-15.0%	$ 431.67	$ 1,553.43	3,335
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 14.26	$ 155.20	1,103	3.0%	0.5%	2.5%	36.6%	36.6%	0.0%	-7.5%	0.0%	-7.5%	$ 19.69	$ 215.21	1,098
Emergency Room	$ 22.03	$ 264.40	1,000	1.5%	0.5%	1.0%	26.9%	26.9%	0.0%	-7.5%	0.0%	-7.5%	$ 27.04	$ 340.55	953
Physician	$ 81.34	$ 90.04	10,841	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 80.44	$ 91.39	10,561
FQHC/RHC	$ 4.34	$ 114.62	455	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 4.26	$ 116.35	440
Other Clinic	$ 36.19	$ 98.28	4,419	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 35.53	$ 99.76	4,274
Other Practitioner	$ 0.01	$ 34.22	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.01	$ 34.74	3
Therapies	$ 0.75	$ 99.92	90	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.73	$ 101.42	87
Prescribed Drugs	$ 13.47	$ 46.55	3,472	-1.5%	-1.5%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 12.65	$ 44.48	3,412
Other BH Services	$ 0.06	$ 23.20	29	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.06	$ 23.91	30
LTSS Services	$ 0.43	$ 19.60	266	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.45	$ 19.89	270
Durable Medical Equipment	$ 7.58	$ 26.72	3,406	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 7.34	$ 27.12	3,246
Limited Dental Services	$ 2.22	$ 24.95	1,070	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.33	$ 25.32	1,102
Optical	$ 0.03	$ 96.58	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 98.03	3
Lab and X-Ray	$ 0.81	$ 16.24	598	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.85	$ 16.49	616
Transportation	$ 0.95	$ 91.49	124	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.92	$ 92.87	119
Subtotal (Medical)	*$ 362.67*	*N/A*	*30,686*	*1.6%*	*0.4%*	*1.2%*	*87.6%*	*87.6%*	*0.0%*	*-12.6%*	*0.0%*	*-12.6%*	*$ 623.99*	*N/A*	*29,547*
CC4C LHD Payments	$ 4.18	$ 4.55	11,040	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,040
OBCM LHD Payments	$ 0.00	$ 4.94	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.94	-
Medical Home Payments	$ 2.05	$ 2.47	9,956	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.05	$ 2.47	9,956
Subtotal (LHD/Medical Home Payments)	*$ 6.24*	*N/A*	*20,997*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.24*	*N/A*	*20,997*
Total (Medical + LHD/Medical Home)	**$ 368.91**	**N/A**	**51,683**	**1.6%**	**0.4%**	**1.2%**	**86.2%**	**86.2%**	**0.0%**	**-12.5%**	**0.0%**	**-12.5%**	**$ 630.22**	**N/A**	**50,544**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 630.22**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.08%)	$ 28.25
Care Management (3.23%)	$ 22.41
Profit/Underwriting Gain (1.75%)	$ 12.13
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 693.01**
Premium Taxes (2.01%)	$ 14.22
Total Capitation Rate:	**$ 707.22**

Exhibit 81

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,297,179**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.66	$ 1,303.09	43	1.5%	0.5%	1.0%	142.3%	142.3%	0.0%	-15.3%	0.0%	-15.3%	$ 10.00	$ 3,204.87	37
Inpatient — BH	$ 0.93	$ 658.91	17	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.96	$ 668.84	17
Outpatient Hospital	$ 10.63	$ 232.55	548	3.0%	0.5%	2.5%	35.7%	35.7%	0.0%	-7.8%	0.0%	-7.8%	$ 14.53	$ 320.41	544
Emergency Room	$ 13.73	$ 322.66	511	1.5%	0.5%	1.0%	28.4%	28.4%	0.0%	-7.8%	0.0%	-7.8%	$ 17.00	$ 420.59	485
Physician	$ 19.58	$ 69.01	3,405	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.2%	0.0%	-7.2%	$ 19.29	$ 70.05	3,305
FQHC/RHC	$ 1.27	$ 112.69	136	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.25	$ 114.39	131
Other Clinic	$ 5.90	$ 103.64	683	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.78	$ 105.21	659
Other Practitioner	$ 0.10	$ 78.83	16	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 80.02	15
Therapies	$ 2.96	$ 116.23	305	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.89	$ 117.98	294
Prescribed Drugs	$ 36.87	$ 96.69	4,576	4.8%	4.3%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 41.33	$ 109.55	4,527
Other BH Services	$ 4.72	$ 77.02	736	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 5.00	$ 79.35	756
LTSS Services	$ 0.09	$ 7.29	148	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.09	$ 7.59	150
Durable Medical Equipment	$ 2.19	$ 2.64	9,940	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.11	$ 2.68	9,441
Limited Dental Services	$ 0.44	$ 24.80	211	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.45	$ 25.17	217
Optical	$ 1.04	$ 83.53	149	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.08	$ 84.79	153
Lab and X-Ray	$ 1.56	$ 18.66	1,001	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.62	$ 18.94	1,028
Transportation	$ 0.42	$ 90.47	55	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.41	$ 91.83	53
Subtotal (Medical)	*$ 107.08*	*N/A*	*22,480*	*2.9%*	*1.8%*	*1.1%*	*13.0%*	*13.0%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 123.90*	*N/A*	*21,812*
CC4C LHD Payments	$ 0.99	$ 4.52	2,627	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.99	$ 4.52	2,627
OBCM LHD Payments	$ 0.56	$ 4.92	1,362	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.56	$ 4.92	1,362
Medical Home Payments	$ 2.30	$ 2.45	11,277	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.30	$ 2.45	11,277
Subtotal (LHD/Medical Home Payments)	*$ 3.85*	*N/A*	*15,265*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.85*	*N/A*	*15,265*
Total (Medical + LHD/Medical Home)	**$ 110.93**	**N/A**	**37,745**	**2.8%**	**1.8%**	**1.1%**	**12.6%**	**12.6%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 127.75**	**N/A**	**37,078**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 127.75**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.51%)	$ 10.95
Care Management (3.12%)	$ 4.54
Profit/Underwriting Gain (1.75%)	$ 2.55
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 145.79**
Premium Taxes (2.01%)	$ 2.99
Total Capitation Rate:	**$ 148.78**

Exhibit 82

Region:	**Region 2**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**468,569**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 25.50	$ 1,075.55	285	3.5%	0.5%	3.0%	164.6%	164.6%	0.0%	-12.2%	0.0%	-12.2%	$ 65.71	$ 2,888.39	273
Inpatient — BH	$ 2.18	$ 684.80	38	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.39	$ 695.12	41
Outpatient Hospital	$ 37.85	$ 345.57	1,314	3.0%	0.5%	2.5%	37.1%	37.1%	0.0%	-15.9%	0.0%	-15.9%	$ 47.69	$ 480.99	1,190
Emergency Room	$ 44.76	$ 459.65	1,168	1.5%	0.5%	1.0%	29.3%	29.3%	0.0%	-12.2%	0.0%	-12.2%	$ 53.18	$ 603.48	1,057
Physician	$ 48.34	$ 108.58	5,342	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.9%	0.0%	-8.9%	$ 46.74	$ 110.22	5,089
FQHC/RHC	$ 0.70	$ 117.82	71	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.68	$ 119.60	68
Other Clinic	$ 7.89	$ 247.13	383	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.67	$ 250.86	367
Other Practitioner	$ 0.38	$ 67.54	68	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.37	$ 68.56	65
Therapies	$ 0.01	$ 55.14	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.01	$ 55.97	2
Prescribed Drugs	$ 109.27	$ 94.39	13,891	5.5%	5.3%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 124.75	$ 110.06	13,602
Other BH Services	$ 7.49	$ 78.18	1,149	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.87	$ 80.54	1,173
LTSS Services	$ 2.29	$ 6.56	4,195	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.37	$ 6.73	4,219
Durable Medical Equipment	$ 5.68	$ 2.17	31,485	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.44	$ 2.20	29,709
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ -	-
Optical	$ 0.52	$ 66.38	93	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.53	$ 67.38	95
Lab and X-Ray	$ 14.24	$ 26.01	6,571	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 14.76	$ 26.40	6,708
Transportation	$ 2.43	$ 92.79	315	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.36	$ 94.19	300
Subtotal (Medical)	*$ 309.54*	*N/A*	*66,372*	*3.4%*	*2.2%*	*1.2%*	*22.1%*	*22.1%*	*0.0%*	*-8.4%*	*0.0%*	*-8.4%*	*$ 382.53*	*N/A*	*63,960*
CC4C LHD Payments	$ 0.00	$ 4.49	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.49	-
OBCM LHD Payments	$ 3.41	$ 4.91	8,345	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.41	$ 4.91	8,345
Medical Home Payments	$ 1.68	$ 2.36	8,542	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.68	$ 2.36	8,542
Subtotal (LHD/Medical Home Payments)	*$ 5.09*	*N/A*	*16,887*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.09*	*N/A*	*16,887*
Total (Medical + LHD/Medical Home)	**$ 314.63**	**N/A**	**83,258**	**3.3%**	**2.2%**	**1.1%**	**21.8%**	**21.8%**	**0.0%**	**-8.3%**	**0.0%**	**-8.3%**	**$ 387.62**	**N/A**	**80,847**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 387.62**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.64%)	$ 19.89
Care Management (3.21%)	$ 13.79
Profit/Underwriting Gain (1.75%)	$ 7.50
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 428.81**
Premium Taxes (2.01%)	$ 8.80
Total Capitation Rate:	**$ 437.60**

Exhibit 83

Region:	**Region 2**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**9,264**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 1,974.45	$ 695.42	34,071	0.5%	0.5%	0.0%	192.2%	192.2%	0.0%	-1.1%	0.0%	-1.1%	$ 5,791.09	$ 2,062.87	33,687
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 422.88	$ 127.27	39,872	3.0%	0.5%	2.5%	39.4%	39.4%	0.0%	-15.0%	0.0%	-15.0%	$ 547.56	$ 180.10	36,484
Emergency Room	$ 482.68	$ 336.14	17,232	1.5%	0.5%	1.0%	30.9%	30.9%	0.0%	-11.3%	0.0%	-11.3%	$ 586.57	$ 446.80	15,754
Physician	$ 1,783.48	$ 223.60	95,712	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,908.00	$ 228.82	100,062
FQHC/RHC	$ 7.03	$ 128.05	658	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 7.46	$ 129.98	688
Other Clinic	$ 103.39	$ 146.12	8,491	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 109.72	$ 148.33	8,876
Other Practitioner	$ 0.01	$ 26.65	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 27.05	3
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.02	$ 44.57	6	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 45.92	6
LTSS Services	$ 2.30	$ 5.43	5,089	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.37	$ 5.51	5,165
Durable Medical Equipment	$ 1.92	$ 28.57	808	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.01	$ 29.00	833
Limited Dental Services	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Optical	$ 0.02	$ 80.24	3	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 81.45	4
Lab and X-Ray	$ 37.25	$ 18.96	23,580	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 38.95	$ 19.24	24,291
Transportation	$ 10.71	$ 98.89	1,300	-0.8%	0.5%	-1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 10.46	$ 100.38	1,250
Subtotal (Medical)	*$ 4,826.14*	*N/A*	*226,824*	*1.4%*	*0.5%*	*0.9%*	*83.5%*	*83.5%*	*0.0%*	*-2.6%*	*0.0%*	*-2.6%*	*$ 9,004.24*	*N/A*	*227,103*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,826.14**	**N/A**	**226,824**	**1.4%**	**0.5%**	**0.9%**	**83.5%**	**83.5%**	**0.0%**	**-2.6%**	**0.0%**	**-2.6%**	**$ 9,004.24**	**N/A**	**227,103**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 9,004.24**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.76%)	$ 72.39
Care Management (3.35%)	$ 320.23
Profit/Underwriting Gain (1.75%)	$ 167.37
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,564.24**
Premium Taxes (2.01%)	$ 196.18
Total Capitation Rate:	**$ 9,760.42**

14.3 Region 3 Capitation Rate Development Exhibits

Exhibit 84

Region:	**Region 3**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**328,525**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 129.48	$ 973.44	1,596	0.5%	0.5%	0.0%	160.5%	160.5%	0.0%	-15.8%	0.0%	-15.8%	$ 288.21	$ 2,574.08	1,344
Inpatient — BH	$ 6.97	$ 564.40	148	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.02	$ 572.90	147
Outpatient Hospital	$ 107.23	$ 473.60	2,717	0.5%	0.5%	0.0%	40.6%	40.6%	0.0%	-27.1%	0.0%	-27.1%	$ 111.56	$ 675.70	1,981
Emergency Room	$ 70.12	$ 506.46	1,661	0.5%	0.5%	0.0%	35.6%	35.6%	0.0%	-19.6%	0.0%	-19.6%	$ 77.62	$ 697.07	1,336
Physician	$ 115.69	$ 135.02	10,282	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-10.8%	0.0%	-10.8%	$ 111.09	$ 137.05	9,727
FQHC/RHC	$ 3.26	$ 111.07	352	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 3.21	$ 112.75	342
Other Clinic	$ 11.05	$ 452.97	293	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 10.91	$ 459.80	285
Other Practitioner	$ 0.88	$ 75.64	140	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.87	$ 76.78	136
Therapies	$ 5.12	$ 110.04	559	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 5.06	$ 111.70	543
Prescribed Drugs	$ 466.24	$ 162.55	34,419	7.3%	6.8%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 561.37	$ 197.74	34,067
Other BH Services	$ 15.73	$ 48.73	3,875	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 16.56	$ 50.20	3,958
LTSS Services	$ 95.93	$ 5.15	223,581	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 106.05	$ 5.88	216,553
Durable Medical Equipment	$ 46.52	$ 3.22	173,462	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 41.55	$ 3.27	152,647
Limited Dental Services	$ 0.03	$ 25.39	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.03	$ 25.77	14
Optical	$ 0.68	$ 71.34	114	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.71	$ 72.42	118
Lab and X-Ray	$ 9.90	$ 23.45	5,066	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 10.42	$ 23.81	5,252
Transportation	$ 10.77	$ 58.66	2,204	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 10.33	$ 59.54	2,083
Subtotal (Medical)	*$ 1,095.59*	*N/A*	*460,482*	*3.8%*	*3.3%*	*0.6%*	*23.9%*	*23.9%*	*0.0%*	*-10.3%*	*0.0%*	*-10.3%*	*$ 1,362.59*	*N/A*	*430,534*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.74	$ 4.93	1,806	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,806
Medical Home Payments	$ 4.33	$ 4.80	10,825	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.33	$ 4.80	10,825
Subtotal (LHD/Medical Home Payments)	*$ 5.07*	*N/A*	*12,643*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.07*	*N/A*	*12,643*
Total (Medical + LHD/Medical Home)	**$ 1,100.67**	**N/A**	**473,125**	**3.8%**	**3.2%**	**0.6%**	**23.8%**	**23.8%**	**0.0%**	**-10.3%**	**0.0%**	**-10.3%**	**$ 1,367.66**	**N/A**	**443,178**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,367.66**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.65%)	$ 54.66
Care Management (3.32%)	$ 49.75
Profit/Underwriting Gain (1.75%)	$ 26.22
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,498.29**
Premium Taxes (2.01%)	$ 30.73
Total Capitation Rate:	**$ 1,529.02**

Exhibit 85

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**211,433**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 180.57	$ 576.42	3,759	1.5%	0.5%	1.0%	185.2%	185.2%	0.0%	-15.0%	0.0%	-15.0%	$ 457.70	$ 1,668.59	3,292
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 10.78	$ 168.14	769	0.5%	0.5%	0.0%	44.3%	44.3%	0.0%	-7.5%	0.0%	-7.5%	$ 14.61	$ 246.35	712
Emergency Room	$ 21.61	$ 251.16	1,033	0.5%	0.5%	0.0%	32.3%	32.3%	0.0%	-7.5%	0.0%	-7.5%	$ 26.84	$ 337.20	955
Physician	$ 84.14	$ 93.02	10,855	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 84.45	$ 94.42	10,733
FQHC/RHC	$ 1.55	$ 111.80	166	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.54	$ 113.48	163
Other Clinic	$ 34.02	$ 95.22	4,287	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 33.89	$ 96.65	4,207
Other Practitioner	$ 0.07	$ 37.45	24	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.07	$ 38.01	23
Therapies	$ 1.04	$ 91.12	137	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 1.04	$ 92.49	135
Prescribed Drugs	$ 15.35	$ 51.56	3,572	-0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 14.86	$ 50.79	3,511
Other BH Services	$ 0.08	$ 16.68	57	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.08	$ 17.19	59
LTSS Services	$ 1.77	$ 14.85	1,433	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 15.07	1,454
Durable Medical Equipment	$ 8.57	$ 26.22	3,920	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 8.41	$ 26.62	3,791
Limited Dental Services	$ 1.72	$ 24.96	829	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 25.34	867
Optical	$ 0.01	$ 95.98	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 97.42	1
Lab and X-Ray	$ 1.68	$ 34.10	590	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.78	$ 34.61	617
Transportation	$ 0.89	$ 95.72	111	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.86	$ 97.16	106
Subtotal (Medical)	*$ 363.84*	*N/A*	*31,543*	*1.7%*	*0.5%*	*1.2%*	*94.6%*	*94.6%*	*0.0%*	*-12.7%*	*0.0%*	*-12.7%*	*$ 649.78*	*N/A*	*30,623*
CC4C LHD Payments	$ 4.17	$ 4.55	10,997	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.17	$ 4.55	10,997
OBCM LHD Payments	$ 0.00	$ 4.91	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.91	-
Medical Home Payments	$ 1.93	$ 2.47	9,370	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.93	$ 2.47	9,370
Subtotal (LHD/Medical Home Payments)	*$ 6.10*	*N/A*	*20,367*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.10*	*N/A*	*20,367*
Total (Medical + LHD/Medical Home)	**$ 369.94**	**N/A**	**51,910**	**1.6%**	**0.5%**	**1.2%**	**93.1%**	**93.1%**	**0.0%**	**-12.6%**	**0.0%**	**-12.6%**	**$ 655.88**	**N/A**	**50,991**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 655.88**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.10%)	$ 29.62
Care Management (3.30%)	$ 23.86
Profit/Underwriting Gain (1.75%)	$ 12.63
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 722.00**
Premium Taxes (2.01%)	$ 14.81
Total Capitation Rate:	**$ 736.81**

Exhibit 86

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**3,243,949**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 3.82	$ 1,102.70	42	1.5%	0.5%	1.0%	158.2%	158.2%	0.0%	-15.3%	0.0%	-15.3%	$ 8.75	$ 2,890.55	36
Inpatient — BH	$ 0.65	$ 543.61	14	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.68	$ 551.80	15
Outpatient Hospital	$ 7.92	$ 265.07	359	0.5%	0.5%	0.0%	41.2%	41.2%	0.0%	-7.8%	0.0%	-7.8%	$ 10.47	$ 379.92	331
Emergency Room	$ 12.75	$ 297.52	514	0.5%	0.5%	0.0%	33.1%	33.1%	0.0%	-7.8%	0.0%	-7.8%	$ 15.89	$ 401.98	474
Physician	$ 21.62	$ 75.97	3,415	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 21.63	$ 77.12	3,365
FQHC/RHC	$ 0.55	$ 116.79	57	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.55	$ 118.55	56
Other Clinic	$ 5.83	$ 99.31	705	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.79	$ 100.81	690
Other Practitioner	$ 0.20	$ 81.18	29	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.20	$ 82.40	29
Therapies	$ 3.05	$ 100.48	364	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.02	$ 101.99	356
Prescribed Drugs	$ 35.23	$ 97.06	4,356	4.5%	4.0%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 39.21	$ 109.18	4,309
Other BH Services	$ 5.36	$ 75.76	849	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 5.67	$ 78.06	872
LTSS Services	$ 0.29	$ 7.85	436	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.30	$ 8.17	441
Durable Medical Equipment	$ 2.10	$ 3.33	7,548	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.05	$ 3.38	7,276
Limited Dental Services	$ 0.31	$ 24.82	151	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.33	$ 25.19	157
Optical	$ 0.63	$ 84.22	90	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.67	$ 85.49	94
Lab and X-Ray	$ 1.61	$ 20.89	927	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.71	$ 21.21	967
Transportation	$ 0.38	$ 71.14	65	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.37	$ 72.21	62
Subtotal (Medical)	*$ 102.32*	*N/A*	*19,921*	*2.7%*	*1.7%*	*0.9%*	*12.6%*	*12.6%*	*0.0%*	*-6.0%*	*0.0%*	*-6.0%*	*$ 117.28*	*N/A*	*19,528*
CC4C LHD Payments	$ 1.00	$ 4.52	2,649	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.00	$ 4.52	2,649
OBCM LHD Payments	$ 0.54	$ 4.92	1,329	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.54	$ 4.92	1,329
Medical Home Payments	$ 2.24	$ 2.46	10,933	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.24	$ 2.46	10,933
Subtotal (LHD/Medical Home Payments)	*$ 3.79*	*N/A*	*14,911*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.79*	*N/A*	*14,911*
Total (Medical + LHD/Medical Home)	**$ 106.10**	**N/A**	**34,832**	**2.6%**	**1.7%**	**0.9%**	**12.2%**	**12.2%**	**0.0%**	**-5.8%**	**0.0%**	**-5.8%**	**$ 121.06**	**N/A**	**34,439**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 121.06**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.79%)	$ 10.81
Care Management (3.18%)	$ 4.40
Profit/Underwriting Gain (1.75%)	$ 2.43
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 138.70**
Premium Taxes (2.01%)	$ 2.85
Total Capitation Rate:	**$ 141.55**

Exhibit 87

Region:	**Region 3**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**711,903**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 21.38	$ 1,109.26	231	3.5%	0.5%	3.0%	177.7%	177.7%	0.0%	-12.2%	0.0%	-12.2%	$ 57.83	$ 3,126.78	222
Inpatient — BH	$ 1.79	$ 570.73	38	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.96	$ 579.33	41
Outpatient Hospital	$ 31.42	$ 314.76	1,198	0.5%	0.5%	0.0%	41.1%	41.1%	0.0%	-15.9%	0.0%	-15.9%	$ 37.85	$ 450.89	1,007
Emergency Room	$ 46.59	$ 442.95	1,262	0.5%	0.5%	0.0%	35.2%	35.2%	0.0%	-12.2%	0.0%	-12.2%	$ 56.19	$ 608.01	1,109
Physician	$ 45.96	$ 110.31	5,000	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.7%	0.0%	-8.7%	$ 45.17	$ 111.97	4,840
FQHC/RHC	$ 1.37	$ 107.36	153	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 1.35	$ 108.98	148
Other Clinic	$ 6.90	$ 219.96	377	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 6.81	$ 223.28	366
Other Practitioner	$ 0.38	$ 61.29	74	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.37	$ 62.21	72
Therapies	$ 0.03	$ 56.50	6	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.03	$ 57.35	6
Prescribed Drugs	$ 90.81	$ 88.16	12,361	6.0%	5.8%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 105.15	$ 104.25	12,103
Other BH Services	$ 6.97	$ 63.22	1,323	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.33	$ 65.14	1,351
LTSS Services	$ 2.71	$ 5.73	5,673	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.79	$ 5.87	5,706
Durable Medical Equipment	$ 5.84	$ 2.42	28,964	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.68	$ 2.46	27,737
Limited Dental Services	$ 0.00	$ 15.06	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.28	-
Optical	$ 0.21	$ 69.10	36	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.22	$ 70.14	37
Lab and X-Ray	$ 11.88	$ 27.77	5,132	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.49	$ 28.19	5,317
Transportation	$ 1.79	$ 73.43	293	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.72	$ 74.54	277
Subtotal (Medical)	*$ 276.02*	*N/A*	*62,119*	*3.1%*	*2.3%*	*0.8%*	*23.8%*	*23.8%*	*0.0%*	*-8.5%*	*0.0%*	*-8.5%*	*$ 342.93*	*N/A*	*60,339*
CC4C LHD Payments	$ 0.00	$ 4.35	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.35	-
OBCM LHD Payments	$ 3.39	$ 4.91	8,284	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.39	$ 4.91	8,284
Medical Home Payments	$ 1.73	$ 2.43	8,529	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.73	$ 2.43	8,529
Subtotal (LHD/Medical Home Payments)	*$ 5.11*	*N/A*	*16,813*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.11*	*N/A*	*16,813*
Total (Medical + LHD/Medical Home)	**$ 281.13**	**N/A**	**78,932**	**3.1%**	**2.2%**	**0.8%**	**23.4%**	**23.4%**	**0.0%**	**-8.4%**	**0.0%**	**-8.4%**	**$ 348.04**	**N/A**	**77,151**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 348.04**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.86%)	$ 18.79
Care Management (3.28%)	$ 12.66
Profit/Underwriting Gain (1.75%)	$ 6.76
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 386.26**
Premium Taxes (2.01%)	$ 7.92
Total Capitation Rate:	**$ 394.18**

Exhibit 88

Region:	**Region 3**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**13,078**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,014.40	$ 731.64	33,039	0.5%	0.5%	0.0%	183.1%	183.1%	0.0%	-1.1%	0.0%	-1.1%	$ 5,723.26	$ 2,102.36	32,668
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 260.14	$ 134.71	23,174	0.5%	0.5%	0.0%	41.5%	41.5%	0.0%	-15.0%	0.0%	-15.0%	$ 317.55	$ 193.45	19,697
Emergency Room	$ 454.86	$ 371.06	14,710	0.5%	0.5%	0.0%	35.8%	35.8%	0.0%	-11.3%	0.0%	-11.3%	$ 556.54	$ 511.55	13,055
Physician	$ 1,637.47	$ 233.26	84,239	2.5%	0.5%	2.0%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,777.69	$ 238.70	89,369
FQHC/RHC	$ 6.89	$ 129.90	636	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 7.42	$ 131.86	675
Other Clinic	$ 229.74	$ 193.00	14,284	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 247.40	$ 195.90	15,154
Other Practitioner	$ 0.25	$ 40.26	75	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.27	$ 40.87	79
Therapies	$ 0.02	$ 89.84	3	2.5%	0.5%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 91.20	3
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ -	$ -	-	2.0%	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
LTSS Services	$ 3.95	$ 1.10	43,314	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.07	$ 1.11	43,964
Durable Medical Equipment	$ 1.83	$ 25.70	852	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.94	$ 26.09	891
Limited Dental Services	$ 0.00	$ 24.71	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 25.08	2
Optical	$ 0.01	$ 69.74	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 70.79	2
Lab and X-Ray	$ 43.38	$ 27.82	18,714	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 46.04	$ 28.24	19,565
Transportation	$ 10.32	$ 91.31	1,356	-1.1%	0.5%	-1.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 9.98	$ 92.68	1,293
Subtotal (Medical)	*$ 4,663.26*	*N/A*	*234,400*	*1.3%*	*0.5%*	*0.8%*	*83.1%*	*83.1%*	*0.0%*	*-2.2%*	*0.0%*	*-2.2%*	*$ 8,692.19*	*N/A*	*236,416*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 4,663.26**	**N/A**	**234,400**	**1.3%**	**0.5%**	**0.8%**	**83.1%**	**83.1%**	**0.0%**	**-2.2%**	**0.0%**	**-2.2%**	**$ 8,692.19**	**N/A**	**236,416**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,692.19**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.77%)	$ 71.48
Care Management (3.42%)	$ 316.20
Profit/Underwriting Gain (1.75%)	$ 161.73
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,241.60**
Premium Taxes (2.01%)	$ 189.57
Total Capitation Rate:	**$ 9,431.17**

14.4 Region 4 Capitation Rate Development Exhibits

Exhibit 89

Region:	**Region 4**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**278,511**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 139.30	$ 981.10	1,704	0.5%	0.5%	0.0%	140.5%	140.5%	0.0%	-15.8%	0.0%	-15.8%	$ 286.30	$ 2,395.56	1,434
Inpatient — BH	$ 7.28	$ 779.26	112	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.33	$ 791.01	111
Outpatient Hospital	$ 99.43	$ 511.26	2,334	2.0%	0.5%	1.5%	27.8%	27.8%	0.0%	-27.1%	0.0%	-27.1%	$ 98.34	$ 663.24	1,779
Emergency Room	$ 60.29	$ 513.40	1,409	3.0%	0.5%	2.5%	29.1%	29.1%	0.0%	-19.6%	0.0%	-19.6%	$ 68.42	$ 672.90	1,220
Physician	$ 102.74	$ 140.47	8,777	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-10.5%	0.0%	-10.5%	$ 97.53	$ 142.59	8,208
FQHC/RHC	$ 7.18	$ 116.80	738	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 6.99	$ 118.56	707
Other Clinic	$ 14.07	$ 482.53	350	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 13.69	$ 489.81	335
Other Practitioner	$ 0.63	$ 79.24	95	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.61	$ 80.44	91
Therapies	$ 6.25	$ 114.97	653	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 6.08	$ 116.70	625
Prescribed Drugs	$ 436.64	$ 172.91	30,303	7.3%	6.8%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 525.73	$ 210.34	29,993
Other BH Services	$ 20.97	$ 57.09	4,407	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 23.06	$ 58.82	4,704
LTSS Services	$ 63.82	$ 4.97	153,947	1.0%	0.5%	0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 70.56	$ 5.68	149,108
Durable Medical Equipment	$ 35.22	$ 2.63	160,886	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 31.46	$ 2.67	141,580
Limited Dental Services	$ 0.04	$ 24.79	17	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.17	18
Optical	$ 1.02	$ 70.57	174	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.07	$ 71.63	180
Lab and X-Ray	$ 8.98	$ 21.73	4,959	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.45	$ 22.06	5,142
Transportation	$ 9.66	$ 58.76	1,973	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.70	$ 59.64	1,951
Subtotal (Medical)	*$ 1,013.52*	*N/A*	*372,838*	*4.1%*	*3.3%*	*0.8%*	*22.3%*	*22.3%*	*0.0%*	*-10.3%*	*0.0%*	*-10.3%*	*$ 1,256.35*	*N/A*	*347,188*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.71	$ 4.93	1,734	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.71	$ 4.93	1,734
Medical Home Payments	$ 4.33	$ 4.81	10,806	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.33	$ 4.81	10,806
Subtotal (LHD/Medical Home Payments)	*$ 5.05*	*N/A*	*12,552*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.05*	*N/A*	*12,552*
Total (Medical + LHD/Medical Home)	**$ 1,018.58**	**N/A**	**385,390**	**4.1%**	**3.3%**	**0.8%**	**22.2%**	**22.2%**	**0.0%**	**-10.2%**	**0.0%**	**-10.2%**	**$ 1,261.40**	**N/A**	**359,740**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,261.40**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.82%)	$ 53.04
Care Management (3.49%)	$ 48.36
Profit/Underwriting Gain (1.75%)	$ 24.27
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,387.08**
Premium Taxes (2.01%)	$ 28.45
Total Capitation Rate:	**$ 1,415.53**

Exhibit 90

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**171,144**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 190.31	$ 557.05	4,100	1.5%	0.5%	1.0%	127.1%	127.1%	0.0%	-15.0%	0.0%	-15.0%	$ 384.15	$ 1,284.17	3,590
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 8.96	$ 155.04	694	2.0%	0.5%	1.5%	26.1%	26.1%	0.0%	-7.5%	0.0%	-7.5%	$ 11.10	$ 198.45	671
Emergency Room	$ 23.20	$ 264.53	1,052	3.0%	0.5%	2.5%	26.7%	26.7%	0.0%	-7.5%	0.0%	-7.5%	$ 29.71	$ 340.27	1,048
Physician	$ 91.70	$ 100.13	10,989	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 90.70	$ 101.64	10,708
FQHC/RHC	$ 7.72	$ 106.01	874	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 7.58	$ 107.61	845
Other Clinic	$ 33.86	$ 94.92	4,280	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 33.23	$ 96.36	4,139
Other Practitioner	$ 0.02	$ 46.61	6	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 47.31	5
Therapies	$ 0.83	$ 100.79	99	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.82	$ 102.31	96
Prescribed Drugs	$ 13.60	$ 55.01	2,966	-0.5%	-0.8%	0.3%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 13.16	$ 53.79	2,937
Other BH Services	$ 0.09	$ 43.76	24	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.10	$ 45.08	26
LTSS Services	$ 0.76	$ 14.77	620	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.79	$ 15.00	629
Durable Medical Equipment	$ 3.36	$ 5.60	7,205	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.30	$ 5.69	6,967
Limited Dental Services	$ 1.96	$ 25.00	942	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.08	$ 25.37	985
Optical	$ 0.02	$ 86.73	3	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 88.04	3
Lab and X-Ray	$ 0.82	$ 20.53	482	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.88	$ 20.84	504
Transportation	$ 1.17	$ 95.08	148	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.18	$ 96.51	147
Subtotal (Medical)	*$ 378.39*	*N/A*	*34,482*	*1.7%*	*0.5%*	*1.3%*	*65.8%*	*65.8%*	*0.0%*	*-12.4%*	*0.0%*	*-12.4%*	*$ 578.82*	*N/A*	*33,299*
CC4C LHD Payments	$ 4.18	$ 4.55	11,024	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,024
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.94	$ 2.45	9,496	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.94	$ 2.45	9,496
Subtotal (LHD/Medical Home Payments)	*$ 6.12*	*N/A*	*20,519*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.12*	*N/A*	*20,519*
Total (Medical + LHD/Medical Home)	**$ 384.51**	**N/A**	**55,001**	**1.7%**	**0.5%**	**1.2%**	**64.8%**	**64.8%**	**0.0%**	**-12.2%**	**0.0%**	**-12.2%**	**$ 584.94**	**N/A**	**53,818**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 584.94**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.35%)	$ 28.11
Care Management (3.47%)	$ 22.43
Profit/Underwriting Gain (1.75%)	$ 11.32
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 646.80**
Premium Taxes (2.01%)	$ 13.27
Total Capitation Rate:	**$ 660.06**

Exhibit 91

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,661,605**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.03	$ 1,142.94	42	1.5%	0.5%	1.0%	139.7%	139.7%	0.0%	-15.3%	0.0%	-15.3%	$ 8.55	$ 2,780.86	37
Inpatient — BH	$ 1.19	$ 677.93	21	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.25	$ 688.15	22
Outpatient Hospital	$ 8.12	$ 315.72	309	2.0%	0.5%	1.5%	28.2%	28.2%	0.0%	-7.8%	0.0%	-7.8%	$ 10.19	$ 410.93	298
Emergency Room	$ 13.17	$ 317.30	498	3.0%	0.5%	2.5%	27.9%	27.9%	0.0%	-7.8%	0.0%	-7.8%	$ 16.97	$ 411.86	494
Physician	$ 19.49	$ 80.97	2,889	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 19.21	$ 82.19	2,805
FQHC/RHC	$ 2.21	$ 104.48	254	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 2.17	$ 106.06	245
Other Clinic	$ 5.57	$ 101.19	660	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.45	$ 102.72	637
Other Practitioner	$ 0.10	$ 81.57	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.09	$ 82.80	14
Therapies	$ 5.80	$ 112.43	619	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.68	$ 114.13	597
Prescribed Drugs	$ 31.22	$ 104.68	3,579	5.0%	4.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 35.25	$ 119.45	3,541
Other BH Services	$ 6.18	$ 82.67	896	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 6.83	$ 85.18	962
LTSS Services	$ 0.17	$ 9.05	230	1.0%	0.5%	0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.18	$ 9.43	233
Durable Medical Equipment	$ 1.97	$ 2.89	8,178	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.93	$ 2.94	7,882
Limited Dental Services	$ 0.37	$ 24.79	180	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.39	$ 25.17	188
Optical	$ 1.08	$ 81.90	158	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.14	$ 83.14	165
Lab and X-Ray	$ 1.32	$ 15.75	1,002	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.39	$ 15.99	1,044
Transportation	$ 0.34	$ 76.95	53	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.35	$ 78.11	53
Subtotal (Medical)	*$ 102.34*	*N/A*	*19,584*	*3.1%*	*1.8%*	*1.3%*	*11.0%*	*11.0%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 117.01*	*N/A*	*19,216*
CC4C LHD Payments	$ 1.00	$ 4.52	2,643	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.00	$ 4.52	2,643
OBCM LHD Payments	$ 0.52	$ 4.92	1,277	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.52	$ 4.92	1,277
Medical Home Payments	$ 2.26	$ 2.46	11,025	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.26	$ 2.46	11,025
Subtotal (LHD/Medical Home Payments)	*$ 3.78*	*N/A*	*14,945*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.78*	*N/A*	*14,945*
Total (Medical + LHD/Medical Home)	**$ 106.11**	**N/A**	**34,529**	**3.0%**	**1.7%**	**1.3%**	**10.6%**	**10.6%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 120.79**	**N/A**	**34,161**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 120.79**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.92%)	$ 11.00
Care Management (3.34%)	$ 4.63
Profit/Underwriting Gain (1.75%)	$ 2.43
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 138.85**
Premium Taxes (2.01%)	$ 2.85
Total Capitation Rate:	**$ 141.70**

Exhibit 92

Region:	**Region 4**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**509,487**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 22.93	$ 1,072.48	257	3.5%	0.5%	3.0%	147.3%	147.3%	0.0%	-12.2%	0.0%	-12.2%	$ 55.23	$ 2,692.51	246
Inpatient — BH	$ 1.52	$ 781.59	23	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.67	$ 793.37	25
Outpatient Hospital	$ 32.56	$ 365.16	1,070	2.0%	0.5%	1.5%	28.0%	28.0%	0.0%	-15.9%	0.0%	-15.9%	$ 37.19	$ 474.34	941
Emergency Room	$ 46.91	$ 477.43	1,179	3.0%	0.5%	2.5%	29.7%	29.7%	0.0%	-12.2%	0.0%	-12.2%	$ 58.43	$ 628.77	1,115
Physician	$ 43.34	$ 114.28	4,551	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.6%	0.0%	-8.6%	$ 42.05	$ 116.00	4,349
FQHC/RHC	$ 3.63	$ 109.90	396	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 3.53	$ 111.56	379
Other Clinic	$ 8.19	$ 173.46	567	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 7.96	$ 176.08	543
Other Practitioner	$ 0.31	$ 76.28	48	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.30	$ 77.43	46
Therapies	$ 0.02	$ 55.71	5	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.02	$ 56.55	5
Prescribed Drugs	$ 85.46	$ 90.48	11,334	5.8%	5.5%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 98.26	$ 106.25	11,098
Other BH Services	$ 8.42	$ 80.12	1,262	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 9.26	$ 82.55	1,346
LTSS Services	$ 1.87	$ 5.78	3,881	1.0%	0.5%	0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.93	$ 5.92	3,903
Durable Medical Equipment	$ 4.52	$ 2.00	27,061	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.39	$ 2.03	25,914
Limited Dental Services	$ 0.00	$ 17.31	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 17.57	-
Optical	$ 0.35	$ 68.98	62	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.37	$ 70.02	64
Lab and X-Ray	$ 11.52	$ 23.80	5,810	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.12	$ 24.16	6,019
Transportation	$ 1.63	$ 73.25	267	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.64	$ 74.35	264
Subtotal (Medical)	*$ 273.19*	*N/A*	*57,772*	*3.5%*	*2.1%*	*1.4%*	*20.6%*	*20.6%*	*0.0%*	*-8.5%*	*0.0%*	*-8.5%*	*$ 334.33*	*N/A*	*56,258*
CC4C LHD Payments	$ 0.00	$ 4.50	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.50	-
OBCM LHD Payments	$ 3.44	$ 4.91	8,407	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.44	$ 4.91	8,407
Medical Home Payments	$ 1.64	$ 2.43	8,122	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.64	$ 2.43	8,122
Subtotal (LHD/Medical Home Payments)	*$ 5.08*	*N/A*	*16,530*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.08*	*N/A*	*16,530*
Total (Medical + LHD/Medical Home)	**$ 278.28**	**N/A**	**74,302**	**3.5%**	**2.0%**	**1.4%**	**20.2%**	**20.2%**	**0.0%**	**-8.4%**	**0.0%**	**-8.4%**	**$ 339.42**	**N/A**	**72,788**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 339.42**
Non-Benefit Expense PMPM/Payment:	
General Administration (5.04%)	$ 19.06
Care Management (3.44%)	$ 13.01
Profit/Underwriting Gain (1.75%)	$ 6.62
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 378.11**
Premium Taxes (2.01%)	$ 7.76
Total Capitation Rate:	**$ 385.86**

Exhibit 93

Region:	**Region 4**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**9,785**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,093.45	$ 740.20	33,939	0.5%	0.5%	0.0%	128.4%	128.4%	0.0%	-1.1%	0.0%	-1.1%	$ 4,798.41	$ 1,715.92	33,557
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 423.85	$ 158.18	32,156	2.0%	0.5%	1.5%	22.9%	22.9%	0.0%	-15.0%	0.0%	-15.0%	$ 469.91	$ 197.34	28,575
Emergency Room	$ 560.31	$ 405.58	16,578	3.0%	0.5%	2.5%	30.8%	30.8%	0.0%	-11.3%	0.0%	-11.3%	$ 710.66	$ 538.42	15,839
Physician	$ 1,617.62	$ 217.64	89,190	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,730.56	$ 222.72	93,243
FQHC/RHC	$ 55.59	$ 127.28	5,241	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 59.00	$ 129.20	5,480
Other Clinic	$ 268.71	$ 163.49	19,724	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 285.16	$ 165.95	20,620
Other Practitioner	$ 0.00	$ 40.83	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 41.45	1
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.10	$ 59.99	20	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.11	$ 61.81	22
LTSS Services	$ 1.87	$ 4.43	5,065	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.93	$ 4.50	5,141
Durable Medical Equipment	$ 1.43	$ 48.06	356	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.51	$ 48.78	372
Limited Dental Services	$ 0.01	$ 25.18	4	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.56	4
Optical	$ 0.00	$ 58.20	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 59.08	1
Lab and X-Ray	$ 69.50	$ 26.95	30,945	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 73.76	$ 27.36	32,352
Transportation	$ 13.88	$ 90.71	1,836	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 14.05	$ 92.08	1,831
Subtotal (Medical)	*$ 5,106.33*	*N/A*	*235,056*	*1.5%*	*0.5%*	*1.0%*	*56.8%*	*56.8%*	*0.0%*	*-2.7%*	*0.0%*	*-2.7%*	*$ 8,145.07*	*N/A*	*237,036*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,106.33**	**N/A**	**235,056**	**1.5%**	**0.5%**	**1.0%**	**56.8%**	**56.8%**	**0.0%**	**-2.7%**	**0.0%**	**-2.7%**	**$ 8,145.07**	**N/A**	**237,036**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,145.07**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.81%)	$ 70.60
Care Management (3.60%)	$ 312.30
Profit/Underwriting Gain (1.75%)	$ 151.90
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 8,679.86**
Premium Taxes (2.01%)	$ 178.04
Total Capitation Rate:	**$ 8,857.91**

14.5 Region 5 Capitation Rate Development Exhibits

Exhibit 94

Region:	**Region 5**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**309,639**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 133.02	$ 956.37	1,669	0.5%	0.5%	0.0%	137.8%	137.8%	0.0%	-15.8%	0.0%	-15.8%	$ 270.34	$ 2,308.99	1,405
Inpatient — BH	$ 5.72	$ 688.22	100	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 5.76	$ 698.60	99
Outpatient Hospital	$ 88.31	$ 518.64	2,043	1.0%	0.5%	0.5%	32.5%	32.5%	0.0%	-27.1%	0.0%	-27.1%	$ 87.91	$ 697.46	1,512
Emergency Room	$ 60.17	$ 476.23	1,516	3.0%	0.5%	2.5%	29.6%	29.6%	0.0%	-19.6%	0.0%	-19.6%	$ 68.54	$ 626.61	1,313
Physician	$ 110.96	$ 138.09	9,642	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-9.6%	0.0%	-9.6%	$ 106.40	$ 140.17	9,109
FQHC/RHC	$ 6.15	$ 100.86	731	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 5.98	$ 102.38	701
Other Clinic	$ 10.65	$ 437.72	292	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 10.37	$ 444.32	280
Other Practitioner	$ 0.89	$ 76.24	141	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.87	$ 77.39	135
Therapies	$ 7.67	$ 107.82	853	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.46	$ 109.45	818
Prescribed Drugs	$ 381.68	$ 135.75	33,740	6.0%	5.5%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 443.68	$ 159.40	33,400
Other BH Services	$ 16.93	$ 72.15	2,816	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 18.62	$ 74.34	3,005
LTSS Services	$ 62.61	$ 4.75	158,180	-0.7%	0.5%	-1.2%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 65.67	$ 5.42	145,381
Durable Medical Equipment	$ 33.46	$ 2.76	145,544	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 29.45	$ 2.80	126,206
Limited Dental Services	$ 0.03	$ 24.85	17	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.22	17
Optical	$ 1.60	$ 65.55	294	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.66	$ 66.54	300
Lab and X-Ray	$ 11.56	$ 24.58	5,643	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 11.99	$ 24.95	5,765
Transportation	$ 6.92	$ 72.58	1,143	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 7.19	$ 73.67	1,172
Subtotal (Medical)	*$ 938.33*	*N/A*	*364,365*	*3.3%*	*2.6%*	*0.6%*	*23.5%*	*23.5%*	*0.0%*	*-10.5%*	*0.0%*	*-10.5%*	*$ 1,141.92*	*N/A*	*330,617*
CC4C LHD Payments	$ 0.01	$ 4.53	13	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 4.53	13
OBCM LHD Payments	$ 0.74	$ 4.93	1,811	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,811
Medical Home Payments	$ 4.35	$ 4.76	10,946	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.35	$ 4.76	10,946
Subtotal (LHD/Medical Home Payments)	*$ 5.10*	*N/A*	*12,771*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.10*	*N/A*	*12,771*
Total (Medical + LHD/Medical Home)	**$ 943.43**	**N/A**	**377,135**	**3.2%**	**2.6%**	**0.6%**	**23.4%**	**23.4%**	**0.0%**	**-10.4%**	**0.0%**	**-10.4%**	**$ 1,147.01**	**N/A**	**343,388**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,147.01**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.55%)	$ 44.42
Care Management (3.13%)	$ 39.22
Profit/Underwriting Gain (1.75%)	$ 21.92
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,252.56**
Premium Taxes (2.01%)	$ 25.69
Total Capitation Rate:	**$ 1,278.26**

Exhibit 95

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**135,338**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 198.39	$ 541.57	4,396	1.5%	0.5%	1.0%	158.4%	158.4%	0.0%	-15.0%	0.0%	-15.0%	$ 455.55	$ 1,420.24	3,849
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 7.84	$ 128.58	732	1.0%	0.5%	0.5%	29.1%	29.1%	0.0%	-7.5%	0.0%	-7.5%	$ 9.65	$ 168.50	687
Emergency Room	$ 21.24	$ 213.83	1,192	3.0%	0.5%	2.5%	26.2%	26.2%	0.0%	-7.5%	0.0%	-7.5%	$ 27.09	$ 273.96	1,187
Physician	$ 97.61	$ 103.51	11,316	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.8%	0.0%	-6.8%	$ 96.54	$ 105.07	11,026
FQHC/RHC	$ 3.18	$ 100.01	381	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.12	$ 101.52	368
Other Clinic	$ 34.93	$ 93.67	4,476	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 34.29	$ 95.08	4,328
Other Practitioner	$ 0.02	$ 71.76	4	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 72.84	4
Therapies	$ 0.89	$ 81.02	132	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.88	$ 82.24	128
Prescribed Drugs	$ 16.28	$ 46.43	4,208	-1.0%	-1.0%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 15.53	$ 45.05	4,136
Other BH Services	$ 0.14	$ 24.17	72	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.16	$ 24.90	77
LTSS Services	$ 0.36	$ 18.84	229	-0.7%	0.5%	-1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.35	$ 19.12	220
Durable Medical Equipment	$ 3.88	$ 3.62	12,863	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 3.75	$ 3.67	12,257
Limited Dental Services	$ 2.30	$ 24.96	1,104	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.40	$ 25.33	1,137
Optical	$ 0.08	$ 78.39	13	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.09	$ 79.57	13
Lab and X-Ray	$ 0.88	$ 25.81	410	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.92	$ 26.20	422
Transportation	$ 1.68	$ 159.80	126	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.76	$ 162.21	130
Subtotal (Medical)	*$ 389.71*	*N/A*	*41,653*	*1.6%*	*0.4%*	*1.2%*	*82.3%*	*82.3%*	*0.0%*	*-12.6%*	*0.0%*	*-12.6%*	*$ 652.11*	*N/A*	*39,971*
CC4C LHD Payments	$ 4.19	$ 4.55	11,043	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.19	$ 4.55	11,043
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.98	$ 2.46	9,682	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.98	$ 2.46	9,682
Subtotal (LHD/Medical Home Payments)	*$ 6.17*	*N/A*	*20,725*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.17*	*N/A*	*20,725*
Total (Medical + LHD/Medical Home)	**$ 395.87**	**N/A**	**62,378**	**1.6%**	**0.4%**	**1.2%**	**81.1%**	**81.1%**	**0.0%**	**-12.5%**	**0.0%**	**-12.5%**	**$ 658.27**	**N/A**	**60,695**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 658.27**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.92%)	$ 28.28
Care Management (3.12%)	$ 22.51
Profit/Underwriting Gain (1.75%)	$ 12.63
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 721.69**
Premium Taxes (2.01%)	$ 14.80
Total Capitation Rate:	**$ 736.49**

Exhibit 96

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**2,183,299**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 5.20	$ 1,165.36	54	1.5%	0.5%	1.0%	130.3%	130.3%	0.0%	-15.3%	0.0%	-15.3%	$ 10.60	$ 2,723.82	47
Inpatient — BH	$ 0.82	$ 660.11	15	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.86	$ 670.06	15
Outpatient Hospital	$ 7.63	$ 281.40	325	1.0%	0.5%	0.5%	26.9%	26.9%	0.0%	-7.8%	0.0%	-7.8%	$ 9.20	$ 362.62	304
Emergency Room	$ 13.39	$ 266.59	603	3.0%	0.5%	2.5%	27.3%	27.3%	0.0%	-7.8%	0.0%	-7.8%	$ 17.18	$ 344.59	598
Physician	$ 20.89	$ 75.62	3,315	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.1%	0.0%	-7.1%	$ 20.59	$ 76.76	3,219
FQHC/RHC	$ 1.36	$ 93.95	174	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.33	$ 95.37	168
Other Clinic	$ 5.67	$ 101.76	668	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.55	$ 103.29	644
Other Practitioner	$ 0.10	$ 83.85	14	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 85.11	13
Therapies	$ 6.24	$ 104.99	714	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 6.11	$ 106.58	688
Prescribed Drugs	$ 36.30	$ 92.19	4,725	3.5%	3.0%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 39.25	$ 100.74	4,676
Other BH Services	$ 5.84	$ 77.45	905	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 6.46	$ 79.80	971
LTSS Services	$ 0.12	$ 7.41	199	-0.7%	0.5%	-1.2%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.12	$ 7.72	191
Durable Medical Equipment	$ 1.67	$ 2.52	7,917	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.61	$ 2.56	7,519
Limited Dental Services	$ 0.46	$ 24.79	222	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.48	$ 25.17	228
Optical	$ 1.35	$ 81.66	199	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.41	$ 82.89	204
Lab and X-Ray	$ 1.28	$ 20.86	737	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.34	$ 21.17	757
Transportation	$ 0.46	$ 96.87	57	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.48	$ 98.33	59
Subtotal (Medical)	*$ 108.79*	*N/A*	*20,843*	*2.6%*	*1.4%*	*1.2%*	*11.2%*	*11.2%*	*0.0%*	*-6.1%*	*0.0%*	*-6.1%*	*$ 122.66*	*N/A*	*20,303*
CC4C LHD Payments	$ 0.98	$ 4.52	2,597	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.98	$ 4.52	2,597
OBCM LHD Payments	$ 0.58	$ 4.92	1,421	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.58	$ 4.92	1,421
Medical Home Payments	$ 2.28	$ 2.45	11,177	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.28	$ 2.45	11,177
Subtotal (LHD/Medical Home Payments)	*$ 3.84*	*N/A*	*15,195*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.84*	*N/A*	*15,195*
Total (Medical + LHD/Medical Home)	**$ 112.63**	**N/A**	**36,038**	**2.5%**	**1.3%**	**1.2%**	**10.9%**	**10.9%**	**0.0%**	**-5.9%**	**0.0%**	**-5.9%**	**$ 126.50**	**N/A**	**35,498**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 126.50**
Non-Benefit Expense PMPM/Payment:	
General Administration (7.44%)	$ 10.72
Care Management (3.00%)	$ 4.33
Profit/Underwriting Gain (1.75%)	$ 2.52
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 144.07**
Premium Taxes (2.01%)	$ 2.96
Total Capitation Rate:	**$ 147.03**

Exhibit 97

Region:	**Region 5**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**540,587**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 25.56	$ 1,056.63	290	3.5%	0.5%	3.0%	151.0%	151.0%	0.0%	-12.2%	0.0%	-12.2%	$ 62.50	$ 2,692.07	279
Inpatient — BH	$ 2.18	$ 720.15	36	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.39	$ 731.00	39
Outpatient Hospital	$ 30.10	$ 344.33	1,049	1.0%	0.5%	0.5%	34.8%	34.8%	0.0%	-15.9%	0.0%	-15.9%	$ 35.15	$ 471.05	895
Emergency Room	$ 45.78	$ 428.39	1,282	3.0%	0.5%	2.5%	30.2%	30.2%	0.0%	-12.2%	0.0%	-12.2%	$ 57.24	$ 566.38	1,213
Physician	$ 53.98	$ 116.47	5,562	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 52.51	$ 118.22	5,330
FQHC/RHC	$ 3.56	$ 98.24	434	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 3.46	$ 99.72	416
Other Clinic	$ 6.99	$ 229.11	366	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 6.80	$ 232.56	351
Other Practitioner	$ 0.34	$ 74.06	55	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.33	$ 75.17	53
Therapies	$ 0.03	$ 56.72	6	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.03	$ 57.58	6
Prescribed Drugs	$ 100.69	$ 84.52	14,295	5.8%	5.5%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 115.77	$ 99.25	13,997
Other BH Services	$ 8.03	$ 74.65	1,291	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 8.82	$ 76.91	1,377
LTSS Services	$ 2.09	$ 5.06	4,942	-0.7%	0.5%	-1.2%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.04	$ 5.19	4,717
Durable Medical Equipment	$ 5.23	$ 2.45	25,588	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 5.01	$ 2.49	24,146
Limited Dental Services	$ 0.00	$ 15.40	0	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.63	-
Optical	$ 0.55	$ 64.90	101	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.57	$ 65.88	103
Lab and X-Ray	$ 14.42	$ 27.68	6,252	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 14.95	$ 28.10	6,383
Transportation	$ 1.79	$ 90.32	238	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.86	$ 91.68	243
Subtotal (Medical)	*$ 301.32*	*N/A*	*61,789*	*3.5%*	*2.2%*	*1.2%*	*20.6%*	*20.6%*	*0.0%*	*-8.2%*	*0.0%*	*-8.2%*	*$ 369.42*	*N/A*	*59,547*
CC4C LHD Payments	$ 0.00	$ 4.29	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.29	-
OBCM LHD Payments	$ 3.44	$ 4.91	8,406	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.44	$ 4.91	8,406
Medical Home Payments	$ 1.82	$ 2.41	9,096	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.82	$ 2.41	9,096
Subtotal (LHD/Medical Home Payments)	*$ 5.26*	*N/A*	*17,502*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.26*	*N/A*	*17,502*
Total (Medical + LHD/Medical Home)	**$ 306.58**	**N/A**	**79,290**	**3.4%**	**2.2%**	**1.2%**	**20.3%**	**20.3%**	**0.0%**	**-8.1%**	**0.0%**	**-8.1%**	**$ 374.69**	**N/A**	**77,049**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 374.69**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.57%)	$ 18.92
Care Management (3.10%)	$ 12.81
Profit/Underwriting Gain (1.75%)	$ 7.24
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 413.65**
Premium Taxes (2.01%)	$ 8.48
Total Capitation Rate:	**$ 422.14**

Exhibit 98

Region:	**Region 5**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**8,871**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,193.63	$ 728.98	36,110	0.5%	0.5%	0.0%	177.4%	177.4%	0.0%	-1.1%	0.0%	-1.1%	$ 6,108.10	$ 2,052.92	35,704
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 364.84	$ 123.36	35,489	1.0%	0.5%	0.5%	38.4%	38.4%	0.0%	-15.0%	0.0%	-15.0%	$ 442.21	$ 173.31	30,618
Emergency Room	$ 494.61	$ 359.72	16,500	3.0%	0.5%	2.5%	32.0%	32.0%	0.0%	-11.3%	0.0%	-11.3%	$ 633.12	$ 481.96	15,764
Physician	$ 1,842.99	$ 244.06	90,616	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,971.67	$ 249.75	94,734
FQHC/RHC	$ 48.15	$ 147.88	3,908	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 51.10	$ 150.11	4,085
Other Clinic	$ 121.52	$ 130.54	11,170	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 128.95	$ 132.51	11,678
Other Practitioner	$ 0.00	$ 39.70	0	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 40.29	-
Therapies	$ 0.03	$ 50.54	8	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.04	$ 51.30	8
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.01	$ 53.51	3	3.5%	1.0%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.02	$ 55.14	4
LTSS Services	$ 2.79	$ 4.71	7,100	-0.7%	0.5%	-1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.73	$ 4.78	6,838
Durable Medical Equipment	$ 4.24	$ 48.05	1,060	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.44	$ 48.77	1,092
Limited Dental Services	$ 0.00	$ 24.88	2	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.26	2
Optical	$ 0.01	$ 74.25	2	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 75.37	2
Lab and X-Ray	$ 53.28	$ 27.25	23,468	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 55.72	$ 27.66	24,175
Transportation	$ 19.34	$ 110.73	2,095	1.6%	0.5%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 20.28	$ 112.40	2,165
Subtotal (Medical)	*$ 5,145.45*	*N/A*	*227,532*	*1.4%*	*0.5%*	*0.9%*	*79.9%*	*79.9%*	*0.0%*	*-2.4%*	*0.0%*	*-2.4%*	*$ 9,418.38*	*N/A*	*226,870*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,145.45**	**N/A**	**227,532**	**1.4%**	**0.5%**	**0.9%**	**79.9%**	**79.9%**	**0.0%**	**-2.4%**	**0.0%**	**-2.4%**	**$ 9,418.38**	**N/A**	**226,870**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 9,418.38**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.73%)	$ 72.80
Care Management (3.22%)	$ 322.02
Profit/Underwriting Gain (1.75%)	$ 174.79
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 9,987.98**
Premium Taxes (2.01%)	$ 204.88
Total Capitation Rate:	**$ 10,192.86**

14.6 Region 6 Capitation Rate Development Exhibits

Exhibit 99

Region:	**Region 6**
Category of Aid:	**Aged, Blind, Disabled**
Sex:	**Male & Female**

Member Months/Deliveries:	**267,136**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 126.88	$ 984.78	1,546	0.5%	0.5%	0.0%	80.4%	80.4%	0.0%	-15.8%	0.0%	-15.8%	$ 195.55	$ 1,803.15	1,301
Inpatient — BH	$ 8.06	$ 739.88	131	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 8.12	$ 751.03	130
Outpatient Hospital	$ 73.69	$ 555.98	1,590	2.5%	0.5%	2.0%	20.9%	20.9%	0.0%	-23.3%	0.0%	-23.3%	$ 73.59	$ 682.56	1,294
Emergency Room	$ 60.23	$ 502.10	1,439	3.0%	0.5%	2.5%	22.8%	22.8%	0.0%	-19.6%	0.0%	-19.6%	$ 64.98	$ 625.74	1,246
Physician	$ 102.52	$ 144.05	8,540	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.6%	0.0%	-8.6%	$ 99.44	$ 146.22	8,161
FQHC/RHC	$ 7.59	$ 105.38	864	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 7.38	$ 106.97	828
Other Clinic	$ 13.59	$ 479.94	340	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 13.22	$ 487.18	326
Other Practitioner	$ 0.92	$ 73.79	150	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 0.90	$ 74.90	144
Therapies	$ 4.90	$ 114.78	512	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.3%	0.0%	-8.3%	$ 4.76	$ 116.51	491
Prescribed Drugs	$ 361.87	$ 137.61	31,556	6.5%	6.0%	0.5%	0.0%	0.0%	0.0%	-2.4%	0.0%	-2.4%	$ 426.63	$ 163.89	31,237
Other BH Services	$ 11.97	$ 58.63	2,450	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 12.78	$ 60.41	2,539
LTSS Services	$ 63.78	$ 5.18	147,724	0.0%	0.5%	-0.5%	12.4%	12.4%	0.0%	-4.6%	0.0%	-4.6%	$ 68.43	$ 5.91	138,872
Durable Medical Equipment	$ 35.69	$ 2.88	148,872	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-15.8%	0.0%	-15.8%	$ 30.95	$ 2.92	127,193
Limited Dental Services	$ 0.03	$ 24.79	17	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 0.04	$ 25.17	17
Optical	$ 1.34	$ 70.15	229	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 1.37	$ 71.21	231
Lab and X-Ray	$ 9.43	$ 21.46	5,270	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.63	$ 21.79	5,305
Transportation	$ 9.36	$ 60.14	1,867	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.8%	0.0%	-0.8%	$ 9.39	$ 61.04	1,846
Subtotal (Medical)	*$ 891.83*	*N/A*	*353,097*	*3.6%*	*2.8%*	*0.8%*	*14.4%*	*14.4%*	*0.0%*	*-9.4%*	*0.0%*	*-9.4%*	*$ 1,027.17*	*N/A*	*321,160*
CC4C LHD Payments	$ 0.00	$ 4.53	12	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.53	12
OBCM LHD Payments	$ 0.74	$ 4.93	1,797	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.74	$ 4.93	1,797
Medical Home Payments	$ 4.43	$ 4.79	11,106	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.43	$ 4.79	11,106
Subtotal (LHD/Medical Home Payments)	*$ 5.17*	*N/A*	*12,914*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.17*	*N/A*	*12,914*
Total (Medical + LHD/Medical Home)	**$ 897.01**	**N/A**	**366,012**	**3.5%**	**2.8%**	**0.8%**	**14.4%**	**14.4%**	**0.0%**	**-9.4%**	**0.0%**	**-9.4%**	**$ 1,032.35**	**N/A**	**334,074**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 1,032.35**
Non-Benefit Expense PMPM/Payment:	
General Administration (3.88%)	$ 44.08
Care Management (3.43%)	$ 38.92
Profit/Underwriting Gain (1.75%)	$ 19.87
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 1,135.21**
Premium Taxes (2.01%)	$ 23.29
Total Capitation Rate:	**$ 1,158.50**

Exhibit 100

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Children (<1)**
Sex:	**Male & Female**

Member Months/Deliveries:	**108,992**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 186.59	$ 563.87	3,971	1.5%	0.5%	1.0%	80.6%	80.6%	0.0%	-15.0%	0.0%	-15.0%	$ 299.59	$ 1,033.95	3,477
Inpatient — BH	$ -	$ -	-	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 9.46	$ 177.29	640	2.5%	0.5%	2.0%	14.7%	14.7%	0.0%	-3.8%	0.0%	-3.8%	$ 11.25	$ 206.49	654
Emergency Room	$ 23.56	$ 250.58	1,128	3.0%	0.5%	2.5%	19.7%	19.7%	0.0%	-7.5%	0.0%	-7.5%	$ 28.51	$ 304.52	1,123
Physician	$ 85.63	$ 99.31	10,346	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.6%	0.0%	-6.6%	$ 84.83	$ 100.81	10,098
FQHC/RHC	$ 5.93	$ 104.62	680	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 5.82	$ 106.20	658
Other Clinic	$ 39.15	$ 107.87	4,355	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 38.43	$ 109.49	4,211
Other Practitioner	$ 0.02	$ 45.25	5	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.02	$ 45.93	5
Therapies	$ 0.93	$ 106.30	105	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 0.91	$ 107.90	101
Prescribed Drugs	$ 14.97	$ 51.97	3,457	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.7%	0.0%	-1.7%	$ 14.72	$ 51.97	3,398
Other BH Services	$ 0.09	$ 18.16	62	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.10	$ 18.71	65
LTSS Services	$ 0.53	$ 61.61	104	0.0%	0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.53	$ 62.54	102
Durable Medical Equipment	$ 2.56	$ 5.93	5,185	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-7.5%	0.0%	-7.5%	$ 2.44	$ 6.02	4,868
Limited Dental Services	$ 2.54	$ 25.00	1,220	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.62	$ 25.38	1,238
Optical	$ 0.06	$ 82.70	9	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.07	$ 83.95	9
Lab and X-Ray	$ 0.57	$ 19.91	344	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.59	$ 20.21	349
Transportation	$ 2.45	$ 121.09	243	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.48	$ 122.91	242
Subtotal (Medical)	*$ 375.04*	*N/A*	*31,854*	*1.7%*	*0.5%*	*1.2%*	*41.5%*	*41.5%*	*0.0%*	*-11.8%*	*0.0%*	*-11.8%*	*$ 492.90*	*N/A*	*30,599*
CC4C LHD Payments	$ 4.18	$ 4.55	11,034	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.18	$ 4.55	11,034
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ 1.98	$ 2.45	9,713	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.98	$ 2.45	9,713
Subtotal (LHD/Medical Home Payments)	*$ 6.17*	*N/A*	*20,746*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 6.17*	*N/A*	*20,746*
Total (Medical + LHD/Medical Home)	**$ 381.21**	**N/A**	**52,601**	**1.7%**	**0.5%**	**1.2%**	**40.9%**	**40.9%**	**0.0%**	**-11.6%**	**0.0%**	**-11.6%**	**$ 499.06**	**N/A**	**51,345**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 499.06**
Non-Benefit Expense PMPM/Payment:	
General Administration (4.47%)	$ 24.69
Care Management (3.41%)	$ 18.82
Profit/Underwriting Gain (1.75%)	$ 9.66
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 552.23**
Premium Taxes (2.01%)	$ 11.33
Total Capitation Rate:	**$ 563.56**

Exhibit 101

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Children (1-20)**
Sex:	**Male & Female**

Member Months/Deliveries:	**1,733,723**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 4.06	$ 1,250.47	39	1.5%	0.5%	1.0%	62.1%	62.1%	0.0%	-15.3%	0.0%	-15.3%	$ 5.83	$ 2,056.96	34
Inpatient — BH	$ 0.79	$ 588.74	16	1.5%	0.5%	1.0%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.83	$ 597.62	17
Outpatient Hospital	$ 7.42	$ 344.68	258	2.5%	0.5%	2.0%	20.8%	20.8%	0.0%	-4.1%	0.0%	-4.1%	$ 9.27	$ 422.64	263
Emergency Room	$ 13.78	$ 283.12	584	3.0%	0.5%	2.5%	21.9%	21.9%	0.0%	-7.8%	0.0%	-7.8%	$ 16.92	$ 350.20	580
Physician	$ 17.85	$ 71.05	3,015	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-6.9%	0.0%	-6.9%	$ 17.64	$ 72.12	2,935
FQHC/RHC	$ 1.93	$ 101.69	228	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.89	$ 103.22	220
Other Clinic	$ 6.11	$ 106.65	688	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 5.98	$ 108.26	663
Other Practitioner	$ 0.10	$ 73.50	17	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 0.10	$ 74.61	16
Therapies	$ 3.39	$ 115.26	353	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 3.31	$ 117.00	340
Prescribed Drugs	$ 36.95	$ 99.29	4,465	4.0%	3.5%	0.5%	0.0%	0.0%	0.0%	-2.5%	0.0%	-2.5%	$ 40.53	$ 110.09	4,418
Other BH Services	$ 4.52	$ 74.47	728	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 4.85	$ 76.73	759
LTSS Services	$ 0.17	$ 10.81	193	0.0%	0.5%	-0.5%	2.6%	2.6%	0.0%	-0.3%	0.0%	-0.3%	$ 0.18	$ 11.26	190
Durable Medical Equipment	$ 1.66	$ 2.70	7,383	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-7.8%	0.0%	-7.8%	$ 1.58	$ 2.74	6,909
Limited Dental Services	$ 0.52	$ 24.80	252	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.53	$ 25.18	255
Optical	$ 1.35	$ 83.40	194	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.39	$ 84.66	196
Lab and X-Ray	$ 1.20	$ 18.64	775	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 1.24	$ 18.92	784
Transportation	$ 0.51	$ 78.21	78	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.3%	0.0%	-0.3%	$ 0.51	$ 79.38	77
Subtotal (Medical)	*$ 102.33*	*N/A*	*19,266*	*2.8%*	*1.6%*	*1.2%*	*6.8%*	*6.8%*	*0.0%*	*-5.3%*	*0.0%*	*-5.3%*	*$ 112.58*	*N/A*	*18,656*
CC4C LHD Payments	$ 0.99	$ 4.52	2,636	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.99	$ 4.52	2,636
OBCM LHD Payments	$ 0.57	$ 4.92	1,392	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.57	$ 4.92	1,392
Medical Home Payments	$ 2.29	$ 2.45	11,236	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 2.29	$ 2.45	11,236
Subtotal (LHD/Medical Home Payments)	*$ 3.86*	*N/A*	*15,264*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 3.86*	*N/A*	*15,264*
Total (Medical + LHD/Medical Home)	**$ 106.19**	**N/A**	**34,530**	**2.7%**	**1.5%**	**1.2%**	**6.6%**	**6.6%**	**0.0%**	**-5.2%**	**0.0%**	**-5.2%**	**$ 116.44**	**N/A**	**33,920**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 116.44**
Non-Benefit Expense PMPM/Payment:	
General Administration (8.05%)	$ 10.78
Care Management (3.28%)	$ 4.39
Profit/Underwriting Gain (1.75%)	$ 2.34
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 133.95**
Premium Taxes (2.01%)	$ 2.75
Total Capitation Rate:	**$ 136.70**

Exhibit 102

Region:	**Region 6**
Category of Aid:	**TANF and Other Related Adults (21+)**
Sex:	**Male & Female**

Member Months/Deliveries:	**407,775**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 23.19	$ 1,176.40	237	3.5%	0.5%	3.0%	81.4%	81.4%	0.0%	-12.2%	0.0%	-12.2%	$ 40.98	$ 2,166.63	227
Inpatient — BH	$ 2.38	$ 809.18	35	3.5%	0.5%	3.0%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 2.62	$ 821.37	38
Outpatient Hospital	$ 27.05	$ 393.56	825	2.5%	0.5%	2.0%	29.3%	29.3%	0.0%	-12.2%	0.0%	-12.2%	$ 33.09	$ 516.49	769
Emergency Room	$ 47.01	$ 414.42	1,361	3.0%	0.5%	2.5%	24.3%	24.3%	0.0%	-12.2%	0.0%	-12.2%	$ 56.09	$ 522.91	1,287
Physician	$ 42.29	$ 113.15	4,485	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-7.6%	0.0%	-7.6%	$ 41.45	$ 114.85	4,331
FQHC/RHC	$ 4.29	$ 101.10	509	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.17	$ 102.63	487
Other Clinic	$ 8.30	$ 190.48	523	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 8.07	$ 193.35	501
Other Practitioner	$ 0.40	$ 70.27	69	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.39	$ 71.33	66
Therapies	$ 0.01	$ 49.06	2	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 0.01	$ 49.80	2
Prescribed Drugs	$ 93.13	$ 89.35	12,508	6.3%	6.0%	0.2%	0.0%	0.0%	0.0%	-2.8%	0.0%	-2.8%	$ 108.61	$ 106.41	12,248
Other BH Services	$ 6.92	$ 67.76	1,225	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 7.38	$ 69.81	1,268
LTSS Services	$ 1.44	$ 5.45	3,177	0.0%	0.5%	-0.5%	1.0%	1.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.44	$ 5.58	3,102
Durable Medical Equipment	$ 5.03	$ 2.27	26,589	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-8.4%	0.0%	-8.4%	$ 4.75	$ 2.30	24,721
Limited Dental Services	$ 0.00	$ 15.11	0	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ -	$ 15.34	-
Optical	$ 0.37	$ 70.19	63	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 0.38	$ 71.25	64
Lab and X-Ray	$ 12.33	$ 25.34	5,840	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 12.59	$ 25.72	5,874
Transportation	$ 1.76	$ 75.48	280	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	-0.9%	0.0%	-0.9%	$ 1.77	$ 76.61	277
Subtotal (Medical)	*$ 275.91*	*N/A*	*57,728*	*3.8%*	*2.4%*	*1.4%*	*13.6%*	*13.6%*	*0.0%*	*-7.5%*	*0.0%*	*-7.5%*	*$ 323.78*	*N/A*	*55,261*
CC4C LHD Payments	$ 0.00	$ 4.30	1	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 4.30	1
OBCM LHD Payments	$ 3.51	$ 4.91	8,579	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 3.51	$ 4.91	8,579
Medical Home Payments	$ 1.83	$ 2.39	9,189	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.83	$ 2.39	9,189
Subtotal (LHD/Medical Home Payments)	*$ 5.34*	*N/A*	*17,769*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ 5.34*	*N/A*	*17,769*
Total (Medical + LHD/Medical Home)	**$ 281.25**	**N/A**	**75,496**	**3.7%**	**2.3%**	**1.3%**	**13.4%**	**13.4%**	**0.0%**	**-7.4%**	**0.0%**	**-7.4%**	**$ 329.12**	**N/A**	**73,030**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 329.12**
Non-Benefit Expense PMPM/Payment:	
General Administration (5.05%)	$ 18.51
Care Management (3.39%)	$ 12.41
Profit/Underwriting Gain (1.75%)	$ 6.41
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 366.46**
Premium Taxes (2.01%)	$ 7.52
Total Capitation Rate:	**$ 373.97**

Exhibit 103

Region:	**Region 6**
Category of Aid:	**Maternity Event**
Sex:	**Female**

Member Months/Deliveries:	**7,245**

Blended Base Data:	**July 1, 2015 - June 30, 2017**
Contract Period:	**July 1, 2019 - June 30, 2020**
Trend Months:	**36**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)
Category of Service	**Base Data**			**Trend**			**Program Changes**			**Managed Care Adjustment**			**Total Medical**		
	PMPM/ Payment	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**	**PMPM/ Payment**	**Unit Cost**	**Util/1000**
Inpatient — PH	$ 2,253.84	$ 796.85	33,941	0.5%	0.5%	0.0%	119.1%	119.1%	0.0%	-1.1%	0.0%	-1.1%	$ 4,955.47	$ 1,771.95	33,559
Inpatient — BH	$ -	$ -	-	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Outpatient Hospital	$ 251.05	$ 142.22	21,183	2.5%	0.5%	2.0%	34.5%	34.5%	0.0%	-11.3%	0.0%	-11.3%	$ 322.65	$ 194.13	19,944
Emergency Room	$ 434.28	$ 300.99	17,314	3.0%	0.5%	2.5%	24.7%	24.7%	0.0%	-11.3%	0.0%	-11.3%	$ 525.27	$ 381.05	16,542
Physician	$ 1,702.46	$ 242.44	84,265	2.0%	0.5%	1.5%	0.8%	0.8%	0.0%	0.0%	0.0%	0.0%	$ 1,821.33	$ 248.10	88,095
FQHC/RHC	$ 135.92	$ 157.13	10,380	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 144.24	$ 159.49	10,852
Other Clinic	$ 271.40	$ 130.77	24,904	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 288.01	$ 132.74	26,036
Other Practitioner	$ 0.01	$ 69.47	1	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 70.51	1
Therapies	$ -	$ -	-	2.0%	0.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Prescribed Drugs	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Other BH Services	$ 0.00	$ 93.72	0	2.5%	1.0%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ 96.56	-
LTSS Services	$ 4.00	$ 13.23	3,623	0.0%	0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 4.00	$ 13.43	3,570
Durable Medical Equipment	$ 1.48	$ 66.69	267	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 1.53	$ 67.69	271
Limited Dental Services	$ 0.01	$ 24.79	3	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.01	$ 25.16	3
Optical	$ 0.02	$ 90.87	3	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 0.03	$ 92.24	3
Lab and X-Ray	$ 52.78	$ 25.94	24,413	1.0%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 54.38	$ 26.33	24,779
Transportation	$ 21.22	$ 112.14	2,270	0.4%	0.5%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ 21.47	$ 113.83	2,263
Subtotal (Medical)	*$ 5,128.46*	*N/A*	*222,569*	*1.4%*	*0.5%*	*0.9%*	*55.1%*	*55.1%*	*0.0%*	*-2.0%*	*0.0%*	*-2.0%*	*$ 8,138.38*	*N/A*	*225,919*
CC4C LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
OBCM LHD Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Medical Home Payments	$ -	$ -	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$ -	$ -	-
Subtotal (LHD/Medical Home Payments)	*$ -*	*N/A*	*-*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*$ -*	*N/A*	*-*
Total (Medical + LHD/Medical Home)	**$ 5,128.46**	**N/A**	**222,569**	**1.4%**	**0.5%**	**0.9%**	**55.1%**	**55.1%**	**0.0%**	**-2.0%**	**0.0%**	**-2.0%**	**$ 8,138.38**	**N/A**	**225,919**

Note: Total Medical Calculation: M = A * [(1 + D) ^ (36/12)] * (1 + G) * (1 + J)

Gross Medical PMPM/Payment:	**$ 8,138.38**
Non-Benefit Expense PMPM/Payment:	
General Administration (0.80%)	$ 69.36
Care Management (3.54%)	$ 306.83
Profit/Underwriting Gain (1.75%)	$ 151.66
Total Service Cost and Non-Benefit Load PMPM/Payment:	**$ 8,666.24**
Premium Taxes (2.01%)	$ 177.76
Total Capitation Rate:	**$ 8,844.00**

15 OTHER CONSIDERATIONS

The following section represents other rating considerations not reflected in the Section 14 capitation rate summaries.

15.1 Member Choice

15.1.1 Tribal Members

DHHS, in consultation with North Carolina's only federally recognized tribe, determined that members of federally-recognized tribes should be exempt from mandatory enrollment in managed care and have the choice between Medicaid FFS and enrolling in a PHP or tribal option, if one is available. Members of federally recognized tribes will default to Medicaid FFS unless a tribal option is available.

Mercer has identified the portion of the Standard Plan population that has accessed services at one of the tribal healthcare facilities. Using this data as a potential proxy for the size and PMPM of the tribal population, Mercer found that approximately 2.3% of the Standard Plan population eligible in Region 1 utilized services at a tribal provider, with limited tribal provider utilization for beneficiaries eligible in other regions. Mercer also noted that the population that accessed services at a tribal provider exhibited a higher than average PMPM cost. If all claims and MMs associated with tribal providers were excluded from the base experience, the average base PMPM in Region 1 would decline by approximately 1.6%. Mercer is working with DHHS to develop a more refined impact analysis to inform an adjustment for final rates. Note that any adjustment included in the final rates will need to also account for the number of beneficiaries anticipated to opt in to managed care.

15.1.2 BH I/DD Tailored Plan

Per S.L. 2018-48[21], the BH I/DD Tailored Plan for individuals with high BH needs will launch one year after the implementation of managed care. The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower BH needs, will receive services through the Standard Plan upon launch of managed care. Individuals with higher BH needs that meet certain eligibility criteria may participate in the BH I/DD Tailored Plans. Beneficiaries passively enrolled in the future BH I/DD Tailored Plan may choose to opt out of the BH I/DD Tailored Plan, and instead receive services under the Standard Plan. Additionally, Standard Plan beneficiaries who exhibit a need for unique BH I/DD Tailored Plan services may also opt out of the Standard Plan and enroll in FFS and LME/MCOs (before BH I/DD Tailored Plans go live). Mercer will work with DHHS to further refine adjustments related to the delineation of Standard Plan and BH I/DD Tailored Plan populations as part of the final rates. Further information about this population and potential member choice can be found in Appendix F.

15.2 Performance Withholds

DHHS has proposed a performance-based incentive system financed through a withhold as part of the program design. Per S.L. 2018-49, performance withholds will not apply to the first 18 months of managed care implementation. The long-term goal of the incentives would be to ensure that PHPs deliver value around the various DHHS priorities and ultimately improve quality of care provided to the Medicaid population in North Carolina.

When the withhold program is enacted, DHHS and its actuaries will ensure the payment implications of withholds are designed to comply with federal regulations. Any withhold must be reviewed by the Actuary to determine that the withhold should be "reasonably achievable" and the capitation rate including the withhold must be certified as actuarially sound. The methodology to perform the actuarial soundness assessment will be further refined as the actual withhold percentages are defined and the metrics finalized.

[21] SL 2018-48/House Bill 403 Medicaid and Behavioral Health Modifications. https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H403v6.pdf

15.3 Risk Adjustment

DHHS will implement a prospective risk adjustment process as required by the managed care legislation (Section 5.5(a) of Session Law 2015-245). Health-based risk adjustment has been documented in multiple Society of Actuaries (SOA) studies and other publications as a significantly better predictor of healthcare costs than traditional age/gender rating. A risk adjusted payment process differentiates capitation payments to PHPs based on measured risk differences in their enrolled populations. Appropriately paying PHPs for their enrolled population, enables the overall managed care program to operate effectively and efficiently and discourages PHPs to avoid enrolling higher risk individuals. Since risk adjustment is reliant on detailed claims or encounter information, the PHPs have a strong incentive to submit complete and accurate encounters. Finally, risk adjustment can simplify the rate structure by reducing the number of rate cells needed from a systems and payment perspective.

15.3.1 Risk Adjustment Model

While many models exist, DHHS is proposing to use the Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model to adjust the capitation payments beginning at the start of Contract Year 1 to reflect the underlying health risk of the members enrolled in each PHP. The CDPS+Rx model is a disease classification system developed by researchers from the University of California, San Diego (UCSD). The model uses medical and pharmacy data to assign risk markers that correlate to predictive, high cost disease conditions. Along with being built on a Medicaid-specific framework, the CDPS+Rx model is the most prevalent model used within Medicaid, approved by CMS, has limited licensing fees and maintains a high level of transparency regarding its model logic and assumptions. Many commercially available models that were developed using commercial healthcare populations and services are not as transparent and are generally more costly to implement. While the CDPS+Rx model inherently addresses some unique aspects of Medicaid members, additional information may be incorporated into the model where appropriate.

Medicaid Rx will also be run in conjunction with CDPS+Rx as a means to evaluate the impact of encounter data submitted by the PHPs. Medicaid Rx was also developed by UCSD and is based on a similar framework and common principles as CDPS+Rx. Since pharmacy claims/encounters are typically more straightforward to collect, Medicaid Rx results can be used as a benchmark against the CDPS+Rx results where full medical claims/encounters are being utilized. Medicaid Rx uses only pharmacy information within the risk assessment process and has been used by states where full diagnostic encounters were not reliable. Both model results will be actively evaluated and available in the event the results need to be adjusted based on the adequacy and validity of PHP-reported encounters.

Both models will be calibrated using State-specific FFS data upon implementation. While the model developers often utilize an external (“national”) data set for producing relative cost categories, the use of State-specific data best reflects North Carolina’s populations, provider practice patterns and covered benefits. FFS data is readily available and of sufficient quality to use for the calibration process. Since the risk adjustment will be applied prospectively to capitation payments, the model weights will be calibrated on a prospective basis. The risk adjustment cost weights may be updated periodically if material changes are made to covered benefits, more relevant data becomes available, or at the discretion of DHHS.

Risk adjustment considerations will be specifically evaluated for the BH I/DD Tailored Plans as well as the LTSS populations to assess whether the current models selected for implementation of the standard plans are suitable for risk adjustment of those populations. Alternatively, other models or calibration will be considered for these specialized populations.

15.3.2 Data Collection

The risk adjustment process utilizes beneficiary eligibility, demographic, diagnosis and pharmacy claims data. Risk adjustment will be implemented at the start of the program and will initially utilize DHHS FFS data. PHP-reported encounter data will also be collected and validated as it becomes available. After the data elements have been collected, they must be validated for completeness and accuracy. Risk adjustment data will be evaluated for consistency of reporting in terms of volume and completeness of critical fields (i.e., diagnosis codes). During the initial months after implementation, DHHS will review encounter data as often as monthly to identify and address issues with the completeness of the data. This validation is crucial for general program monitoring as well as rate-setting and risk adjustment.

For risk adjustment analysis, data will be extracted and analyzed on a semi-annual basis for development of beneficiary risk scores. The data extraction dates will be clearly communicated to the PHPs to ensure they have a chance to submit/re-submit any encounters to be considered in the risk adjustment process. While the PHPs are expected to constantly be submitting encounters to DHHS in a timely manner, clearly communicating cut-off dates when the data are utilized for risk adjustment analysis will allow the PHPs to plan resubmissions, adjustments and other transactions to ensure they are included in the risk adjustment process.

The presence of a single diagnosis, regardless of position on the claim, or a single national drug code is sufficient to support a classification into a CDPS+Rx diagnostic category. Consistent with general risk adjustment practices, laboratory and diagnostic radiology claims will be excluded from the disease classification process. These services often do not indicate the presence of a disease condition and may produce "false positives" within the results. While only managed care covered benefits will be included in the cost weight development, FFS claims will be used for disease condition flagging where available and appropriate.

15.3.3 Calculation of Risk Scores

Beneficiary Risk Score Development

Using the models and data described above, a risk assessment will be performed for each scored beneficiary. Scored beneficiaries are defined as any individual with at least six months of eligibility (non-continuous) during the 12-month study period. The six month scoring criteria provides sufficient time to accumulate beneficiary's applicable health diagnosis and pharmacy usage.

The risk assessment is performed by assigning any applicable disease condition categories to each scored beneficiary. Once the disease condition flagging is complete, each beneficiary's acuity level (i.e., beneficiary risk score) will be determined by adding the relative cost of all their flagged conditions and demographic category. This process of calculating individual beneficiary risk scores is anticipated to occur every six months.

PHP Enrollment

Once the scored and unscored beneficiaries are given a risk score, actual PHP enrollment is collected to evaluate the average risk scores for each PHP. Since the goal of risk adjustment is to project payments during the contract period, an enrollment snapshot that represents PHP membership will be applied as close to the contract period start date as possible. For example, for July risk adjustment, an enrollment snapshot as of June based on beneficiary selection and assignment is expected to be utilized.

The enrollment snapshot is cross-referenced to the individual beneficiary risk score file to develop a raw average risk score for each PHP. DHHS is considering updating the enrollment snapshot each month for the first six months of program implementation in each region to account for the higher member movement that may occur. At that point it will be evaluated if moving to quarterly updates is appropriate and eventually moving to semi-annual updates when deemed appropriate. Similarly, as populations are phased into managed care, the PHP enrollment snapshots may be updated monthly for the first six months of managed care.

Budget Neutral Risk Scores

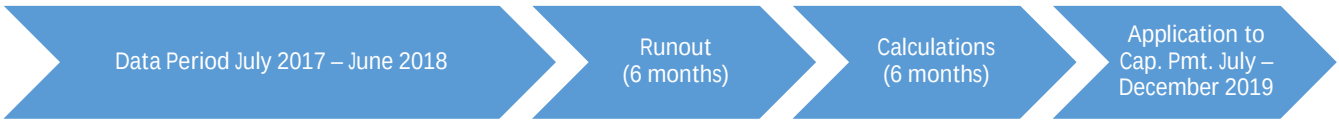
The average risk scores will be calculated for each rate cell for all beneficiaries who are enrolled in each PHP. Since the data used to produce the risk adjustment cost weights and the 12 month application are from different time periods, distortions in the model results occur due to changes in practice patterns and coding specificity. Therefore, the initial results are considered to be "raw" risk scores. The distortions described previously may cause the raw risk scores to be inappropriately inflated or deflated, depending on the populations and models being applied. To address this issue, a budget neutrality adjustment is required.

CMS requires that risk adjustment be applied in a budget neutral manner. This calculation is done by dividing each PHP's raw risk score by the total PHP raw risk score for each rate cell. This adjustment will result in the weighted average of the budget neutral risk scores equaling 1.0. The final payments made to the PHP are determined by multiplying a base capitation rate by each PHP's budget neutral risk score and by its enrollment for each rate cell.

15.3.4 Frequency of Updates

The risk adjustment study period (used to set risk scores by beneficiary) will be updated every six months corresponding with the first and second half of each contract year. For each six month update cycle, a full year of encounter or claims data will be pulled for a time period beginning two years before the beginning of the cycle. This timing allows for six months of runout and six months of calculation time. This semi-annual process will also allow for 6 months of overlapping data with each update. The illustration below shows a sample timeline.

Figure 3: Risk Adjustment Analysis



15.3.5 Final Capitation Rates

The final budget neutral risk scores for each PHP will be applied to the base capitation rates for the Medicaid and NC Health Choice populations, thus producing the risk adjusted rates for each rate cell. The resulting capitation rates will reflect the relative risk between PHPs and rate cells. Risk adjustment is anticipated to be applied to all managed care populations, but will not be applied to the Maternity Event payments and newborn rate cells. Maternity Event payments are not typically risk adjusted because the delivery payment is already a form of risk adjustment. Newborns are also typically excluded from risk adjustment because it is challenging due to the lack of historical data at the beneficiary level. DHHS is utilizing a separate rate cell for newborns to account for their higher than average costs.

The resulting risk adjustment scores are projections of relative risk, and actual relative risk will likely differ from that which was projected. The PHPs are encouraged to review the results with their own data. DHHS will use the risk adjustment scores to adjust actuarially sound base capitation rates as a means of matching PHP payments to their relative risks. Use of the risk adjustment results for any purpose beyond that stated may not be appropriate. The risk adjustment model produces precise adjustment factors that are applied to the capitation rates. However, acceptable variation exists within the calculated results due to the specific risk adjustment model chosen, the various assumptions applied and the availability and accuracy of the source data utilized. Although health-based risk adjustment is not a perfect system that predicts all variation in beneficiary and PHP

costs, published results have shown that using health status as a predictor of costs is a significant improvement over age/gender rating.

When developing a risk adjustment payment approach, there are many decision points and assumptions that need to be determined. The methodology described in this section is based on program goals and objectives, multiple discussions between DHHS and its actuaries and best/common practice of risk adjustment use in other state Medicaid programs. Further, DHHS made decisions based on the specific implementation schedule and approach to managed care within North Carolina's Medicaid program. For example, the selection of both a diagnosis and pharmacy-based models provides DHHS with flexibility and options in light of encounter data uncertainty at the onset of the program. As the program matures, certain assumptions may be re-evaluated to enable the risk adjustment methodology to best achieve DHHS' objectives.

15.4 Medical Loss Ratio

The CMS Final Rule outlines requirements for rate-setting and financial reporting related to the medical loss ratio (MLR). From a rate-setting standpoint, 42 CFR 438.4(b)(9) stipulates that rates must be established in such a way that a PHP would reasonably achieve a MLR of at least 85%. From a financial reporting perspective, CMS prescribes the MLR calculation methodology in 42 CFR 438.8 for states and their contractors including how to classify various incurred costs and how to develop the numerator and denominator included in the ratio. Lastly, the Final Rule allows, but does not require, states to implement a remittance process for PHPs which do not meet state-established minimum MLR thresholds.

15.4.1 Implied MLR Calculation based on Capitation Rate Development

The capitation rates are developed independent of the MLR implications and are based on anticipated, reasonable expenditures required to meet the obligations put forth in the PHP contract. The capitation rates have not been developed based on a target MLR, nor are they influenced by any potential remittance process to be implemented by the State. Mercer calculated the implied MLRs for each rate cell on a statewide average basis using the MLR methodology outlined in the Final Rule. A summary of this calculation is offered below and illustrated in the Table 24. While CMS has established a minimum MLR for Medicaid rate-setting of 85%, the higher MLRs are allowable as long as rates "are adequate for reasonable, appropriate, and attainable non benefit costs" as noted in 42 CFR 438.4(b)(9).

As is shown, the numerator includes all of the expected medical claims for the rate cell (i.e., Gross Medical PMPM) as well as 85.0% of the included care management considerations included as part of the non-benefit expenses. These care management costs were included in the numerator as DHHS expects much of the care management costs incurred by the PHPs to meet the definition of Health Care Quality Improvements (HCQI) which is included as part of the numerator within the Final Rule MLR methodology. HCQI are defined within 42 CFR 438.8(e)(3) as:

- Those activities that improve health quality and increase the likelihood of desired health outcomes as defined in 45 CFR 158.150
- Activities related to any External-Quality Review (EQR) activities as defined at 42 CFR 438.358(b) and (c)
- Health Information Technology expenses as defined at 45 CFR 158.151

Additionally, within 42 CFR 438.8(f), CMS outlines that the denominator of the MLR should be premium revenues excluding amounts for PHP taxes/fees/assessments. As a result, Mercer set the denominator in the table below as the total capitation rate less the PHP premium tax considerations included in the rate development process.

For comparison, Mercer also included a traditional pricing MLR calculation in the table below using a methodology that compares the Gross Medical PMPM to the total capitation rate. This pricing MLR is shown in

row H of the table below. This was included to illustrate what portion of the total capitation rate is for medical costs. Also, one minus this ratio illustrates what portion of total capitation is intended for General Administration and Utilization Management, Care Management, Profit/Underwriting Gain and Premium Taxes. These ratios are significantly lower than the Final Rule MLR as they do not include any care management costs in the numerator and premium taxes are included in the denominator.

Table 24: Statewide Implied MLR Calculation by Rate Cell Utilizing Draft Capitation Rates

Capitation Rate Component	ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
(A) = Gross Medical PMPM or Payment	$1,212.36	$618.85	$124.56	$357.00	$8,705.66	$300.86
(B) = Care Management PMPM or Payment	$43.79	$22.34	$4.50	$12.87	$313.95	$10.86
(C) = (A) + 85% x (B)	$1,249.58	$637.84	$128.39	$367.94	$8,972.52	$310.09
(D) = Total Capitation Rate	$1,355.46	$695.20	$145.37	$403.88	$9,442.29	$340.78
(E) = Premium Taxes PMPM or Payment	$27.24	$13.97	$2.92	$8.12	$189.79	$6.85
(F) = (D) – (E)	$1,328.22	$681.23	$142.44	$395.76	$9,252.50	$333.93
(G) = (C) / (F) = Implied MLR	94.1%	93.6%	90.1%	93.0%	97.0%	92.9%
(H) = (A) / (D) = Pricing MLR	89.4%	89.0%	85.7%	88.4%	92.2%	88.3%

15.4.2 Minimum MLR Threshold

As part of Medicaid Transformation, DHHS will institute a MLR reporting and remittance process for all PHPs to ensure on a retrospective basis that PHPs directed a sufficient portion of the capitation payments received from DHHS to services and activities that improve health in alignment with the program goals and objectives. In accordance with S.L. 2018-49, a statewide minimum MLR threshold will be established at 88% for health care services, with the components of the numerator and denominator to be defined by DHHS (DHHS-defined MLR). To recognize MLR variability across rate cells (as demonstrated in Table 24), the minimum MLR threshold for each PHP shall be calculated based on the actual capitation revenue mix of the PHP, by taking the revenue weighted average of factors to be defined by DHHS for each rating group (ABD; TANF, Newborn; TANF, Child; TANF, Adult; and Maternity Event), based on the total capitation payments for the rating year for each rating group. The factors will be developed from the Implied MLR calculated from the final capitation rates and calibrated to an 88% MLR threshold.

PHPs will be required to calculate and report aggregate MLR on an annual, retrospective basis aligned to the contract year according to two formulas, CMS-defined MLR and DHHS-defined MLR as outlined in the RFP.

If the PHP's DHHS-defined MLR is less than the minimum MLR threshold as defined above, the PHP shall remit to the Department a rebate equal to the denominator of the DHHS-defined MLR, multiplied by the difference between the minimum MLR threshold and the DHHS-defined MLR result. The PHP may make contributions to health-related resources (that meet certain requirements) in lieu of all or a portion of the required rebate.

APPENDIX A — MATERNITY EVENT CRITERIA

Under managed care, DHHS will pay a Maternity Event payment on all live birth events. The Maternity Event payment was constructed to reflect a single payment per delivery, even in the case of multiple births during a delivery event. This payment includes cost of the delivery event, along with pregnancy-related care during the prenatal and postpartum period. The tables below outline the specific logic used to develop the Maternity Event payment structure.

Step 1: Identify Delivery Event

The live birth event is identified using the following logic of CPT codes and DRG codes. The live birth event is flagged if there is either a CPT code or DRG code on the claim.

Live Birth CPT Codes

CPT Code	Type	Description
59400	Vaginal	Delivery, Antepartum Care and Postpartum Care
59409	Vaginal	Delivery
59410	Vaginal	Delivery and Postpartum Care
59510	Cesarean	Delivery, Antepartum Care and Postpartum Care
59514	Cesarean	Delivery
59515	Cesarean	Delivery and Postpartum Care

Live Birth DRG Codes

DRG Code	Description
765	Cesarean section with CC/MCC
766	Cesarean section without CC/MCC
767	Vaginal delivery with sterilization and/or D&C
768	Vaginal delivery with O.R. procedure except sterilization and/or D&C
774	Vaginal delivery with complicating diagnoses
775	Vaginal delivery without complicating diagnoses

Step 2: Identify Prenatal and Postpartum Care

For beneficiaries identified in Step 1 above as having a live birth event, Mercer included all claims with the following International Classification of Diseases (ICD)-10 codes in any diagnosis position for eight full months prior to the delivery event and two full months following the delivery event. This captures the pregnancy-related costs for the prenatal and postpartum periods.

ICD-10 Code Ranges for Prenatal and Postpartum Care

Code Range	Description	Prenatal Care	Postpartum Care
O00-O08	Pregnancy with abortive outcome	Included only codes where pregnancy outcome is unclear	Included only codes relating to puerperium
O09	Supervision of high risk pregnancy	Included all codes	N/A
O10-O16	Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium	Excluded codes relating to childbirth and puerperium	Included only codes relating to puerperium
O20-O29	Other maternal disorders	Excluded codes relating to	N/A

Code Range	Description	Prenatal Care	Postpartum Care
	predominately related to pregnancy	childbirth and puerperium	
O30-O48	Maternal care related to the fetus and amniotic cavity and possible delivery problems	Included all codes	N/A
O60-O77	Complications of labor and delivery	Included all codes dealing with unspecified, second and third trimester	Included only codes relating to puerperium
O80-O82	Encounter for delivery	N/A	N/A
O85-O92	Complications predominately related to the puerperium	Included all codes dealing with unspecified, first, second and third trimester	Included only codes relating to puerperium
O94-O9A	Other obstetric conditions, not elsewhere classified	Excluded codes relating to childbirth and puerperium	Included only codes relating to puerperium

Step 3: Identify Other Pregnancy-Related Services

For beneficiaries identified in Step 1 above as having a live birth event, Mercer also included other pregnancy-related services, consistent with current State clinical coverage policies. Utilization for these services are included for eight full months prior to and two full months following the delivery event.

Childbirth Education Clinical Coverage Policy

CPT Code	Description
S9442	Birthing Class

Obstetrics and PMH Clinical Coverage Policy

CPT Code	Description
59425	Antepartum care only; 4–6 visits
59426	Antepartum care only; 7 or more visits
59430	Postpartum care only (separate procedure)
T1015	FQHC/RHC visit
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta (separate procedure)
99360	Physician standby service, requiring prolonged physician attendance, each 30 minutes (e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)
99464	Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn
S0280	PMH Incentive
S0281	PMH Incentive

Fetal Surveillance Clinical Coverage Policy

CPT Code	Description
Ultrasound in Maternity Care	
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional

CPT Code	Description
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or + 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, reevaluation of organ system(s) suspected or confirmed to be abnormal on a 76801
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
Fetal Oxytocin Stress Testing	
59020	Fetal Contract Stress Test
Fetal Non-Stress Testing	
59025	Fetal Non-Stress Test
Biophysical Profile	
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
Fetal Echocardiography	
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
93325	Doppler echocardiography color flow velocity mapping
Amniocentesis & Chorionic Villus Sampling	
59000	Amniocentesis, Diagnostic
59001	Amniocentesis, Therapeutic
76946	Echo Guide For Amniocentesis
82143	Amniotic Fluid Scan
82963	Assay Of Glucosidase
83661	L/S Ratio, Fetal Lung

CPT Code	Description
83662	Foam Stability, Fetal Lung
83663	Fluoro Polarize, Fetal Lung
83664	Lamellar Body, Fetal Lung
84081	Amniotic Fluid Enzyme Test
88235	Tissue Culture, Placenta
88267	Chromosome Analysis, Placenta
88269	Chromosome Analysis, Amniotic
59015	Chorion Biopsy
76945	Echo Guide, Villus Sampling
Cordocentesis	
59012	Fetal Cord Puncture, Prenatal
Fetal Fibronectin Testing	
82731	Assay Of Fetal Fibronectin

Budget-Neutral Maternity Adjustment

As previously outlined in Section 4, the Maternity Event payment is constructed to capture costs related to the delivery event along with the cost of providing prenatal services (occurring 8 full months prior to the live birth event) and postpartum services (occurring 2 full months after the live birth event). However, the data extract only reflects claims paid through September 2017. As such, prenatal costs associated with deliveries occurring after September 30, 2017 are not captured using the Maternity Event payment logic outlined in Steps 1-3 above. To account for this delivery event lag, Mercer made a budget-neutral adjustment to the data to capture additional prenatal costs, not necessarily tied to a live birth event, and summarized those under the Maternity Event payment. The table below illustrates the budget neutral shift in costs for prenatal services under the Maternity Event payment.

SFY 2017 Impact of Maternity Event Payment Adjustment

COA	Dollar Amount
ABD	$(898,826)
TANF, Newborn (<1)	$(12,445)
TANF, Children (1-20)	$(3,787,242)
TANF, Adults (21+)	$(13,469,265)
Maternity Event	$18,167,778
Total Standard Plan	$0

APPENDIX B — OTHER POPULATION ELIGIBILITY CRITERIA

Future Managed Care Populations Criteria

The following table represents the mapping logic used to define the future populations that DHHS has proposed to phase in to managed care after initial implementation (pending legislation).

Future Managed Care Populations

Population Group	Program Aid Code/Eligibility Code
BH I/DD Tailored Plan	See Appendix E
Foster Children and Adopted Children	HSFCY, HSFNN, IASCN, IASCY, MFCNN
Non-Dual LTSS — Nursing Facility Level Of Care (NFLOC)	Identify 3 months of consecutive nursing home utilization; mark member as being NF from first month of 3 month consecutive utilization forward
Dual Eligibles, not eligible for BH I/DD Tailored Plan	A beneficiary was identified as dual-eligible if either their eligibility fields "MA_STATUS" or "MB_STATUS" had a value of "MA" or "MB" respectively. Dual eligible beneficiaries not identified as eligible for the BH I/DD Tailored Plan were summarized into the following population groupings: • LTSS Population: NFLOC • Non-LTSS Population: ABD, TANF and Other Related Children/Adults, NC Health Choice, M-CHIP and Foster Children and Adopted Children

Permanently Excluded Population Criteria

The following table represents the mapping logic used to define the proposed permanently excluded populations.

Permanently Excluded Population Criteria

Population Group	Program Aid Code/Eligibility Code
Medically Needy	Fourth digit of program category code of "M"
Family Planning	MAFDN
Partial Duals	MQBBN, MQBEN, MQBQN
Aliens (Emergency Services Only)	Eligibility codes with a fourth character of F, H, O, R or V
Refugees	MRFMN, MRFNN, RRFCN
Health Insurance Premium Program	Beneficiary roster provided by DHHS
Inmates	Living Arrangement Code 16
CAP/C	Setting of Care codes (HC, IC or SC)
CAP/DA	Setting of Care codes (CI, CS, ID or SD)

Note that beneficiaries enrolled in Program of All-Inclusive Care for the Elderly (PACE) are excluded from managed care and population criteria will be refined for final capitation rate development.

APPENDIX C — RATE CELL DETERMINATION

As a part of the capitation rate development to support DHHS, Mercer developed rate cell recommendations for the Standard Plan population. The following section provides background and support for the recommended rate cell structure. Overall, Mercer developed the rate cell recommendations to (1) best match payment to risk and (2) consider the operational challenges to payout on the recommended rate cells.

Rate cells are used to develop variable payment rates accounting for material cost differences amongst regions and populations. Since the managed care population will have choice of PHP, the rate cell structure is intended to differentiate payments to PHPs where disproportionate enrollment of certain populations occurs. For example, if a PHP has a disproportionate share of higher cost newborns, a rate cell structure with a special payment for newborns would allow that PHP to be adequately reimbursed for their higher share of newborn members. However, the number of rate cells necessary to account for these material differences is predicated on DHHS' decision to risk adjust the rates. A risk adjustment model accounts for much of the age/gender risk within a population, and differentiates payments to PHPs based on their enrolled population risk profile. Since DHHS has chosen to use the CDPS+Rx model to risk adjust the capitation rates, the rate cell structure does not necessitate as many age/gender splits.

The following subsections outline key considerations, methodology and recommendations for structuring the Standard Plan rate cells.

Methodology

To evaluate rate cell recommendations, Mercer reviewed summarized historical cost and utilization data for the Medicaid and NC Health Choice programs. This data summarization included FFS claims experience for services covered under DHHS' FFS program, as well as encounter data for BH services covered under the Medicaid BH managed care program currently operated by the LME/MCOs. The data was initially evaluated based on detailed population, age and regional breakouts.

Mercer weighed a number of factors when developing the rate cell recommendations, such as:

- Rate cell groupings should be developed by grouping populations with similar cost profiles together.
- Rate cells must contain a credible number of MMs to be able to mitigate volatility to help control predictability of expenses. More rate cells may better match payment to risk, but may be more difficult administratively and some rate cells may lack credibility.
- Fewer rate cells simplifies the rate-setting and payment processes and increases credibility, but may not do as good of a job matching payment to risk as each rate cells has a broader range of members.
- Risk adjustment helps reduce the number of rate cells needed as the risk adjustment process captures age/gender factors.
- Rate cells may, but are not required to, consider the unique characteristics and services available to certain populations.
- Rate cells are easier to operationalize if they rely on data readily available on administrative or eligibility records. For example, populations requiring a qualifying diagnosis or level of care assessment may be more administratively difficult for DHHS to operationalize on an ongoing basis.

Additionally, Mercer reviewed ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification) to understand acceptable factors used to establish distinct rate cells. Specifically, section 3.2.2 of ASOP 49 provides guidance for the structure of Medicaid managed care capitation rates by rate cell developed to account for material cost differences. Examples of reasonable rate cell characteristics, outlined in ASOP 49, include: age, gender, qualifying event (e.g., maternity delivery), geographic region, Medicaid eligibility group, eligibility for Medicare benefits, diagnosis or risk adjustment factors. In the recommendations outlined below

for the Standard Plan population, Mercer focused on the following: Medicaid eligibility group, age, qualifying event and geographic region.

Population Rate Cell Recommendations

Historical data was summarized by population and age group for beneficiaries covered under the Standard Plan. Mercer first reviewed the cost volatility, cost differential and membership levels on a statewide basis for various population/age splits.

Mercer also reviewed other state rate cell structures to understand industry standards and also considered how risk adjustment would help account for any cost differentials by population. As a reminder, the risk adjustment model assigns cost weights by gender, age and also based on certain disease prevalence. Since the risk adjustment model will be calibrated to North Carolina's specific experience, certain cost differences amongst age bands (e.g., the ABD adult PMPM is more than twice the ABD child PMPM) may be accounted for through the risk adjustment process.

Given that DHHS has chosen to risk adjust the capitation rates, Mercer recommended reducing the number of population/age delineations since there is not a large population difference (other than for ABD) and much of the cost differential associated with age breakouts will be captured under the risk adjustment model. As such, Mercer recommended the following four rate cells plus the Maternity Event payment.

See below for observations used to determine the necessary level of detail to retain in the rate cell structure.

The ABD population is much more costly than TANF, NC Health Choice and M-CHIP (ABD costs are more than five times the total PMPM cost for other Standard Plan populations). Additionally, there is a separate risk adjustment model for the TANF and ABD population. As such, Mercer recommended a separate ABD rate cell.

ABD observations:

- When looking closer at the ABD population, there is a clear cost differential between the newborn, child and adult group. However, recall that the risk adjustment model will calibrate the cost weights for the defined age/gender splits in the model and will thus account for the differential. As a point of reference, Mercer reviewed average risk scores from another state Medicaid program by age/gender band for the ABD non-dual population. Mercer observed that cost weights from other state experience mirror some of the differential observed in the North Carolina experience. Mercer expects the calibration of risk scores to the North Carolina data will result in more alignment of the risk scores to the differential child and adult costs in the North Carolina ABD population.
- Specific to ABD newborn beneficiaries, in some years these beneficiaries have costs more than three times that of the child and adult ABD age groups. However, this group is highly volatile year over year. What's more, ABD newborn beneficiaries make up less than 1.0% of the ABD population and less than 0.1% of the total Standard Plan membership. As such, Mercer recommended blending the ABD newborns with the rest of the ABD population.

TANF and Other Related Children/Adult observations:

- The TANF newborn population has a substantial membership base (approximately 900,000), with steady PMPMs year over year. However, costs are over three times the cost of TANF children (1-20). Thus, given TANF newborns are more costly and have a robust membership base, Mercer recommended a separate TANF newborn rate cell.
- For the remaining child (1-20 population), Mercer recommended combining the TANF, NC Health Choice and M-CHIP population into a single rate cell. In the base experience, NC Health Choice and M-CHIP are within +5.0% of the TANF child PMPM. Using a similar risk adjustment analysis as described above, Mercer observes the risk scores for these populations are also similar.
- The remaining Medicaid population is exclusively TANF adults; as such, Mercer recommended a separate rate cell for the TANF adult (21+ population).

As previously discussed, DHHS will make a Maternity Event payment alongside the monthly capitation payment. Maternity Event payments help to align payment to risk. Deliveries are expensive, and prospective risk adjustment models are generally designed to reflect costs associated with chronic conditions, not pregnancy. As a result, in risk adjusted payment models, event payments are often used to mitigate the risk that any PHP has a disproportionate number of enrollees with maternity expenses.

Regional Rate Cell Recommendations

DHHS has defined six PHP regions (see Section 3, Figure 1). For the Standard Plan population each region has over 1.7 million MMs; review of the six regional/rate cell combinations also shows a credible number of MMs to be able to mitigate volatility to help control predictability of expenses. The capitation rates provided in this Draft Rate Book reflect the six PHP regions. However, as a part of final capitation rate development, Mercer will evaluate further regional breakouts that may be necessary due to meaningful cost and utilization variances within certain regions beyond those addressed through rate cells and risk adjustment.

APPENDIX D — CATEGORY OF SERVICE CRITERIA

The following tables represent the mapping logic used to define the detailed COS. The FFS data detailed COS logic is based on a combination of claim type and State-defined categories based on provider taxonomy. The encounter data detailed COS logic is based on logic defined and used for the development of the LME/MCO capitation rates. The COS groups are assigned in a hierarchy, as outlined in the tables below. Note that this list includes a comprehensive assignment of all COS, and is not limited to those covered under the Standard Plan.

Excluded Services

COS Description	Data Source	Coding Logic
Capitation	FFS	Claim_Type '4' This excludes the following capitation payments: MedSolutions, PACE, BH LME Capitation, Innovations LME Capitation
Dental	FFS	Claim_Type 'D' OR (Procedure codes with first character 'D', but NOT [(D0145 OR D1206) AND not claim type D])
Local Education Agency	FFS	Claim_Type '0'
Children's Developmental Services Agencies	FFS	Claim_Type 'V'
Excluded Optical Services (Eyeglasses and Fittings)	FFS	Billing Provider NPI = 1376576777 (Nash Optical Lab) OR Procedure Codes = 92340, 92341, 92342, 92353, 92370
Excluded PCMH Payments	FFS	Claim_Type 'M' AND not identified as an included PCMH Payment below

Covered Services

COS Description	COS Detailed Description	Data Source	Coding Logic
Included PCMH Payments	Medical Home Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is Null AND paid amount is: $1.00 OR $2.50 OR $5.00
	OBCM Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is NOT Null AND paid amount is: $4.96 or $4.71
	CC4C Payments	FFS	Claim_Type 'M' AND BILL_PRVDR_ATYP_NPI is NOT Null AND -For all months: paid amount is $4.56 -For only September 2015: paid amount $4.56 or $4.33
Therapies	Therapies	FFS	Claim_type '2'
Dental (limited)	Dental (limited)	FFS	Procedure codes D0145 OR D1206, when billed without claim type 'D'
Inpatient — PH	Inpatient — PH	FFS	[State COS = 0015 (HOSP INPT-GENERAL) OR 0019 (HOSP INPT-SPECIALITY) OR 0051 (HOSP INPT-GEN XOVERS) OR 0040 (HOSP INPT-INDIAN)]
Inpatient — BH	Inpatient — BH	LME/MCO Encounters	Revenue code 101–182, 184–219
Emergency Room	Emergency Room	FFS	Revenue code 0450 - 0459 OR CPT codes 99281 - 99285 State COS = 0050 (HOSP OUTPT-EMER. ROOM) Note: If claim has Inpatient bill type, dollars should be assigned to Inpatient regardless of Emergency Room revenue code or Emergency Room State COS.
		LME/MCO Encounters	Revenue code 0450 - 0459 OR CPT codes 99281 - 99285 Note: If claim has Inpatient bill type, dollars should be assigned to Inpatient regardless of Emergency Room revenue code.

COS Description	COS Detailed Description	Data Source	Coding Logic
Outpatient Hospital — PH	Outpatient Hospital — PH	FFS	[State COS = 0016 (HOSP OUTPT-GENERAL) OR 0045 (HOSP OUTPT-SPECIALITY) OR 0048 (AMBULATORY SURG CENTER) OR 0052 (HOSP OUTPT-GEN XOVERS) OR 0042 (HOSP OUTPT-INDIAN)]
Outpatient Hospital — BH	Outpatient Hospital — BH	LME/MCO Encounters	Procedure codes 90785, 90791, 90792, 90801–90899, 96100, 96101, 96110, 96111, 96115–96118, G0431, G0434, H0001, H0002, H0004, H0005, H0010, H0012–H0015, H0020, H0031, H2035, Q3014, S9485, T1023, covered E/M codes (99xxx) or Revenue codes 450–459, 900–910, 912–918
LTSS — ICF/IID and Nursing Home	ICF/IID	FFS	State COS = 0021 (LTC-ICF MRC, SO) OR 0047 (LTC-ICF MRC, NSO)
		LME/MCO Encounters	Revenue code 100 or 183
	Nursing Home	FFS	State COS = 0020 (LTC-ICF SO AND NSO) OR 0022 (NF-ICF SWING BEDS) OR 0035 (LTC-SNF SO AND NSO) OR 0036 (NF-SNF SWING BEDS) OR 0039 (NF-INDIAN HEALTH) OR 0049 (HOSP LONG TERM CARE) OR 0071 (NF-HEAD LEVEL OF CARE) OR 0072 (NF-VENT LEVEL OF CARE)
Other BH Services	Psychiatric Residential Treatment Facility (PRTF)	FFS	State COS = 0017 (HOSP INPT-MTL,SO < 21) OR 0041 (HOSP INPT-MTL,NSO < 21)
		LME/MCO Encounters	Revenue code 911 or 919
	Other BH Services	FFS	State COS = 0070 (PRACTITIONER-NON PHYS) OR 0084 (HIGH RISK INTERVENTION)
	Assertive Community Treatment (ACT)	LME/MCO Encounters	Procedure code H0040
	Community Support	LME/MCO Encounters	Procedure code H0036, [H2015 AND COA other than Innovations]
	Crisis Services	LME/MCO Encounters	Procedure code S9484, [H2011 AND COA other than Innovations]
	Intensive In-Home Services (IIHS)	LME/MCO Encounters	Procedure code H2022
	Multisystemic Therapy (MST)	LME/MCO Encounters	Procedure code H2033
	Outpatient (including psychotherapy and limited alcohol/drug services)	LME/MCO Encounters	Procedure codes 90785, 90791, 90792, 90801–90899, 96100, 96101, 96110, 96111, 96115–96118, G0431, G0434, H0001, H0002, H0004, H0005, H0010, H0012–H0015, H0020, H0031, H2035, Q3014, S9485, T1023, covered E/M codes (99xxx) or Revenue codes 450–459, 900–910, 912–919
	Partial Hosp/Day Tx	LME/MCO Encounters	Procedure code H0035, H2012
	Psych Rehab	LME/MCO Encounters	Procedure code H2017
	BH Long-term Residential	LME/MCO Encounters	Procedure code H0019, H0046, H2020, S5145

COS Description	COS Detailed Description	Data Source	Coding Logic
Physician — Primary Care	Physician — Primary Care	FFS	State COS = 0027 (PHYSICIAN) AND Taxonomy_Codes = 207Q00000X, 207RA0000X, 208000000X, 2080A0000X, 208D00000X, 363A00000X, 363L00000X, 363LF0000X
Physician — Specialty	Physician — Specialty	FFS	State COS = 0027 (PHYSICIAN) without the taxonomy restriction on Physician Primary Care.
FQHC/RHC	FQHC/RHC	FFS	State COS = 0006 (CLINICS-RURAL HEALTH) OR 0061 (HEALTH CHECK-RURAL HLT) OR 0065 (CLINICS-FQHC,CORE&AMB) OR 0067 (HEALTH CHECK-FQHC) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND Claim_Type '5' (RURAL HLTH CLINIC / FEDERALLY QUALIFIED HLTH CNTR)]
Other Clinic	Free-standing Clinics/Health Check — Health Department	FFS	State COS = 0002 (CLINICS-FREE STANDING) OR 0003 (CLINICS-HEALTH DEPT) OR 0033 (HEALTH CHECK-HLTH DEPT) OR 0034 (HEALTH CHECK-OTHR PROV) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND NOT (Claim_Type '3' (INSTITUTIONAL AMBULANCE) OR Claim_Type 'T' (AMBULANCE (PROFESSIONAL)))]
	Family Planning Services	FFS	State COS = 0010 (FAMILY PLAN-HOSP INPT) OR 0011 (FAMILY PLAN-HOSP OUTPT) OR 0012 (FAMILY PLAN-PHYSICIAN) OR 0024 (FAMILY PLAN-STERILIZATION) OR 0031 (FAMILY PLAN-DRUGS) OR 0037 (FAMILY PLAN-RURAL HLTH) OR 0038 (FAMILY PLAN-HLTH DEPT) OR 0066 (FAMILY PLAN-FQHC)
Other Practitioner	Other Practitioner	FFS	State COS = 0028 (CHIROPRACTIC) OR 0046 (PODIATRY)
Case Management	Case Management	FFS	State COS = 0062 (CASE MANAGEMENT-FSO) OR 0081 (CASE MANAGEMENT-HIV)
LTSS — State Plan Home and Community Based Services (HCBS)	Home Health	FFS	State COS = 0014 (HOME HEALTH) OR 0026 (HOME HEALTH-INDIAN) OR 0059 (HOME INFUSION THERAPY)
	Personal Care	FFS	State COS = 0053 (PERSONAL CARE)
	Hospice	FFS	State COS = 0060 (HOSPICE)
LTSS —HCBS Waiver Services	HCBS Services — FFS	FFS	State COS = 0055 (CAP-DISABLED) OR 0057 (CAP-CHILDREN) OR 0085 (CAP CHOICE)
	Innovations — Day Support	LME/MCO Encounters	Procedure code T2021, T2027
	Innovations — In-Home Services	LME/MCO Encounters	Procedure code H2015, T1015, T2013
	Innovations — Personal Care	LME/MCO Encounters	Procedure code S5125, T1019
	Innovations — Residential Supports	LME/MCO Encounters	Procedure code H2016, T2014, T2016, T2020, T2033
	Innovations — Respite	LME/MCO Encounters	Procedure code H0045, S5150, T1005
	Innovations — Supported Employment	LME/MCO Encounters	Procedure code H2023, H2025, H2026

COS Description	COS Detailed Description	Data Source	Coding Logic
	Innovations — Other	LME/MCO Encounters	Procedure code H2011, S5110, S5111, S5165, T1999, T2025, T2029, T2034, T2038, T2039, T2041 or [B4100–B4162 AND [age_group] = 21+]
	FFS Innovations Services	FFS	State COS = 0056 (CAP-MENTALLY RETARDED)
B3 Services	B3 Services	LME/MCO Encounters	Procedure code 99241 U4, 99242 U4, 99244 U4, H0038, S5151, T1012, H2022 U4, [(H0045, H2016, H2023, H2025-H2026, S5110, S5111, S5125, S5150, S5165, T1005, T1015, T1019, T2013, T2014, T2020, T2021, T2025, T2027, T2029, T2034, T2038, T2039 or T2041) AND COA other than Innovations]
Prescribed Drugs	Prescribed Drugs	FFS	State COS = 0032 (PRESCRIBED DRUGS)
Durable Medical Equipment	Durable Medical Equipment	FFS	State COS = 0013 (HEARING AIDS) OR 0054 (DURABLE MEDICAL EQUIP)
Optical	Optical	FFS	State COS = 0029 (OPTICAL SUPPLIES) OR 0030 (OPTICAL)
Lab and X-ray	Lab and X-ray	FFS	State COS = 0023 (LAB AND X-RAY)
Transportation	Transportation	FFS	State COS = 0001 (AMBULANCE) OR [SCOS 0073 (OTHER AMB CARE-INDIAN) AND (Claim_Type '3' (INSTITUTIONAL AMBULANCE) OR Claim_Type 'T' (AMBULANCE (PROFESSIONAL)))]
Transportation	NEMT	FFS	State COS = 0088 (TRANSPORTATION-COUNTY)

APPENDIX E — BH I/DD TAILORED PLAN CRITERIA

The criteria utilized to summarize beneficiaries eligible for the BH I/DD Tailored Plan is outlined below and is based on DHHS' initially proposed approach from the Fall of 2018. S.L. 2018-48 put forth additional criteria for BH I/DD Tailored Plan eligibility which will be evaluated and considered in final capitation rate development. All diagnosis codes provided in Appendix E will be reviewed for final rate development to ensure consistency with final program requirements.

Mercer identified beneficiaries eligible for a BH I/DD Tailored Plan by reviewing historical data for beneficiaries meeting the clinical criteria at least once during a SFY (July 1 through June 30). The Foster Children and Adopted Children, CAP/C, CAP/DA and NFLOC population groups were not categorized as BH I/DD Tailored Plan unless they were enrolled in the Innovations waiver. The clinical condition criteria are applied as a hierarchy such that beneficiaries only fall within one of the clinical condition categories in a given year. The following populations would be included in the BH I/DD Tailored Plan:

- I/DD
- Serious Emotional Disturbance (SED)/Serious and Persistent Mental Illness (SPMI)
- SUD

Beneficiaries enrolled in the TBI waiver and those with historical utilization of State-funded mental health services will also be eligible for BH I/DD Tailored Plans. However, the TBI waiver was not in effect during the base time period, so claims data for TBI waiver enrollees was not available. Additionally, the identification logic was limited to Medicaid and NC Health Choice claims data, and thus did not capture State-funded mental health service recipients. Children with complex needs, children ages 0 to 3 years old at risk for developmental delay or disability, and children/youth involved with the Division of Juvenile Justice of the Department of Public Safety who meet certain criteria may also be included in the BH I/DD Tailored Plans. However, these groups have not been separately identified for purposes of summarizing the BH I/DD Tailored Plan population at this time.

I/DD Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment. In order to identify qualifying beneficiaries, Mercer used the available claims and eligibility information to identify the I/DD group; specifically, beneficiaries were assigned if they met at least one of the following criteria:

- Innovations — Special Coverage Code of CM, C2 or IN (Innovations eligibility indicators).
- ICF/IID — FFS data claim type Q (Mental Health) and FFS COS 0021 (LTC-ICF MRC, SO) or 0047 (LTC-ICF MRC, NSO). Encounter data claim experience with revenue codes 100 (room and board, all-inclusive plus ancillary) or 183 (therapeutic leave) used by the LME/MCOs to reimburse for ICF/IID services.
- B3 — One or more claims falling under the B3 COS.
- Innovations Waitlist — Beneficiaries who were included on the waitlist for the Innovations waiver provided by DHHS.
- Transition to Community Living Initiative (TCLI) — Beneficiaries who were included on the TCLI roster provided by DHHS.
- Diagnosis — List of I/DD diagnosis codes (all diagnosis positions) supplied by DHHS.

A list of qualifying I/DD ICD-10 diagnosis codes supplied by DHHS is provided in the table below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

Code	Description	Code	Description
D82.10	Di George's syndrome	F84.90	Pervasive Developmental Disorder, Unspecified
E70.00	Classical phenylketonuria	F88.00	Other disorders of psychological development
E75.02	Tay-Sachs disease	F89.00	Unspecified disorder of psychological development
E75.19	Other Gangliosidosis	G31.81	Alpers disease

Code	Description	Code	Description
E75.23	Krabbe disease	G31.82	Leigh's Disease
E75.25	Metachromatic Leukodystrophy	G80.20	Spastic Hemiplegic Cerebral Palsy
E75.29	Other Sphingolipidosis	Q00.00	Anencephaly
E75.40	Neuronal ceroid lipofuscinosis	Q02.00	Microcephaly
E76.01	Hurler's syndrome	Q03.00	Malformations of aqueduct of Sylvius
E76.10	Mucopolysaccharidosis, type II	Q03.10	Atresia Of Foramina Of Magendie And Luschka
E76.22	Sanfilippo Mucopolysaccharidoses	Q03.80	Other congenital hydrocephalus
E76.29	Other Mucopolysaccharidoses	Q05.40	Unspecified Spina Bifida With Hydrocephalus
E76.30	Mucopolysaccharidosis, unspecified	Q05.80	Sacral spina bifida without hydrocephalus
E77.10	Defects In Glycoprotein Degradation	Q07.02	Arnold-Chiari Syndrome with Hydrocephalus
E78.71	Barth syndrome	Q07.03	Arnold-Chiari Syndrome With Spina Bifida And Hydrocephalus
E78.72	Smith-Lemli-Opitz Syndrome	Q85.10	Tuberous sclerosis
F70.00	Mild intellectual disabilities	Q86.00	Fetal Alcohol Syndrome
F71.00	Moderate intellectual disabilities	Q87.10	Congenital Malformation Syndromes with short stature
F72.00	Severe intellectual disabilities	Q87.20	Congenital Malformation Syndromes
F73.00	Profound intellectual disabilities	Q87.89	Congenital Malformation Syndromes
F78.00	Other intellectual disabilities	Q90.90	Down Syndrome, Unspecified
F79.00	Unspecified intellectual disabilities	Q91.30	Trisomy 18, unspecified
F84.00	Autistic Disorder	Q91.70	Trisomy 13, unspecified
F84.20	Rett's Syndrome	Q93.40	Deletion of short arm of chromosome 5
F84.30	Other childhood disintegrative disorder	Q98.40	Klinefelter syndrome, unspecified
F84.50	Asperger's Syndrome	Q99.20	Fragile X Chromosome
F84.80	Other Pervasive Developmental Disorders		

SED (Ages 0-17.99) and SPMI (Ages 18+) Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment; beneficiaries needed to have accessed an enhanced BH service and were identified based on a list of diagnosis codes (primary diagnosis position) supplied by DHHS. SED is defined as being for individuals ages 0 to 17.99 and SPMI is defined as being for individuals ages 18+. A list of qualifying SED and SPMI ICD-10 diagnosis codes supplied by DHHS is provided in the table below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

SED Diagnosis Code List

Code	Description	Code	Description
F06.30	Mood disorder due to known physiological condition, unsp	F32.20	Major depressv disord, single epsd, sev w/o psych features
F06.31	Mood disorder due to known physiol cond w depressv features	F32.30	Major depressv disord, single epsd, severe w psych features
F06.32	Mood disord d/t physiol cond w major depressive-like epsd	F32.40	Major depressv disorder, single episode, in partial remis
F06.80	Oth mental disorders due to known physiological condition	F32.50	Major depressive disorder, single episode, in full remission
F09.00	Unsp mental disorder due to known physiological condition	F32.80	Other depressive episodes
F20.00	Paranoid schizophrenia	F32.90	Major depressive disorder, single episode, unspecified
F20.10	Disorganized schizophrenia	F33.00	Major depressive disorder, recurrent, mild
F20.20	Catatonic schizophrenia	F33.10	Major depressive disorder, recurrent, moderate
F20.30	Undifferentiated schizophrenia	F33.20	Major depressv disorder, recurrent severe w/o psych features

Code	Description	Code	Description
F20.50	Residual schizophrenia	F33.30	Major depressv disorder, recurrent, severe w psych symptoms
F20.81	Schizophreniform disorder	F33.40	Major depressive disorder, recurrent, in remission, unsp
F20.89	Other schizophrenia	F33.41	Major depressive disorder, recurrent, in partial remission
F20.90	Schizophrenia, unspecified	F33.42	Major depressive disorder, recurrent, in full remission
F22.00	Delusional disorders	F33.80	Other recurrent depressive disorders
F23.00	Brief psychotic disorder	F33.90	Major depressive disorder, recurrent, unspecified
F24.00	Shared psychotic disorder	F34.10	Dysthymic disorder
F25.00	Schizoaffective disorder, bipolar type	F34.80	Other persistent mood [affective] disorders
F25.10	Schizoaffective disorder, depressive type	F34.90	Persistent mood [affective] disorder, unspecified
F25.80	Other schizoaffective disorders	F39.00	Unspecified mood [affective] disorder
F25.90	Schizoaffective disorder, unspecified	F40.00	Agoraphobia, unspecified
F28.00	Oth psych disorder not due to a sub or known physiol cond	F40.01	Agoraphobia with panic disorder
F29.00	Unsp psychosis not due to a substance or known physiol cond	F40.02	Agoraphobia without panic disorder
F30.10	Manic episode without psychotic symptoms, unspecified	F40.10	Social phobia, unspecified
F30.11	Manic episode without psychotic symptoms, mild	F40.11	Social phobia, generalized
F30.12	Manic episode without psychotic symptoms, moderate	F40.80	Other phobic anxiety disorders
F30.13	Manic episode, severe, without psychotic symptoms	F41.00	Panic disorder without agoraphobia
F30.20	Manic episode, severe with psychotic symptoms	F41.10	Generalized anxiety disorder
F30.30	Manic episode in partial remission	F41.30	Other mixed anxiety disorders
F30.40	Manic episode in full remission	F41.80	Other specified anxiety disorders
F30.80	Other manic episodes	F41.90	Anxiety disorder, unspecified
F30.90	Manic episode, unspecified	F42.00	Obsessive-compulsive disorder
F31.00	Bipolar disorder, current episode hypomanic	F43.10	Post-traumatic stress disorder, unspecified
F31.10	Bipolar disord, crnt episode manic w/o psych features, unsp	F43.12	Post-traumatic stress disorder, chronic
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild	F44.89	Other dissociative and conversion disorders
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod	F50.00	Anorexia nervosa, unspecified
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe	F50.01	Anorexia nervosa, restricting type
F31.20	Bipolar disord, crnt episode manic severe w psych features	F50.02	Anorexia nervosa, binge eating/purging type
F31.30	Bipolar disord, crnt epsd depress, mild or mod severt, unsp	F50.20	Bulimia nervosa
F31.31	Bipolar disorder, current episode depressed, mild	F50.80	Other eating disorders
F31.32	Bipolar disorder, current episode depressed, moderate	F50.90	Eating disorder, unspecified
F31.40	Bipolar disord, crnt epsd depress, sev, w/o psych features	F63.10	Pyromania

Code	Description	Code	Description
F31.50	Bipolar disord, crnt epsd depress, severe, w psych features	F63.30	Trichotillomania
F31.60	Bipolar disorder, current episode mixed, unspecified	F63.81	Intermittent explosive disorder
F31.61	Bipolar disorder, current episode mixed, mild	F63.89	Other impulse disorders
F31.62	Bipolar disorder, current episode mixed, moderate	F84.00	Autistic disorder
F31.63	Bipolar disord, crnt epsd mixed, severe, w/o psych features	F84.50	Asperger's syndrome
F31.64	Bipolar disord, crnt episode mixed, severe, w psych features	F90.00	Attn-defct hyperactivity disorder, predom inattentive type
F31.70	Bipolar disord, currently in remis, most recent episode unsp	F90.10	Attn-defct hyperactivity disorder, predom hyperactive type
F31.71	Bipolar disord, in partial remis, most recent epsd hypomanic	F90.20	Attention-deficit hyperactivity disorder, combined type
F31.72	Bipolar disord, in full remis, most recent episode hypomanic	F90.80	Attention-deficit hyperactivity disorder, other type
F31.73	Bipolar disord, in partial remis, most recent episode manic	F90.90	Attention-deficit hyperactivity disorder, unspecified type
F31.74	Bipolar disorder, in full remis, most recent episode manic	F91.00	Conduct disorder confined to family context
F31.75	Bipolar disord, in partial remis, most recent epsd depress	F91.10	Conduct disorder, childhood-onset type
F31.76	Bipolar disorder, in full remis, most recent episode depress	F91.20	Conduct disorder, adolescent-onset type
F31.77	Bipolar disord, in partial remis, most recent episode mixed	F91.30	Oppositional defiant disorder
F31.78	Bipolar disorder, in full remis, most recent episode mixed	F91.80	Other conduct disorders
F31.81	Bipolar II disorder	F91.90	Conduct disorder, unspecified
F31.89	Other bipolar disorder	F94.10	Reactive attachment disorder of childhood
F31.90	Bipolar disorder, unspecified	F94.20	Disinhibited attachment disorder of childhood
F32.00	Major depressive disorder, single episode, mild	F98.80	Oth behav/emotn disord w onset usly occur in chldhd and adol
F32.10	Major depressive disorder, single episode, moderate	F99.00	Mental disorder, not otherwise specified

SPMI Diagnosis Code List

Code	Description	Code	Description
F20.81	Schizophreniform disorder	F32.10	Major depressive disorder, single episode, moderate
F20.90	Schizophrenia, unspecified	F32.20	Major depressv disord, single epsd, sev w/o psych features
F21.00	Schizotypal disorder	F32.30	Major depressv disord, single epsd, severe w psych features
F25.00	Schizoaffective disorder, bipolar type	F32.40	Major depressv disorder, single episode, in partial remis
F25.10	Schizoaffective disorder, depressive type	F32.90	Major depressive disorder, single episode, unspecified
F29.00	Unsp psychosis not due to a substance or known physiol cond	F33.00	Major depressive disorder, recurrent, mild
F31.00	Bipolar disorder, current episode hypomanic	F33.10	Major depressive disorder, recurrent, moderate

Code	Description	Code	Description
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild	F33.20	Major depressv disorder, recurrent severe w/o psych features
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod	F33.30	Major depressv disorder, recurrent, severe w psych symptoms
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe	F33.41	Major depressive disorder, recurrent, in partial remission
F31.20	Bipolar disord, crnt episode manic severe w psych features	F33.90	Major depressive disorder, recurrent, unspecified
F31.31	Bipolar disorder, current episode depressed, mild	F40.00	Agoraphobia, unspecified
F31.32	Bipolar disorder, current episode depressed, moderate	F41.00	Panic disorder without agoraphobia
F31.40	Bipolar disord, crnt epsd depress, sev, w/o psych features	F41.10	Generalized anxiety disorder
F31.50	Bipolar disord, crnt epsd depress, severe, w psych features	F42.00	Obsessive-compulsive disorder
F31.73	Bipolar disord, in partial remis, most recent episode manic	F43.10	Post-traumatic stress disorder, unspecified
F31.75	Bipolar disord, in partial remis, most recent epsd depress	F44.00	Dissociative amnesia
F31.81	Bipolar II disorder	F44.10	Dissociative fugue
F31.89	Other bipolar disorder	F44.81	Dissociative identity disorder
F31.90	Bipolar disorder, unspecified	F44.89	Other dissociative and conversion disorders
F32.00	Major depressive disorder, single episode, mild	F44.90	Dissociative and conversion disorder, unspecified

SUD Criteria

This group will be eligible for the BH I/DD Tailored Plan, and exempt from Standard Plan enrollment; beneficiaries needed to have accessed an enhanced BH service and were identified based on a list of diagnosis codes (primary diagnosis position) supplied by DHHS along with beneficiaries with a qualifying SUD drug claim. A list of qualifying SUD ICD-10 diagnosis codes supplied by DHHS for both non-severe and dependence-level conditions is provided in the tables below. These diagnoses will be reviewed for final rate development for consistency with final program requirements.

SUD Non-Severe Diagnosis Code List

Code	Description	Code	Description
F10.10	Alcohol abuse, uncomplicated	F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F10.121	Alcohol abuse with intoxication delirium	F13.231	Sedatv/hyp/anxiolytc dependence w withdrawal delirium
F10.221	Alcohol dependence with intoxication delirium	F13.232	Sedatv/hyp/anxiolytc depend w w/drawal w perceptual disturb
F10.231	Alcohol dependence with withdrawal delirium	F13.239	Sedatv/hyp/anxiolytc dependence w withdrawal, unsp
F10.232	Alcohol dependence w withdrawal with perceptual disturbance	F14.10	Cocaine abuse, uncomplicated
F10.239	Alcohol dependence with withdrawal, unspecified	F14.23	Cocaine dependence with withdrawal
F10.921	Alcohol use, unspecified with intoxication delirium	F15.10	Other stimulant abuse, uncomplicated
F11.10	Opioid abuse, uncomplicated	F15.23	Other stimulant dependence with withdrawal
F11.120	Opioid abuse with intoxication,	F15.929	Other stimulant use, unsp with intoxication,

Code	Description	Code	Description
	uncomplicated		unspecified
F11.129	Opioid abuse with intoxication, unspecified	F15.93	Other stimulant use, unspecified with withdrawal
F11.23	Opioid dependence with withdrawal	F16.10	Hallucinogen abuse, uncomplicated
F11.90	Opioid use, unspecified, uncomplicated	F17.203	Nicotine dependence unspecified, with withdrawal
F11.93	Opioid use, unspecified with withdrawal	F18.10	Inhalant abuse, uncomplicated
F12.10	Cannabis abuse, uncomplicated	F19.10	Other psychoactive substance abuse, uncomplicated
F12.288	Cannabis dependence with other cannabis-induced disorder	F19.231	Oth psychoactive substance dependence w withdrawal delirium
F12.90	Cannabis use, unspecified, uncomplicated	F19.239	Oth psychoactive substance dependence with withdrawal, unsp

SUD Dependence-Level Diagnosis Code List

Code	Description	Code	Description
F10.20	Alcohol dependence, uncomplicated	F19.220	Oth psychoactive substance dependence w intoxication, uncomp
F11.20	Opioid dependence, uncomplicated	F19.24	Oth psychoactive substance dependence w mood disorder
F12.20	Cannabis dependence, uncomplicated	F19.259	Oth psychoactv substance depend w psychotic disorder, unsp
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	F19.26	Oth psychoactv substance depend w persist amnestic disorder
F14.20	Cocaine dependence, uncomplicated	F19.280	Oth psychoactive substance dependence w anxiety disorder
F15.20	Other stimulant dependence, uncomplicated	F19.281	Oth psychoactive substance dependence w sexual dysfunction
F16.20	Hallucinogen dependence, uncomplicated	F19.282	Oth psychoactive substance dependence w sleep disorder
F18.20	Inhalant dependence, uncomplicated	F19.288	Oth psychoactive substance dependence w oth disorder
F19.20	Other psychoactive substance dependence, uncomplicated	F19.29	Oth psychoactive substance dependence w unsp disorder
F19.21	Other psychoactive substance dependence, in remission		

APPENDIX F — BH I/DD TAILORED PLAN POPULATION

Pursuant to S.L. 2015-245, as amended, DHHS will contract with BH I/DD Tailored Plans for individuals with high BH needs. The BH I/DD Tailored Plans are expected to launch no sooner than one year after the implementation of Standard Plans. The majority of Medicaid and NC Health Choice beneficiaries, including adults and children with lower BH needs, will receive services through the Standard Plan upon launch of managed care. Prior to launch of the BH I/DD Tailored Plans, individuals with higher BH needs that meet certain eligibility criteria will continue to receive coverage through their current delivery system, and have the option to enroll in a Standard Plan. Following launch of the BH I/DD Tailored Plans, eligible beneficiaries will be enrolled into the BH I/DD Tailored Plans with the option to enroll in a Standard Plan. Please see the Behavioral Health and Intellectual/Developmental Disability Tailored Plan Medicaid Managed Care Proposed Concept Paper, released on November 9, 2017 for additional information on the proposed BH I/DD Tailored Plan design.[22] Additional information is included in S.L. 2018-48 legislation. Information outlined below does not reflect legislative changes made during the 2018 session.

Population Eligible for BH I/DD Tailored Plan

Detailed logic used for identifying the population eligible for BH I/DD Tailored Plans that were excluded from the Standard Plan population for purposes of draft rate development is outlined in Appendix E. This logic will be reviewed for final rate development for consistency with final program requirements.

The tables below illustrate the PMPM and average monthly member count for the Standard Plan population, as well as various sub-populations of the BH I/DD Tailored Plan group. The BH I/DD Tailored Plan columns are also summarized by Standard Plan rate cells to illustrate what population group these members would be included in if they opt out of the BH I/DD Tailored Plan (or their current delivery system prior to BH I/DD Tailored Plan launch). Approximately 10.0% of the I/DD population represents Innovations waiver participants and ICF/IID users who are not expected to opt out of the BH I/DD Tailored Plan as these services will only be available through the BH I/DD Tailored Plan. These individuals are included in the I/DD figures below.

Standard Plan and Non-Dual BH I/DD Tailored Plan Population PMPM Summary (based on SFY 2017 experience)

		BH I/DD Tailored Plan Population			
COA	Standard Plan Population	I/DD	SPMI/SED	SUD	Total BH I/DD Tailored Plan Population
ABD	$993.02	$2,707.27	$2,314.62	$1,643.31	$2,594.58
TANF, Newborn (<1)	$388.12	$2,146.91	$2,064.69	$1,786.54	$2,146.65
TANF, Child (1-20)	$110.47	$666.82	$1,666.39	$499.46	$1,013.98
TANF, Adult (21+)	$292.20	$1,211.15	$1,257.40	$893.45	$1,069.22
Maternity Event	$4,991.76	$8,822.83	$8,198.65	$6,356.14	$7,466.61
Total	$240.91	$1,942.30	$1,829.09	$1,070.28	$1,831.13

Standard Plan and Non-Dual BH I/DD Tailored Plan Population Average Monthly Member Count

		BH I/DD Tailored Plan Population			
COA	Standard Plan Population	I/DD	SPMI/SED	SUD	Total BH I/DD Tailored Plan Population
ABD	132,816	33,330	7,062	1,870	42,262
TANF, Newborn (<1)	70,808	1,289	2	1	1,292
TANF, Child (1-20)	1,111,653	19,237	10,962	920	31,118
TANF, Adult (21+)	242,395	2,032	3,435	5,318	10,785
Maternity Event	4,456	30	39	62	130
Total	1,557,672	55,888	21,460	8,108	85,456

[22] Behavioral Health and I/DD Tailored Plan Concept Paper. November 9, 2017. https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQSrSwWPrqi41aVP

As shown above, the non-dual BH I/DD Tailored Plan population assumed for draft capitation rate development is approximately eight times costlier, on a per member basis, compared to the Standard Plan population. When narrowing this comparison to non-I/DD non-dual BH I/DD Tailored Plan members, this sub-population is approximately seven times costlier, on a per member basis, compared to the Standard Plan population. However, it is important to note that overall the Standard Plan has a significantly larger membership base. The total non-dual BH I/DD Tailored Plan population exempt from Standard Plan enrollment represents approximately 5.5% of the total combined Standard Plan and non-dual BH I/DD Tailored Plan members on a statewide basis.

Standard Plan Beneficiaries Demonstrating Potential Need for BH I/DD Tailored Plans

Beneficiaries who are enrolled in a Standard Plan will have the ability to opt in to the BH I/DD Tailored Plan (or FFS and LME/MCO prior to the launch of the BH I/DD Tailored Plans) if they demonstrate a need for a service offered only through the BH I/DD Tailored Plan (or LME/MCO). Given the potential for individuals to shift between the Standard Plan and BH I/DD Tailored Plan, Mercer will continue to evaluate the cost profiles of these different populations to understand potential impact to capitation rates. No considerations have been made in the draft rates for any shifting expectation. Mercer and DHHS will continue to discuss this issue and may incorporate consideration into risk adjustment or an adjustment into final rate development.

Information related to the BH I/DD Tailored Plan population does not reflect legislative changes made during the 2018 session.

APPENDIX G – APPROACH TO MEDICAID HOSPITAL PAYMENTS AFTER THE TRANSITION TO MANAGED CARE

North Carolina's Department of Health and Human Services (DHHS) and North Carolina hospitals, working through the North Carolina Hospital Association (NCHA), participated in a collaborative process to develop an approach to non-behavioral health-related hospital payments as part of the State's transition to managed care.[23] The table below outlines the approach agreed to by all parties, which will be incorporated in the final PHP rate-setting methodology.[24]

Key Issue	Approach
Hospital payment rate floors under managed care	• Require PHPs to reimburse hospitals no less than the applicable Medicaid fee-for-service (FFS) rate, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology, for the following durations: o Five contract years to all critical access hospitals and all hospitals located in economically distressed counties as defined by the Department. o Three contract years to all other hospitals.
Inpatient payment methodology	• Each hospital assigned unique DRG base rate that applies in Medicaid FFS and serves as the basis for rate floor under managed care[25]. o Base rate calculated to ensure all hospitals in a class of providers receive the same portion of total inpatient Medicaid and uninsured costs covered; base rate for hospitals owned by UNC Health Care and for Vidant Medical Center set according to same methodology o Inpatient base rates for critical access hospitals (CAHs) calculated to approximate each CAH's current FFS per-discharge reimbursement • The rate floor for PHPs includes Medicaid case weights and outlier methodologies used in calculating inpatient payments to hospitals under FFS. • Each hospital's DRG base rate will be increased annually by the Medicare inpatient hospital PPS market basket update less the productivity adjustment, as published in the Medicare Hospital Inpatient

[23] Hospitals currently negotiate behavioral health reimbursement with LME/MCOs and will continue to negotiate behavioral health reimbursement with PHPs after the managed care transition. Additionally, the FFS reimbursement methodology for behavioral health claims will remain unchanged.
[24] Note that many categories include special treatment for hospitals owned by UNC Health Care and for Vidant Medical Center in order to maintain current net payment levels and reflecting the fact that these hospitals have historically been treated differently under fee-for-service Medicaid.
[25] Hospital rate floor requirements are prescribed in the PHP contract.

Key Issue	Approach
	Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (called "Medicare market basket update minus productivity adjustment" throughout remainder of document)[26] • PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain current net payment levels (in combination with other payments).
Outpatient payment methodology	• Each hospital paid defined percentage of charges that approximates 100% of outpatient costs • Applies in Medicaid FFS and serves as the rate floor under managed care[27]. • For purposes of the outpatient payment methodology, charges will not be permitted to increase by more than the Medicare market basket update minus productivity adjustment. • PHPs make additional, utilization based, directed payments to hospitals owned by UNC Health Care and Vidant Medical Center to maintain current net payment levels and in combination with other payments).
Graduate Medical Education	• DHHS will make Medicaid GME payments directly to hospitals; GME payments excluded in developing hospital-specific inpatient DRG base rates (see above) • Direct graduate medical education payments (DGME) calculated using statewide per-resident average of salary/fringe benefit costs, multiplied by each hospital's number of residents (not subject to Medicare resident caps) and adjusted for hospital's share of Medicaid days o For UNC Hospitals and Vidant Medical Center (as the primary affiliated teaching hospitals for each University of North Carolina medical school), DGME payments will be calculated using hospital-specific fully-loaded salary/fringe benefit costs, multiplied by each hospital's number of residents and adjusted for hospital's share of Medicaid days • Indirect medical education (IME) calculated using Medicare formula (excluding Medicare resident caps), multiplied by each hospital's number of Medicaid discharges and CMI o UNC Hospitals and Vidant Medical Center will calculate IME according to the same

[26] "Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule," available at: https://www.federalregister.gov/documents/2017/08/14/2017-16434/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. CMS also tracks quarterly changes in the market basket update. The Final Rule incorporates this data in setting the annual market basket update. Quarterly market basket data is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

[27] Hospital rate floor requirements are prescribed in the PHP contract.

Key Issue	Approach
	methodology • GME payment amounts to be recalculated annually.
Fee-for-Service	• Inpatient and outpatient payment methodologies listed above apply to FFS discharges/encounters. • Approach will lead to increased gross payments only for "crossover claims" (claims where Medicaid is secondary to Medicare or third-party coverage), since supplemental payments are not currently made on those claims. • Increase in provider assessment and/or IGTs will fund the non-federal share of additional payments, so this will not result in increased cost to the State.
MCHIP/NC Health Choice	• Inpatient and outpatient payment methodologies listed above apply to MCHIP and NC Health Choice discharges/encounters. • Approach will lead to increased gross payments, as supplemental payments are not currently paid on NC Health Choice population. • Increase in provider assessment/IGTs will fund non-federal share of additional payments, so this will not result in increased cost to the State.
Additional physician payment methodology for primary affiliated teaching hospitals for each University of North Carolina medical school	• DHHS to leverage current physician UPL payment methodology memorialized in state plan to extent possible; minor adjustments will be made to comply with managed care regulations and transition reimbursement to "directed payment" framework under 42 C.F.R. § 438.6(c).
Financing	<u>Provider Assessment</u>[28] • Establish two separate assessments: o Base assessment. Applies to qualified public hospitals (QPH) and non-qualified public hospitals (NPQH). o Supplemental assessment. Applies to NQPHs only. • Base assessment methodology. o Identify total amount collected under current UPL assessment. o Add non-federal share of crossover claims, incremental GME costs and enhanced NC Health

[28] Revisions to assessment methodology require legislative approval.

Key Issue	Approach
	Choice payments. o Divide amount by total hospital costs for all hospitals subject to the base assessment. • Supplemental assessment methodology. o Identify dollar amount collected under current equity assessment. o Divide amount by total hospital costs for all hospitals subject to the supplemental assessment. • State retains $140 million annually, trended annually based on the Medicare market basket index minus productivity adjustment, from assessment proceeds. Remainder of proceeds used to fund PHP capitation payments, Medicaid and CHIP FFS inpatient and outpatient hospital payments and GME payments. • State to recalculate assessment rates annually to account for changes in Medicaid hospital payments, GME slots, and Medicaid/CHIP federal matching rates, among other factors. • Hospitals currently exempt from the provider assessment under NC 108A-122 will remain exempt from the assessment under the new hospital payment plan. <u>Intergovernmental Transfers (IGTs)</u> • All hospitals that currently make IGTs will continue to make IGTs after the transition to managed care. • Aggregate IGT amounts will be calculated to approximate total IGTs made in the 2018 MRI/GAP plan, adjusted to account for increased crossover claims, incremental GME costs, enhanced NC Health Choice payments, and any other payment increases, and will be adjusted annually to account for changes in Medicaid hospital payments.