Amendment Number 13 (14)
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

THIS Amendment to the Prepaid Health Plan Services Contract #30-190029-DHB – PHP Name (Contract) awarded

February 4, 2019 and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PHP Name (Contractor), each, a Party and collectively, the Parties.

Background:

The purpose of this Amendment is to make clarifications, technical corrections and updates related to the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
II. Section V. Scope of Services;
III. Section VI. Contract Performance;
IV. Section VII. Attachments A – N; and
V. Section X. Sixth Revised and Restated Summary of Contractual Payments and Risk Sharing Terms.

The Parties agree as follows:

I. <u>Modifications to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections</u>

Specific subsections are modified as stated herein.

a. Section III. A. Definitions: The following Terms are revised and restated as identified herein:

i. **Clean Claim:** A claim submitted to a PHP by a service provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system (claims that will deny). It does not include a claim from a provider who is suspended or under investigation for fraud or abuse, or a claim under review for medical necessity. 42 C.F.R. § 447.45(b). Determination of whether a claim is clean rest with the Contractor and must be determined for each claim, provided applied consistently and reasonably. 85 FR 72754, 72819.

ii. **Designated Pilot Care Management Entity:** A Designated Care Management Entity that is assuming care management responsibilities specifically related to the Healthy Opportunities Pilot. Throughout this Contract, the Designated Pilot Care Management Entity may also be referred to as a "care management team."

iii. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a). In North Carolina, an IHCP is a provider of service which includes all services that Cherokee Indian Hospital Authority or the Eastern Band of Cherokee Indians offer under Medicaid.

iv. **Indian Managed Care Entity (IMCE):** Means an IMCE as defined by 42 C.F.R. § 438.14(a). In North Carolina, the IMCE is referred to as the Eastern Band of Cherokee Indian Tribal Option. It provides care management for all members enrolled in Tribal Option and is separate from the Indian Health Care Provider.

b. Section III. A. Definitions: The following newly defined terms are incorporated as stated herein:

i. **Interpersonal Violence (IPV)-Related Healthy Opportunity Pilot Services (IPV-Related Services):** Any services authorized to be furnished under the Healthy Opportunities Pilot to Members experiencing or at risk of experiencing interpersonal violence or other threats to personal safety, not only including services described in the Interpersonal Violence/Toxic Stress domain and the Cross-Domain categories of the Healthy Opportunities Pilot fee schedule, but also include any services in the Housing, Food, or Transportation domains set forth in the Healthy Opportunities fee schedule that are recommended to a Member to help address interpersonal violence.

ii. **IPV-Related Service Data:** Any authorizations, services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member.

iii. **IPV-Trained Individual:** All members of the PHP's workforce (including PHP's employees and contractors, whether or not they are Care Managers) with access to IPV-Related Service Data who have completed all Pilot-related IPV-trainings provided or approved in advance by the Department.

iv. **IPV-Related Data Training:** All relevant trainings, each as provided or approved in advance by the Department, prior to PHP's workforce initiating a Member contact or an initial Pilot assessment.

v. **Work Hour: Includes each traditional work hour of a Business Day.**

c. Section III.B. Acronyms is revised to add the following new acronym:

IPV: Interpersonal Violence

d. Section III.D. Terms and Conditions, 10. <u>COMPLIANCE WITH LAWS</u>, is revised and restated as follows:

<u>10. COMPLIANCE WITH LAWS:</u>

a. Contractor shall comply with all laws, ordinances, codes, rules, regulations, licensing requirements, electronic storage standards concerning privacy, data protection, confidentiality, and security that are applicable to the conduct of its business and performance in accordance with this Contract, including those of federal, State, NCDHHS, and local departments and agencies having jurisdiction and/or authority.

b. Contractor must include in its Subcontractor agreements an attestation clause that the Subcontractor must comply with all laws, rules, regulations, and licensing requirements applicable to Contractor's performance under this Contract, including but not limited to the applicable provisions of (a) Title XIX of the Social Security Act and Titles 42 and 45 of the Code of Federal Regulations; and (b) those laws, rules, or regulations of federal and State

agencies having jurisdiction over the subject matter of this Contract, whether in effect when this Contract is signed, or becoming effective during the term of this Contract.

c. Clean Air Act
   i. Contractor agrees to comply to the extent practicable with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.
   ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.
   iii. Contractor agrees to include these requirements in each Subcontractor Agreement.
d. Federal Water Pollution Control Act
   i. Contractor agrees to comply to the extent practicable with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.
   ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the federal agency providing funds hereunder, and the appropriate Environmental Protection Agency Regional Office.
   iii. Contractor agrees that these requirements will be included in each Subcontractor Agreement.
e. Pandemic, Endemic and Other North Carolina State Emergencies
   i. Contractor agrees to comply with all applicable standards, Executive Orders and Department issued guidance for pandemics, endemics, and other North Carolina State emergencies.
   ii. Notice shall be provided by the Department of the standards, orders and Department issued guidance prior to the Effective Date of the requirements, where practical.
   iii. In the event requirements are announced and made effective immediately, such as Executive Orders, the Contractor shall adhere to such requirements.
   iv. Contractor agrees to communicate to Subcontractors for compliance with all applicable standards, orders, and Department-issued guidance.

e. Section III.D. Terms and Conditions, 13.5. <u>CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY</u>, is revised and restated as follows:

13.5. <u>CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY</u>

Contractor shall make a good faith effort to recruit, train, promote, and retain a culturally and linguistically diverse governance, leadership, and workforce, who are responsive to the population in the service area, in accordance with applicable Federal and State law and CMS Guidelines.

To support the Department's vision on diversity, equity and inclusion, Contractor shall make a good faith effort to recruit, develop and retain a diverse workforce and encourage and promote an inclusive and equitable workplace, in accordance with Federal and State law.

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

e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments:

i. General Information

a) If the Contractor covers a Healthy Opportunities Pilot region, the Contractor shall receive, separate from capitation payments, the following funds from the Department to use for the Pilots, subject to availability of State funds:

1. Capped allocation which includes funding for two payment types:
    i. Pilot service delivery payments; and
    ii. Pilot administrative payments;
2. Pilot care management payments; and
3. Pilot value-based payments.

b) Contractor shall participate in the reconciliation of actual Pilot spending against Pilot payments received from the Department. Contractor shall be required to return all unused Pilot funds to the Department at the end of the Pilot program in accordance with the Department's Healthy Opportunities Pilot Payment Protocol.

ii. Capped Allocation

a) The Department will set an initial capped allocation amount for each Pilot Service Delivery Period as defined in the Department's Healthy Opportunities Pilot Payment Protocol.

b) The Department will notify Contractor of its capped allocation amount, including the amounts for Pilot service delivery payments and Pilot administrative payments, at least thirty (30) Calendar Days prior to the start of each Pilot Service Delivery Period.

c) The Department reserves the right to adjust Contractor's capped allocation during the Pilot Service Delivery Period based on actual spending on Pilot services or due to significant changes to enrollment from that assumed in the allocation formula (e.g., if the Department determines Contractor is at significant risk of not expending the eighty (80%) percent of its allocation within the Pilot service delivery year).

i. Before adjusting Contractor's capped allocation, the Department will inform Contractor within sixty (60) Calendar Days that it is at risk of an adjustment and allow Contractor to submit a report explaining its anticipated spending through the remainder of the Pilot Service Delivery Period for the Department's consideration. The Contractor shall submit this report within

ten (10) Calendar Days of being informed by the Department that it is at risk of an adjustment.

d) Pilot Service Delivery Payments
   1. The Department shall distribute monthly, prospective payments to Contractor from the Pilot service delivery payment component of its capped allocation.
   2. The Department shall distribute the first payment at least thirty (30) Calendar Days prior to Pilot Service Delivery Period.

e) Pilot Administrative Payments
   1. The Department shall distribute as part of Contractor's capped allocation Pilot administrative payments for Contractor to retain to cover administrative costs associated with Pilot operations.
   2. The Department shall determine the amount of Contractor's Pilot administrative payments.
   3. The Department shall distribute the Pilot administrative payment for each Pilot Service Delivery Period at a frequency as defined in the Department's Healthy Opportunities Pilot Payment Protocol.

iii. Pilot Care Management Payments:
   a) The Department shall make fixed payments to Contractor and Contractor shall make Pilot care management payments to Designated Pilot Care Management Entities as specified in *Section V.D.4. Provider Payments*. The Department will determine Pilot care management payments and document them in the Department's Healthy Opportunities Pilot Payment Protocol.

iv. Pilot Value-Based Payments:
   a) The Department will establish a Pilot-specific value-based payment (VBP) program.
   b) As provided in *Section V.I. 6. Healthy Opportunities Pilot Payments*, the Contractor will be eligible to receive separate Pilot-specific valued-based payments from the Department. Payment will be made after the Department has reviewed documentation of Contractor's performance against targets and benchmarks. The value-based payments made by the Department to Contractor will be subject to adjustments in accordance with the Department's assessment of Contractor's performance against specific targets and benchmarks to be detailed in the Department's Healthy Opportunities PHP Implementation Period Incentive Payments Milestone Guide.

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

Specific subsections are modified as stated herein.

a. Section V.A. Administration and Management, 1. Program Administration, h. Compliance with Department Policies i. is revised and restated as follows:

i. The PHP shall comply with Department policies as identified and required by the Department, including the following:

a) Medicaid Managed Care Enrollment Policy
b) Department Clinical Coverage Policies;
c) Transition of Care Policy;
d) Care Management Policy;
e) Advanced Medical Home Program Policy;
f) Care Management for High-Risk Pregnancy Policy;
g) Care Management for At-Risk Children Policy;
h) Management of Inborn Errors of Metabolism Policy;
i) Uniform Credentialing and Recredentialing Policy;
j) NC Non-Emergency Medical Transportation Managed Care Policy;
k) Advanced Medical Home Provider Manual;
l) Healthy Opportunities Pilot Care Management Protocol;
m) Healthy Opportunities Pilot Payment Protocol;
n) Healthy Opportunities Pilot Transitions of Care Protocol;
o) Healthy Opportunities Standard Plan Implementation Period Incentive Payments Milestone Guide;
p) Managed Care Clinical Supplemental Guidance;
q) PHP Member Advisory Committee Guidance; and
r) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions.

b. Section V.B. Members, 2. Medicaid Managed Care Enrollment and Disenrollment, f. is revised and restated to add the following:

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 period of two (2) months or less. 42 C.F.R. § 438.56(g). From September 27, 2022 through seventeen (17) months after the end of the COVID-19 Public Health Emergency, 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 ninety (90) days as allowed in under the Department's CMS approved waiver of Automatic Reenrollment into Medicaid Managed Care Plans as defined in section 1902(e)(14)(A) of the Social Security Act.

c. Section V.B. Members, 3. Member Engagement, o. Engagement with Consumers is revised to add the following:

v. The PHP shall adhere to the Department's PHP Member Advisory Committee Guidance.
vi. The PHP shall develop a Member Advisory Committee Charter in accordance with the Department's PHP Member Advisory Committee Guidance and submit to the Department for approval annually, and sixty (60) Calendar Days prior to any significant changes to the Charter.
vii. The PHP shall develop a Member Advisory Committee Recruitment Plan in accordance with the Department's PHP Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant change to the Plan.

d. Section V.B. Members, 3. Member Engagement, p. Engagement with Beneficiaries Utilizing Long Term Services and Supports is revised to add the following:

viii. The PHP shall adhere to the Department's PHP Member Advisory Committee Guidance.

ix. The PHP shall develop a LTSS Member Advisory Committee Charter in accordance with the Department's PHP Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Charter.

x. The PHP shall develop a LTSS Member Advisory Committee Recruitment Plan in accordance with Department's Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Plan.

e. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, i. and ii. is revised and restated as follows:

i. The PHP shall give the Member timely and adequate notice of an Adverse Benefit Determination in writing consistent with the notice content and timing requirements below and in 42 C.F.R. § 438.10. 42 C.F.R. § 438.404(a). The PHP shall give the 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.~~4~~210(c).

ii. Each Notice of Adverse Benefit Determination shall conform with 42 C.F.R. § 438.404(b), contain and explain:

a) Adverse Benefit Determination the PHP has made or intends to make. 42 C.F.R. § 438.404(b)(1);

b) The reasons for the Adverse Benefit Determination, 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 Benefit Determination 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).

f. Section V.B. Members, 6. Member Grievance and Appeals, d. Notice of Adverse Benefit Determination, v. Timing of the Notice of Adverse Benefit Determination, d) is revised and restated as follows:

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). A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a clean claim at 42 C.F.R. § 447.45(b) is not an adverse benefit determination. 42 C.F.R. § 438.400(b)(3).

g. Section V.B. Members, 6. Member Grievance and Appeals, f. State Fair Hearing Process is revised and restated as follows:

f. State Fair Hearing Process

i. PHP shall comply with Chapter 108D and 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. The PHP will designate an email address for receipt of Department communications regarding State Fair Hearings. The PHP will have a process in place to ensure that Department communications regarding expedited State Fair Hearing requests made pursuant to N.C. Gen. Stat. § 108D-15.1 are responded to as soon as possible and in no event later than nine (9) Work Hours from the timestamp of the Department's email communication. The PHP will respond to Department communications about standard State Fair Hearing requests per the requirement in *Section III.D.37 RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION*. The Department shall notify the PHP as expeditiously as possible, but no later than nine (9) Work Hours of any expedited State Fair Hearing request involving the PHP.

vii. The PHP will have a process in place to upload to the Department all documentation reviewed by the PHP in connection with the internal plan appeal. For expedited State Fair Hearing requests made pursuant to N.C. Gen. Stat. § 108D-15.1, the PHP will upload documentation as soon as possible and in no event later than nine (9) Work Hours from the timestamp on the Department communication requesting the documentation. For standard State Fair Hearing requests, the PHP will upload the requested documentation per the requirements laid out in *Section III.D.37 RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION*.

viii. Mediation

a) The PHP shall notify Members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.

b) The PHP shall inform Members that mediation is voluntary and that the Member is not required to request a mediation to receive a State Fair Hearing with OAH.
c) The PHP shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.

ix. 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).

h. Section V.C. Benefits and Care Management, Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services, is revised and restated in its entirety as Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services and attached to this Amendment as Attachment 1.

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

l) The PHP shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the PHP shall submit the attestation required by this Section annually, unless otherwise directed by the Department. The Department will conduct ad hoc reviews of the PHP's adherence to the attestation of compliance with UM and clinical coverage requirements on an ongoing basis. The PHP shall provide an analysis of their compliance with the attestation upon request as follows:
1. Within thirty (30) Business Days for routine requests; and
2. Within seven (7) Business Days for expedited requests.

j. Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, i. Dispensing Fees, b) is revised and restated as follows:

b) The PHP shall reimburse based on a flat dispensing fee defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).

k. Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, iv. is revised and restated as follows:

iv. Subject to Department review and approval, in Contract Year Two (2) or per Section 9D.19A. of Session Law 2021-180, whichever is later, 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.

l. Section V.C. Benefits and Management, 4. Transition of Care, e. Transition of Care for Members enrolled in the Healthy Opportunities Pilot is revised and restated as follows:

e. Transition of Care for Members enrolled in the Healthy Opportunities Pilot
   i. The PHP shall develop policies, processes, and procedures to support Pilot enrollees transitioning between PHPs, the Tribal Option and NC Medicaid Direct.
   ii. Pilot enrollees moving to another PHP, delivery system, or county not covered by the Healthy Opportunities Pilot:
      a) If the Member transitions to another PHP or delivery system and the Member's address remains in the same county or changes to another county covered by the Healthy Opportunities Pilot:
         1. Upon notification via the Department's standard eligibility file that a Pilot enrollee is transitioning to another PHP or the Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, the PHP or its Designated Pilot Care Management Entity shall provide Pilot-related information to the PHP or Tribal Option using a Transition of Care Assessment in NCCARE360 and through DHB's defined processes in the Healthy Opportunities Pilot Transition of Care Protocol, including:
            i. Pilot enrollment status;
            ii. Member consent documentation; and
            iii. Completed Pilot Eligibility and Service Assessment (PESA), including:
               a. Pilot-qualifying physical/behavioral health and social risk factor(s);
               b. Current and previously authorized Pilot services and duration of services (e.g., healthy food box for three (3) months);
               c. Documentation of Member's Pilot consents;
               d. Date of Pilot enrollment; and
               Payments made for Pilot services.
      b) The PHP shall end date its coverage of the Pilot enrollee and add the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, in NCCARE360. The end date shall be the later of the date of disenrollment from the PHP or the date of notification of retroactive disenrollment provided to the PHP by the Department via the Department's standard eligibility file.
      c) If the transition results in a change to the Member's care management team, the PHP shall:
         1. Inform the care management team of the change outside of NCCARE360. Care management teams will receive the notification via the Beneficiary Assignment file;

2. Ensure that medical records, including the Pilot information in the Member's Care Plan when available, is transferred to the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.
3. Ensure that the Member's care management team completes the Transition of Care Assessment and sends via a Transition of Care Referral Request in NCCARE360 to the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.

d) The PHP shall notify the Network Lead and HSO(s) of the change in PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, and where invoices for Pilot services for that Pilot enrollee should be routed.

e) The PHP shall bear the financial responsibility of authorized Pilot services that have been delivered to the Member while still enrolled with its PHP even if the associated invoice is received after the Member is no longer enrolled with the PHP.

f) The PHP shall bear the financial responsibility of a passthrough service and/or an authorized, one-time Pilot service (e.g., home modifications) which has been authorized and started while the Member is still enrolled with the PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members. Such services shall be considered non-transferrable to a receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.

g) If the PHP receives an invoice that is not within its payment responsibilities, as defined by the Department, the PHP shall deny the invoice, following existing Pilot invoice denial steps defined in the Healthy Opportunities Pilot Payment Protocol and the Healthy Opportunities Pilot NCCARE360 Invoice File(s) Companion Guides, and notify the receiving PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members, and Network Lead.

h) For Pilot enrollees transitioning to Medicaid Direct, the Tribal Option, in advance of launch of the Healthy Opportunities Pilot for Tribal Option Members, or to a county not covered by the Healthy Opportunities Pilots:
    1. The PHP shall end date its coverage of the Pilot enrollee in NCCARE360 to be the later of the date of disenrollment or notification of retroactive disenrollment provided by the Department via the Department's standard eligibility file.
    2. Within ten (10) Calendar Days of notification via the Department's standard eligibility file that a Pilot enrollee is transitioning to Medicaid Direct, the Tribal Option, in advance of the launch of Healthy Opportunities Pilot for Tribal Option Members, or to a county not covered by the Healthy Opportunities Pilots, the PHP shall inform the HSO(s) outside of NCCARE360 (e.g., by phone or through the HSO's Network Lead) of the date of disenrollment. The PHP shall bear the financial responsibility of authorized

Pilot services that have been delivered to the Pilot enrollee through the date of disenrollment or the date that the HSO was notified, whichever is later. The PHP will not be required to return pilot funding to the Department for authorized Pilot services delivered prior to the date of disenrollment.

3. If there are authorized services remaining on a referral on the date of disenrollment, the PHP shall work with the HSO(s) to close the case for those services and inform the HSO that those services are no longer reimbursable by Medicaid.

iii. Pilot enrollees enrolling in the PHP

a) The PHP shall ensure that Pilot enrollees who were receiving Pilot services authorized by the former PHP or Tribal Option, upon launch of the Healthy Opportunity Pilot for Tribal Option Members:

1. Continue receiving the services authorized by the former PHP or Tribal Option for up to ninety (90) Calendar Days from the time of enrollment with the PHP or until the authorized number or duration of current Pilot service expires, whichever comes first; and,
2. Are reassessed for ongoing Pilot eligibility and service mix within ninety (90) Calendar Days of transfer to the PHP.

b) The PHP shall accept the Transition of Care Assessment in NCCARE360 from the former PHP or Tribal Option, upon launch of the Healthy Opportunities Pilot for Tribal Option Members.

c) If the Member remains Pilot-enrolled and the transition results in a change to the Member's care management team, the PHP shall ensure that the Member has been assigned a new care management team that meets their needs and preferences and that is able to assume Pilot-related responsibilities. The PHP shall provide the new care management team with Pilot-related information from the Member's Care Plan.

1. If the Pilot enrollee will receive care management from a new Designated Pilot Care Management Entity, the PHP shall send the Transition of Care Assessment in NCCARE360 to the new Designated Pilot Care Management Entity.

d) If the Member remains Pilot-enrolled and will be managed by the existing Designated Pilot Care Management Entity, then the existing Designated Pilot Care Management Entity will send a new service authorization(s) to the PHP for services included in the Transition of Care Assessment. The PHP will follow the normal authorization process referenced in *Section V.C. 8.g.xxiv.f) Pilot Service Authorization.*

iv. Healthy Opportunities Pilot Continuation of Care

a) In an instance where an HSO that is providing Pilot services to a PHP's Members is terminated from the Network Lead's network, the PHP shall:

1. Ensure that the care management team at the Designated Pilot Care Management Entity identifies an alternative HSO in the Pilot network providing that service, if possible.
2. Work with the care management team to authorize the continuation of that services at the alternative HSO.

m. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xii., c) is revised and restated as follows:

c) The PHP shall ensure members can be identified as potentially Pilot-eligible via the following pathways:
   1. Care Needs Screening: The PHP shall undertake best efforts to conduct a Care Needs Screening of every Member within the first ninety (90) Calendar Days of the effective date of PHP enrollment as described in *Section V.C.6.a.v.a.1*.
   2. Population Health Management Capabilities: At least quarterly, the PHP shall proactively identify potential Pilot enrollees as part of their population health management capabilities and care management risk scoring and stratification processes, including through the following pathways:
      i. Claims/encounters data;
      ii. 834 files;
      iii. Admission, Discharge, Transfer (ADT) feed information;
      iv. Care management systems;
      v. Provider-reported Z codes;
      vi. Enrollment in other programs that may serve as a proxy for Pilot eligibility (e.g., care management for high-risk pregnancy or at-risk children); and
      vii. Other methods as available to each PHP.
   3. Existing Care Management/Coordination Team: The PHP shall ensure potentially-Pilot eligible members can be identified by their care manager during the administration of the Care Management Comprehensive Assessment or in the course of ongoing delivery of care management.
   4. No Wrong Door Approach: The PHP shall accept referrals for potentially Pilot eligible individuals identified through any pathway, including but not limited to a provider, Human Service Organization (HSO), or self/family member.

n. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot xxiii. a) 3. is revised and restated as follows:

3. Member must live in a Pilot region, as defined by Department and in Network Lead contracts. However, Members residing or receiving care in a congregate or institutional setting are not eligible for Pilot services, as specified in the Healthy Opportunities Pilot Care Management Protocol; and

o. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot xxiv. Pilot Eligibility and Service Assessment (PESA), c) is revised and restated as follows:

c) Assessing for Pilot Eligibility and Recommending Pilot Services

1. The PHP shall ensure that the Member's care management team uses NCCARE360 to:
   i. Assess and document a Member's Pilot program eligibility (based on the Pilot program eligibility criteria outlined in this Section), Pilot service-level eligibility outlined in the Healthy Opportunities Pilot Fee Schedule.
   ii. Recommend the Pilot services from the Fee Schedule that a Member would benefit from based on Member need and the Pilot services available in the Member's Pilot region.
   iii. Document, where appropriate, Member preferences for, and relationships with, particular HSOs.
   iv. Assess and document any changes to Member needs or services during the Member's three (3) month Pilot service mix review and six (6) month Pilot eligibility reassessment as required in *Section V.C.8. g.xxix Pilot Service Mix and Eligibility Reassessment.*
   v. Update any time there is a change to the Member's Pilot service needs or eligibility.
   vi. Transmit the PESA to the Member's PHP for eligibility and service authorization.

p. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot xxiv. Pilot Eligibility and Service Assessment (PESA), xxiv. Pilot Eligibility and Service Assessment (PESA), f) is revised and restated as following:

f) Pilot Service Authorization

1. Within NCCARE360, the PHP shall review the care management team's recommended Pilot services for a Member and verify whether the Member is eligible for the recommended Pilot service(s).
   i. The PHP shall verify that the Member meets the Pilot service-specific eligibility criteria as articulated in the Healthy Opportunities Pilot Fee Schedule.
   ii. The PHP shall review any required documentation or narrative for Pilot services in NCCARE360 if required by the Healthy Opportunities Pilot Fee Schedule (e.g., Member attestation of enrollment in SNAP or recent determination of SNAP ineligibility for a healthy food box).
   iii. The PHP shall make best efforts to validate that no other federal, State or local service, resource or program is available (including Medicaid State Plan services, Medicaid waiver services, or other resources or programs available to the Member, including those provided by the PHP) and would

better meet the Member's needs at the time of Pilot service authorization.

a) If a Member's need may be met by either an ILOS offered by the PHP or a Pilot service (i.e., the Pilot service is a component of the ILOS or the Pilot service and the ILOS essentially offer the same or substantially similar services) and the Member is eligible for both the ILOS and the Pilot service, the PHP shall provide the ILOS.

iv. The PHP shall make best efforts to validate that Pilot services do not displace or duplicate other services, resources or programs which are available to the Pilot enrollee.

2. Within NCCARE360, the PHP shall authorize or deny Pilot service(s) for the Member, as detailed in the Healthy Opportunities Pilot Care Management Protocol.
   i. The PHP shall take into account the care management team's recommendation(s), Member information on file with the PHP, and the PHP's remaining budget within the capped allocation of Pilot service funds when deciding whether to authorize or deny a Pilot service.
   ii. If NCCARE360 is missing information needed for Pilot service authorization, the PHP shall attempt at least three (3) times to obtain the missing information prior to denying services. If the Member has an assigned care management team, the PHP shall work with the care management team to attempt to obtain the missing information. If the Member does not have an assigned care management team, the PHP shall work with the Member or the Member's authorized representative to obtain the missing information.
   iii. Reserved.
   iv. Reserved.
3. The PHP shall document Pilot service authorization or denial in NCCARE360, along with rationale if the service(s) is denied.
4. The PHP shall adhere to Department-standardized timeframes for authorization or denial of all Pilot services in accordance with *Attachment M.13. Timeframes for Healthy Opportunities Pilot Service Authorization*.
5. In cases where the PHP denies a Pilot service, the PHP shall ensure that the Member's care management team continues care management or care coordination for the Member, as appropriate, and refers the Member to other Pilot or non-Pilot services to meet the Member's need(s).
6. The PHP shall reassess a Member's eligibility for the Pilot program or a Pilot service when a care management team or Member requests to have the Member's eligibility status reassessed in the case that the Member was determined ineligible and there is an indication the Member's health status or social risk factors have changed.
7. The PHP shall communicate the process for Members to request a reassessment of Pilot eligibility and needed services via the Member service denial notice.
8. Within ninety (90) Calendar Days of receiving the Advanced Pilot Functionality

Service Authorization File Companion Guide from the Department, the PHP shall begin providing written notice using the Department-developed template to Members on decisions related to denial(s) of Pilot services as specified below:

i. Within five (5) Calendar Days of a decision by the PHP to not authorize Pilot service(s), the PHP shall provide written notice to the Member. The Member notice shall, at a minimum, provide the following information:
   a) The name of Pilot service(s) denied;
   b) The basis for the denial;
   c) Clarification that the Member is still enrolled in Medicaid, eligible to receive care coordination or care management, as appropriate, and be referred to non-Pilot services;
   d) The process to file a Healthy Opportunities Pilot grievance; and
   e) The opportunity and process to request a reassessment for Pilot services if the Member's health status or social risk factors change.

q. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxv. Pilot Enrollment, e) is revised and restated as follows:

e) Within ninety (90) Calendar Days of receiving the Healthy Opportunities Pilot Enrollee Rights and Responsibilities Form from the Department, the PHP shall begin providing a written Healthy Opportunities Pilot Enrollee Rights and Responsibilities Form, using the Department-developed template, to Members within fourteen (14) Calendar Days of a Member's enrollment in the Healthy Opportunities Pilot. The information in this form must be mailed to the Member and be made available online. The Member may choose to receive an electronic copy of this form rather than a mailed hard copy.

r. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxv. Pilot Enrollment, is revised to add the following:

f) No later than forty-five (45) Calendar Days prior to the start of Pilot Service Delivery Period II, the PHP shall submit to the Department an Enrollment of High-Priority Pilot Populations Plan, in a Department defined format. The Enrollment of High-Priority Pilot Populations Plan shall include:

1. Anticipated Pilot enrollment for the second Pilot Service Delivery Year stratified, at a minimum, to identify priority populations as follows:
   i. Proportion of enrollees who are pregnant women or children ages 0-21;
   ii. Proportion of enrollees who have high health care expenditures;
   iii. Definition of high-cost populations and methods the PHP will use to identify high-cost Pilot enrollees;
   iv. At the PHP's option, any additional priority populations the PHP intends to focus on for Pilot enrollment, and proportion of enrollees they will represent; and

v. Strategies and methods for identifying and enrolling members residing in Pilot regions to ensure inclusive representation of priority populations.

2. Strategies to make best efforts to ensure that historically marginalized populations and communities in the Pilot region be proportionally represented among Pilot enrollees and service expenditures.

g) Starting in Pilot Service Delivery Period II, the PHP shall direct Pilot services to be distributed to the following groups during each Pilot Service Delivery Period:
   1. At least thirty-three percent (33%) of Pilot enrollees are pregnant women and children ages 0-21.
   2. At least thirty-three percent (33%) of Pilot enrollees are high-cost populations.

h) The PHP shall make best efforts to ensure that historically marginalized populations and communities in the Pilot region be proportionately represented in the delivery of Pilot services and service expenditures.

i) The Department may, in its sole discretion, waive or adjust the Pilot service distribution requirements in g) and h) of this section for any Pilot Service Delivery Period.

s. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxix. Pilot Service Mix and Eligibility Reassessment, a), 6. is revised and restated as follows:

6. Discontinues a Pilot service if it is no longer meeting the Member's needs. For Pilot services that must be discontinued, the PHP shall ensure that the Pilot Enrollee's care management team:
   i. Documents the service being discontinued and the rationale (e.g., if the service is no longer meeting the Member's need) in the Member's PESA; and
   ii. Transmits the Member's PESA to the PHP via NCCARE360 to notify of the discontinued service.
   iii. For members that require new or modified Pilot services in lieu of the discontinued service, submits a recommended Pilot service to the PHP as part of the PESA.

t. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxxi. Quality Improvement and Pilot Program Evaluation is revised to add the following:

d) The PHP shall ensure it and its Designated Pilot Care Management Entities participate in relevant Pilot-related learning collaboratives, training, technical assistance activities, and meetings as requested by the Network Lead or the Department.

u. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot is revised to add the following:

xxxiv. Interpersonal Violence (IPV)-Related Services

a) In order to operationalize the provision of IPV-Related Services through the Healthy Opportunities Pilot, the PHP acknowledges and agrees that certain privacy, security, access, functional, and other system changes to NCCARE360 enabling and supporting the authorization of, reimbursement for, and safe delivery of IPV-Related Services shall be developed by the Department and Unite Us, approved by the Department, built by Unite Us, tested for functionality by the PHP, and, upon successful completion of testing, implemented by Unite Us at a date to be determined by the Department. The PHP shall use the NCCARE360 functionality for IPV-Related Services for Healthy Opportunities Pilot Enrollees once it is available. The PHP is not required to cover the cost of the system changes to NCCARE360 related to functionality of IPV-Related Services.

b) At a date to be determined by the Department and communicated to the PHP in writing with at least ninety (90) Calendar Days notice, IPV-Related Services will become available to eligible Members participating in the Healthy Opportunities Pilot and the PHP shall adhere to those certain conditions, requirements, and standards regarding IPV-Related Services, data referencing or regarding IPV-Related Services and Members receiving such services, and communications to Members receiving IPV-Related services, collectively as set forth in *Attachment M. 14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards.*

1. The conditions, requirements, and standards contained in *Attachment M. 14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* are in addition to, and not in lieu of, all other conditions, requirements, and standards set forth in this Contract, and to the greatest extent possible the provisions of *Attachment M. 14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* shall be read and interpreted to be conjunctive with the provisions of this Contract; provided, however, that to the extent that the terms of *Attachment M. 14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* directly conflicts with a provision of this Contract, the terms of *Attachment M. 14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* shall govern.

xxxv. Healthy Opportunities Pilot Enrollee Communication Preferences

a) Healthy Opportunities Pilot Enrollee Contact Preferences. The PHP shall ensure that:

1. Its employed or contracted Care Managers obtain the Healthy Opportunities Pilot Enrollee's contact preferences from each Healthy Opportunities Pilot Enrollee assigned to them, which preferences Care Managers shall record in NCCARE360 using the greatest degree of specificity possible. At a minimum,

Care Managers shall obtain from and record for each Healthy Opportunities Pilot Enrollee assigned to them such Enrollee's:

i. Preferred dates or days of the week for being contacted, time of day at which to be contacted, and modality of contact (e.g., calls vs. texts, use of voicemail, email, postal mail, etc.);
ii. Whether any other days of the week, times of day, or modalities for contact must not be used; and
iii. Whether it is acceptable to leave a message for the Healthy Opportunities Pilot Enrollee using their preferred modality of contact.

2. Upon request by a Healthy Opportunities Pilot Enrollee, the Care Manager shall update such Enrollee's contact preferences in NCCARE360 within one (1) Business Day.
3. Each individual in the PHP's employed or contracted workforce who, as part of their role or function, is expected to or does conduct direct outreach to Healthy Opportunities Pilot Enrollees, including but not limited to Care Managers, reviews and adheres to a Healthy Opportunities Pilot Enrollee's recorded contact preferences, as outlined in the Healthy Opportunities Pilot IPV Protocol, prior to each instance of conducting outreach to such Enrollee.

b) Healthy Opportunities Pilot Enrollee Opt-In/Opt-Out Communication Preferences

1. The PHP shall ensure that all individuals in PHP's employed and contracted workforce (including Care Managers) adhere to Healthy Opportunities Pilot Enrollees' preferences for either opting-in or opting-out of Pilot-specific communications from Pilot entities, as selected by Healthy Opportunities Pilot Enrollees during their initial Pilot assessment with their respective Care Managers and as amended from time to time thereafter in the Healthy Opportunities Pilot Enrollee's sole discretion.
2. Notwithstanding *Section V.C.8.g.xxxv.b)1. Member Opt-In/Opt-Out Communications Preferences* above, if a Care Manager or individual in the PHP's workforce needs to communicate with a Healthy Opportunities Pilot Enrollee, including but not limited to, regarding a three-month Pilot service mix review and/or a six-month eligibility reassessment, or related to automated notifications from NCCARE360 (e.g., for notice of an accepted referral), such Care Manager or individual in the PHP's workforce may send such communications only if adhering to the requirements set forth in *Section V.C.8.g.xxxv. Healthy Opportunities Pilot Enrollee Communications Preferences.*

v. Section V.D. Providers, 4. Provider Payments, l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)) is revised and restated as follows:

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 prescribed by the Department and approved by CMS, to certain in-network providers described in this *Section*

V.D.4.l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).

ii. The PHP shall include the Department defined additional directed payments in its contracts with applicable providers.

iii. 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.

iv. The PHP shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) Business Days of receiving the payment from the State.
   a) Reserved.
   b) Reserved.

v. 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.

vi. The Department shall reconcile the data to the PHP's encounter submissions. The PHP shall support the reconciliation process upon request from the Department.

vii. The PHP shall adhere to the directed payment service unit encounter requirements as described in *Section V. H. 2. Encounters.*

viii. Interest and Penalties
   a) The PHP shall pay interest on late directed payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid as specified in the Contract.
   b) In addition to the interest on late directed payments required by this Section, the PHP shall pay the provider a penalty equal to one percent (1%) of the directed payment for each Calendar Day following the date that the directed payment should have been paid as specified in the Contract.

ix. For Directed Payments for Local Health Departments (LHDs):
   a) The Department will establish a cost-to-charge ratio for each LHD that will be used to determine a minimum fee schedule.
   b) The Department will adjust each LHD's cost-to-charge ratio annually by Medicare Economic Index (MEI) and any change to the LHD's chargemaster to assure that annual per-unit payment growth rate does not exceed the MEI.
   c) The Department will use LHD submitted charges and the established cost-to-charge ratio to develop the uniform dollar or percentage increase.
   d) The Department will calculate the directed payment amount to the PHP on a quarterly basis as the difference between the rate paid to the LHDs by the Standard Plan and the minimum fee schedule amount determined by the State multiplied by the LHD claims for each PHP.
   e) The Department will perform an annual verification of the LHD directed payments based on PHP encounter data submitted to the State to assure all claims data has been properly captured and calculated for directed payments.

x. For Directed Payment for 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:
    a) The Department will establish a uniform dollar increase annually at the average commercial rate for certain eligible medical professionals as defined in the Medicaid State Plan, Attachment 4.19-B, Section 5, Page 2, Subsection (c)(2).
    b) The Department will calculate the directed payment amount to the PHP on a quarterly basis as the difference between the rate paid to the eligible medical professionals PHP and the minimum fee schedule amount determined by the Department multiplied by the actual utilization for the eligible professionals.
    c) The Department will establish an annual aggregate cap for total eligible medical professional directed payments pursuant to State Law.[1]
    d) The Department will perform an annual verification of the eligible medical professional directed payments based on PHP encounter data submitted to the Department to assure all claims data has been properly captured and calculated for directed payments and to assure compliance with aggregate annual payment cap.

xi. For Directed Payments to Vidant Medical Center:
    a) The Department will establish a uniform dollar increase for each managed care discharge (inpatient), initially determined by dividing the projected inpatient quality pool amount by the number of projected inpatient managed care discharges.
    b) The Department will establish a uniform increase per billed charge (outpatient), initially determined by dividing the total outpatient pool amount by the projected managed care outpatient charges.
    c) The Department will calculate the directed payment amount to the PHP on a quarterly basis as the actual number of managed care discharges multiplied by the uniform per discharge amount (inpatient) plus the actual managed care billed charges multiplied by the uniform per charge amount (outpatient).

xii. For Directed Payments to University of North Carolina Health Care System Hospitals:
    a) The Department will establish a uniform dollar increase for each managed care discharge (inpatient), initially determined by dividing the projected inpatient quality pool amount by the number of projected inpatient managed care discharges.
    b) The Department will establish a uniform percentage increase per billed charge (outpatient), initially determined by dividing the total outpatient pool amount by the projected managed care outpatient charges.
    c) The Department will calculate the directed payment amount to the PHP on a quarterly basis as the actual number of managed care discharges multiplied by the uniform per discharge amount (inpatient) plus the actual managed care billed charges multiplied by the uniform per charge amount (outpatient).

[1] Section 13.(b) of Session Law 2020-88.

w. Section V.D. Providers, 4. Provider Payments, x. Payments for Durable Medical Equipment, i. is revised and restated as follows:

i. The PHP shall reimburse durable medical equipment, supplies, orthotics and prosthetics at one hundred percent (100%) of the lesser of the supplier's usual and customary rate or the maximum allowable Medicaid fee-for-service rates for durable medical equipment and supplies, orthotics and prosthetics in accordance with Section 11 of Session Law 2020-88, as amended by Section 3.6 of Session Law 2021-62.

x. Section V.D. Providers, 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, i. HSO Payments for Pilot Service Invoices, a) – b) is revised and restated as follows:

i. HSO Payments for Pilot Service Invoices

a) The PHP shall:

1. Authorize and reimburse for Pilot services in all Pilot domains (housing, food, transportation and interpersonal/toxic stress);
2. Use the Pilot service delivery payment component of its capped allocation to make payments directly to HSOs for the delivery of authorized Pilot services to Pilot enrollees in accordance with the Healthy Opportunities Pilot fee schedule developed by the Department; and
3. Not negotiate rates in the Healthy Opportunities Pilot Service fee schedule.

b) Invoice Requirements

1. The PHP shall ingest invoices from NCCARE360 for Pilot services delivered by the HSO that were previously authorized by the PHP and take one of the following actions:
   i. If the invoice is accurate and the service(s) was authorized by the PHP:
      a. The PHP shall send an invoice response file to NCCARE360 to approve or deny the invoice within thirty (30) Calendar Days of receipt of the invoice from NCCARE360; and
      b. If approved, within thirty (30) Calendar Days of the date of approval of the invoice, the PHP shall effectuate payment, via check or direct deposit, to the HSO and send an invoice response file to NCCARE360 that includes the amount paid to the HSO.
   ii. If the invoice is inaccurate or invalid, the PHP shall send an invoice response file to NCCARE360 with an explanation of the basis for denial within thirty (30) Calendar Days of receipt of the invoice from NCCARE360.
2. The PHP shall process invoices from NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 837 Invoice File(s) Companion Guide.
3. The PHP shall send invoice response file back to NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 837 Invoice File(s) Companion Guide.
4. In the event that a PHP authorized a Pilot service, PHP shall not deny an invoice from an HSO on the basis of having subsequently retracted such authorization after the Pilot service has been provided by an HSO.
5. The PHP shall pay the HSO in the event of a payment error that requires initial, corrected or additional payment.

y. Section V.D. Providers, 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, i. HSO Payments for Pilot Service Invoices is revised to add the following:

e) The PHP shall, at a minimum, include the following information on the Remittance Advice (RA) to the HSOs:

1. Invoice ID: This shall be identical to the field Invoice_Short_ID from NCCARE360 and be provided for all applicable invoices included in a particular payment made to an HSO;
2. Actual dollar amount: This shall include the actual amount paid for each invoice processed on the payment;
3. Date: This shall reflect the date the payment was made to the HSO; and
4. Payment Reference Number.

z. Section V.D. Providers, 4. Provider Payments, bb. Provider Hardship Payments, i. is revised and restated as follows:

i. The PHP shall process Hardship Payment requests from a provider within seven (7) Business Days of receipt of all documentation required to process a hardship request or three (3) Business Days of receipt of all documentation required to process an urgent hardship request.

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

gg. Beginning April 1, 2023, the PHP shall reimburse Opioid Treatment Programs no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

hh. Payment for Behavioral Health Services provided to Members awaiting hospital discharge

i. Upon CMS approval, the PHP shall reimburse in-network providers for Behavioral Health Services provided to Members awaiting hospital discharge as defined in the NC Medicaid State Plan and in Clinical Coverage Policy 2A-1 at no less than one hundred percent (100%) of the Medicaid Direct Fee schedule, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

bb. Section V. E. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, g. iv.-v. are revised and restated as follows:

iv. The PHP's projections and plans to meet the Department's VBP 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 results related to VBP/APM by year.

cc. Section V. E. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, g. viii. is revised and restated as follows:

viii. The PHP's expected percent of total medical expenditures flowing to providers through shared savings.

dd. Section V. E. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, h. iv. is revised and restated as follows:

iv. Progress toward the PHP's projections and plans to meet the Department's VBP targets for amount of funding in VBP/APM arrangements.

ee. Section V. E. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, h. vi. is revised and restated as follows:

vi. Results of the PHP's outcome measurements and analysis of the outcomes and results by year and to-date.

ff. Second Revised and Restated Section V.G. Table 1: Member and Provider Support Call Center Operations is revised and restated as follows:

Third Revised and Restated Section V.G. Table 1: Member and Provider Support Call Center Operations				
Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
i. Member Service Line	1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch) 2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week 3. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
ii. Provider Support Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
iii. Pharmacy Service Line	1. Monday – Saturday: 7AM – 6PM ET 2. Prescriber prior authorization services available to meet 24-hour review requirements as defined in *Section V. C. 3. Pharmacy Benefits* 3. Open all State holidays	Yes (except for pharmacists performing UM functions, such as PA)	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
iv. Nurse Line	1. Twenty-four (24) hours per day / seven (7) days per week / 365 days per year	No	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch

v. Behavioral Health Crisis Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	Yes (except for bilingual agents providing services to Members)	Yes	At least thirty (30) Calendar Days prior to Medicaid Managed Care launch
vi. Non-Emergency Medical Transportation (NEMT) Member Service Line	1. Monday - Saturday: 7AM - 6PM ET 2. Open all state holidays	No	No	No later than July 1, 2021
vii. Non-Emergency Medical Transportation (NEMT) Provider Service Line	1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	No	No	No later than July 1, 2021

gg. Section V. G. Program Operations, 1. Service Lines, t. Behavioral Health Crisis Line is revised to add the following:

v. The Behavioral Health Crisis Line may use interpretation services for no more than twenty percent (20%) of Behavioral Health Crisis Line calls received from Members who prefer to speak in Spanish, but these interpreters must be healthcare or medically certified.
   a) Interpreters must have at least one of the following certifications:
      1. Certified Medical Interpreter from National Board of Certification for Medical Interpreters;
      2. Certified Healthcare Interpreter from Certification Commission for Healthcare Interpreters;
      3. Core Certification Healthcare Interpreter from Certification Commission for Healthcare Interpreters; or
      4. Internal healthcare or medical certification from language/interpreter vendor.

vi. When providing services to Members, Behavioral Health Crisis Line bi-lingual agents may be located outside of North Carolina.

hh. Section V. G. Program Operations, 5. Business Continuity Plan, b is revised and restated as follows:

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 update the Business Continuity Plan every six (6) months. The PHP shall demonstrate how it will restore call center operations, website 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, epidemic or pandemic), which could result in a major failure or disruption in care. As part of the PHP's business continuity planning, the PHP shall identify and review all federal or state disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Award to inform future disaster or emergency planning. For each identified disaster or emergency situation, the PHP shall explain in detail:

i. The preventive measures that would be instituted to minimize the impact;
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;
iii. Reserved;
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. Current contact information for all critical staff and relevant personnel and notification procedures (i.e. call tree);
vi. Approach for providing care coordination activities to high risk Medicaid members;
vii. Approach for supporting the Department' priorities for statewide and local disaster or emergency planning;
viii. Process to provide information and resources to Medicaid members on how to protect themselves during a disaster or emergency and assist members with understanding how and when to access Medicaid benefits;
ix. Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a member;
x. Processes to ensure that providers deliver all necessary care to members during a disaster or emergency;
xi. Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
xii. Approach to supporting providers in the event of provider revenue disruptions;
xiii. Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
xiv. The recovery procedures that would be instituted to archive normal operations, including any remote access relocations plans or alternative worksite locations;
xv. The time-frame required to accomplish full recovery from the point of interruption;

xvi. A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
xvii. The procedures for coordinating with the Department in the event of a disaster;
xviii. Employee training and awareness detailing activation process;
xix. Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results;
xx. 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.
xxi. Approach to incorporating the Department best-practices from disaster or emergency response including:
    a) Increasing care management for medically fragile enrollees to include high risk enrollees (e.g., high risk pregnant women, dialysis patients, medically frail, hemophiliacs, long term care population) during a disaster or emergency:
        1. Pre-Emergency:
            i. Incorporate disaster or emergency planning in the care planning process; and
            ii. Reserved.
        2. During an Emergency:
            i. Continue to check-in on high risk members to ensure safety and access to supports to address their Unmet Health-Related Resource Needs;
            ii. Arrange for NEMT to evacuate if needed;
            iii. Offer extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries; and
            iv. Ensure continuity of care, as directed by the Department, to:
                a. Remove and/or reduce required prior authorizations and concurrent review,
                b. Ensure all Members have access to out-of-network and telehealth providers, and
                c. Increase member access to medications by removing maximum dosage limits for required medication including medication assisted treatment (MAT), anti-psychotics, and insulin.
        3. Post-Emergency:
            i. Follow up with high risk members to ensure safety and identify additional behavioral or medical needs, or Unmet Health-Related Resource Needs; and
            ii. Offer extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries.
    b) Supporting the Department's priorities for state-wide and local disaster or emergency planning, including:

1. Participation in the development of community disaster or emergency response plans as needed;
2. Collaboration with the other Department vendors to align efforts, as needed;
3. Appointment of at least one representative to the statewide disaster or emergency response panel; ~~and~~
4. Recruitment and training for in-network behavioral health providers to staff local disaster shelters; and
5. Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.

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

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

i. When the Department releases revisions to the Managed Care Billing Guide, the PHP shall update their systems to process new claims received within forty-five (45) Calendar days of the Managed Care Billing Guide publish date, and reprocess impacted claims within seventy-five (75) Calendar Days of publication of this new guidance. If the PHP is unable to update their system and reprocess claims within the seventy-five (75) Calendar Day timeline, interest and penalties shall be paid on those claims according to requirements in *Section V.H.1.d.iv. Interest and Penalties*.

jj. Section V. H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iv. is revised to add the following:

k) The PHP is required to have a no cost option for providers to select for claims submitted by electronic funds transfer (EFT) for transmission of claims through switch companies and/or clearinghouses. Requiring transaction fees, including but not limited to clearinghouse fees and electronic funds transfer (EFT) fees, are in violation of the PHP's rate floor requirements in the Contract. The PHP shall provide a no-cost option for processing all claim types.

kk. Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. is revised and restated as follows:

iv. 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 health care provider and health care facility 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.

a) The PHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member for pharmacy point of sale claims and may not limit the time to fewer than three hundred sixty-five (365) Calendar Days.
b) When a Member is retroactively enrolled, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

ll. Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, d) is revised and restated as follows:

d) The PHP shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. The PHP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates within seventy-five (75) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section.

mm. Section V.H. Claims and Encounter Management, 1. Claims, i. National Correct Coding Initiative (NCCI) iii. – iv. is revised and restated as follows to correct section numbering:

iii. The PHP and its Subcontractors are subject to the terms and conditions of *Attachment M.11. National Correct Coding Initiative Confidentiality Agreement*.
iv. The PHP shall only apply Outpatient Hospital NCCI edits to outpatient lab, drugs, and radiology claims.

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

k. Payer Initiated Claim Adjustment

i. The PHP shall have the capability to complete payer initiated claim adjustments of adjudicated claims by provider types, claim types, and time period.
ii. The PHP shall comply with the Departments policies and procedures on claim adjustments/reprocessing.
iii. The PHP shall have the capability to complete a report of adjudicated claims and provide all relevant claim data including claim number, Member Medicaid number, provider NPI, and date of service.

iv. The PHP shall complete the adjustment report as requested by the Department when a previously processed claim by the PHP has been adjusted/reprocessed. There is no minimum number of claims required for the report. If an issue has been identified, all claims impacted should be corrected and included in the report.

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

ix. The PHP shall submit all claims processed as encounters, as defined in this Section. Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

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 and monthly medical home and care management fees, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.
2. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the payment date.
3. The PHP encounter data submissions shall meet or exceed a timely submission standard of ninety-eight percent (98%) within thirty (30) Calendar Days after payment whether paid or denied for medical claims and within seven (7) Calendar Days after payment whether paid or denied for pharmacy claims.
    i. Medical: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.
    ii. Pharmacy: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters will be counted by the Department as pharmacy encounters.
4. Encounter data timeliness shall be defined 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.

b) Reserved.

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.

i. Medical: for purposes of determining if the PHP has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.

ii. Pharmacy: for purposes of determining if the PHP has met the accuracy encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.

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.

d) Reconciliation

1. PHP encounter submissions shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.

i. Medical: For purposes of determining if the PHP has met the reconciliation encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters.

ii. Pharmacy: For purposes of determining if the PHP has met the reconciliation encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.

2. Encounter data reconciliation shall be defined as 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.

e) Historical Medical Home and Care Management Fee Encounters

1. The PHP shall submit no later than October 1, 2023 or one hundred eighty (180) Calendar Days from the date the specific encounter types are available within the EPS, whichever is later, encounters for all monthly medical home fees and care management fees, including AMH medical home and care management payments, and CMARC, CMHRP and Healthy Opportunities PMPM payments made prior to **January 1, 2023.**

pp. Section V.I. Financial Requirements, 2. Medical Loss Ratio, c. v. is revised and restated as follows:

v. Payments related to the Healthy Opportunities Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.

qq. Section V.I. Financial Requirements, 6. Healthy Opportunities Pilot Payments, b.-c. are revised and restated as follows:

b. The PHP shall participate in a Pilot-specific value-based payment (VBP) program and be subject to value-based payment adjustments in accordance with the Department's

assessment of the PHP's performance against specific targets and benchmarks detailed in the Department's Healthy Opportunities Standard Plan Implementation Period Incentive Payments Milestone Guide and Healthy Opportunities Standard Plan Pilot Value-Based Payment Period 2 Incentive Payments - Milestone Guide.

c. The PHP shall submit information required by the Department to receive value-based payments, including documentation demonstrating that the PHP has met the required milestones, as described in the Department's Healthy Opportunities Standard Plan Implementation Period Incentive Payments Milestone Guide and Healthy Opportunities Standard Plan Pilot Value-Based Payment Period 2 Incentive Payments - Milestone Guide.

rr. Section V.J. Compliance, 2. Program Integrity, b. i. b) is revised and restated as follows:

b) The PHP shall disclose to the Department within thirty (30) Calendar Days of PHP's knowledge of any disciplinary actions or exclusions that have not been communicated on the Provider Enrollment File as a Termination to the PHP imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.

ss. Section V.J. Compliance, 2. Program Integrity, b. i. c) is revised and restated follows:

c) Reserved.

tt. Section V.J. Compliance, 3. Fraud, Waste, and Abuse Prevention, c. Investigation Coordination, viii. is revised as and restated follows:

viii. The PHP cannot take action, such as termination of a provider, suspension of payment, or withhold of payment, related to potential findings of fraud without approval of the Department. Any such action taken after PHP has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.

The remainder of this page is intentionally left blank.

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

Specific subsections are modified as stated herein.

a. Section VI.A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, v. Liquidated Damages, Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages is revised and restated as follows and effective January 1, 2023:

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
1.	Failure to meet plan readiness review deadlines as set by the Department.	$5,000 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section V.A.9. Staffing and Facilities* and *Attachment O. 10. Disclosure of Conflicts of Interest*.	$10,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Attachment O.9. 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.
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

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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
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.	Reserved.	Reserved.
10.	Failure to comply with all orders and final decisions relating to claim disputes, appeals and/or State Fair Hearing as issued or as directed by the Department.	$5,000 per occurrence
11.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *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
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 and V.C.3. Pharmacy Benefits.*	$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

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
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.	Reserved.	Reserved.
25.	Reserved.	Reserved.
		Reserved.
		Reserved.
26.	Reserved.	Reserved.
27.	Reserved.	Reserved.
28.	Reserved.	Reserved.

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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 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 with the Opioid Misuse Prevention Program requirements
31.	Failure to update online and printed provider directory as required by *Section V.D.2. Provider Network Management.*	$1,000 per provider, per Calendar Day
32.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by *Section V.D.2. Provider Network Management.*	$100 per Calendar Day per Member for failure to timely notify the affected Member
33.	Reserved.	Reserved
34.	Reserved.	Reserved.
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
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
39.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in *Section V.E.1. Quality Management and Quality Improvement.*	$5,000 per Calendar Day

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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
43.	Failure to timely submit monthly encounter data set certification.	$1,000 per Calendar Day
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Attachment J: Fifth Revised and Restated 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. Fifth Revised and Restated Reporting Requirements.*	$2,000 per Calendar Day
46.	Failure to timely and accurately submit monthly financial reports in accordance with *Attachment J: Fifth Revised and Restated Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per Calendar Day
47.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.J.3. Fraud, Waste and Abuse Prevention.*	$5,000 per Calendar Day that the Department determines the PHP is not in compliance
48.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.J.1. Compliance Program* and *Attachment J: Reporting Requirements.*	$1,000 per Calendar Day
49.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.J.4. Third Party Liability* and *Attachment J: Fifth Revised and Restated Reporting Requirements*	$250 per Calendar Day

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
50.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$2,500 per incident for failure to fully cooperate during an investigation
51.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	$250 per Calendar Day
52.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.J.3. Fraud, Waste and Abuse Prevention* and *Attachment J: Fifth Revised and Restated Reporting Requirements.*	$2,000 per Calendar Day
53.	Failure by the PHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$500 per Member per occurrence per AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PHP's failure to comply with the terms of this Contract, the PHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
54.	Failure by the PHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$500 per Member per occurrence
55.	Failure by the PHP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500 per Member per occurrence, not to exceed $10,000,000
56.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$500 per Calendar Day that the Department determines the PHP is not in compliance

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
57.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$1,000 per occurrence per committee that the Department determines the PHP is not in compliance
58.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$500 per Calendar Day the unapproved agreement or materials are in use
59.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$1,500 per occurrence per plan/program that the Department determines the PHP is not in compliance
60.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	$500 per Calendar Day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action
61.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$500 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
62.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$1,000 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
63.	Failure to implement and maintain a Member Lock-In Program as described in *Section V.C.7. Prevention and Population Health Management Program.*	$500 per calendar day per member that the PHP is not meeting Lock-In Requirements outlined in *Section V.C.7 Prevention and Population Health Management Program* and N.C. Gen. Stat. § 108A-68.2.
64.	Failure to remove providers that are not actively enrolled in NC Medicaid within the PHP Network File within one (1) Business Day as specified in *Section V.D.2. Provider Network Management.*	$1,000 per provider per Business Day
65.	Engaging in gross customer abuse of Members by PHP service line agents as prohibited by *Section V.G.1. Service Lines*.	$1,000 per occurrence

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
66.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.G.1. Service Lines.*	$250 per Business Day the PHP fails to timely report to the Department
67.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in *Section V.C.8. Opportunities for Health*.	$500 per Calendar Day that the Department determines the PHP is not in compliance beginning on or after August 1, 2022.
68.	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes as specified in *Attachment M.13. Timeframes for Health Opportunities Pilot Service Authorization*.	$500 per Calendar Day beginning on or after September 1, 2022
69.	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes as specified in *Section V.D.4. Provider Payments*.	$500 per Calendar Day beginning on or after September 1, 2022
70.	Failure to comply with the following provisions enumerated in *Attachment M. 14* Healthy Opportunities *Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that PHP workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment	$500 per occurrence beginning ninety (90) Calendar Days after Interpersonal Violence services become available to Members.

Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
71.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the PHP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the PHP in connection with the internal plan appeal within the requirements in *Section III.D.37 Response to State Inquiries and Request for Information*.	$500 per occurrence
72.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$500 per occurrence

b. Section VI.B. Service Level Agreements, Fourth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements is revised and restated in its entirety as follows:

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Monthly	$1,000 per eligibility file that does not meet the submission guidelines of the eligibility file.
2.	Member Appeals Resolution - Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Member Appeals Resolution - Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$5,000 per month
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls	Monthly	$5,000 per service line per month
7.	Call Response Time/Call Answer Timeliness - Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

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

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
16.	Call Response Time/Call Answer Timeliness - Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month
19.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
20.	Call Wait/Hold Times - Pharmacy Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
22.	Encounter Data Timeliness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after payment whether paid or denied. *For purposes of this standard, medical encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x.* *Effective October 1. 2023 , this includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.*	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

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
23.	Encounter Data Timeliness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after payment whether paid or denied. *For purposes of this standard, pharmacy encounters only include 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.*	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. *For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters.* *Effective October 1, 2023 this includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.*	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

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$50,000 per week
26.	Encounter Data Reconciliation - Pharmacy	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within thirty (30) Calendar Days or at least ninety-nine percent (99~~.8~~%) of paid claim amounts reported on financial reports within sixty (60) Calendar Days. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$100,000 per month
27.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	$2,500 per occurrence
28.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
29.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence (each communication outside of the standard for the month)
30.	Encounter Data Reconciliation - Medical	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. *For purposes of this standard, medical encounters only include 837-P encounters and 837-I encounters.*	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$10,000 per month
31.	Call Response Time/Call Answer Timeliness – NEMT Member Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
32.	Call Wait/Hold Times – NEMT Member Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
33.	Call Abandonment Rate – NEMT Member Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
34.	Call Response Time/Call Answer Timeliness – NEMT Provider Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and the number of calls abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
35.	Call Wait/Hold Times – NEMT Provider Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
36.	Call Abandonment Rate – NEMT Provider Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month

Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
37.	Non-Emergency Transportation – Hospital Discharge	The PHP shall ensure that at least ninety-eight percent (98%) of Medicaid Members discharged from hospitals or emergency departments are picked up within three (3) hours of receipt of the request from the Member, the Member's authorized representative, or hospital staff, or within (3) hours of the Member's scheduled discharge, whichever is later, as specified in the *NC Non-Emergency Medical Transportation Managed Care Policy*.	The number of trips per month that Contractor fails to pick up at least ninety-eight percent (98%) of Medicaid Members being discharged from a hospital or emergency department within the established timeframes after receipt of a request from the Member, the Member's authorized representative, or hospital staff for NEMT.	Monthly	$3,000 per trip for any delay beyond the three (3) hour pick-up requirement for any trip above the 2% threshold

The remainder of this page is intentionally left blank.

IV. Modifications to Section VII. Attachments

Specific subsections are modified as stated herein.

1. **Attachment A. First Revised and Restated PHP Organization Roles and Positions, is revised and restated in its entirety to modify Role 5. Full-Time Utilization Management Staff, Minimum Certifications and/or Credential Requested by the Department as set forth in** Attachment 2: *Attachment A. Second Revised and Restated PHP Organization Roles and Positions* to this Amendment.

2. **Attachment F: Third Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards, is revised and restated in its entirety to modify Service Type Definitions for Behavioral Health Time/Distance Standards and Appointment Wait Time Standards for Routine Services for SUDs as set as set forth in** Attachment 3: *Attachment F: Fourth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* to this Amendment and effective April 1, 2023 in accordance with *Contract Section V.D. Providers, 1. Provider Network, d. Furnishing of Services (42 C.F.R. § 438.206(c)).i.b)*.

3. **Attachment G. Fourth Revised and Restated Required Standard Provisions for PHP and Provider Contracts is revised and restated in its entirety to modify *Section 1. cc*. of this attachment as set forth in** Attachment 4: *Attachment G. Fifth Revised and Restated Required Standard Provisions for PHP and Provider Contracts* to this Amendment.

4. **Section VII. Attachment J. Fourth Revised and Restated Reporting Requirements is revised and restated in its entirety to incorporate reports associated with the Healthy Opportunities Pilot as set forth in** Attachment 5: *Attachment J. Fifth Revised and Restated Reporting Requirements* to this Amendment**.**

5. **Attachment M.6. Second Revised and Restated Uniform Credentialing and Re-credentialing Policy is revised and restated in its entirety to modify Section 3. b. of this Attachment M.6. as set forth in** Attachment 6: *Attachment M.6. Third Revised and Restated Uniform Credentialing and Re-credentialing Policy* to this Amendment.

6. **Attachment M.8. Behavioral Health Service Definition Policy is revised and restated in its entirety to modify definitions with this Attachment M.8. as set forth in** Attachment 7: *Attachment M.8. First Revised and Restated Behavioral Health Service Definition Policy* to this Amendment.

7. **Attachment M.14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards** is incorporated into the Contract to define the Healthy Opportunities Interpersonal Violence (IPV) Related Services conditions, requirements and standards as stated in Attachment 8: *Attachment M.14. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* to this Amendment.

V. **Section X, Fifth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms** is revised and restated in its entirety as *Section X. Sixth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms* and attachment to this Amendment.

VI. **Effective Date**

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

VII. **Other Requirements**

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

Execution:

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

Department of Health and Human Services

_____ Date: _____

Dave Richard, Deputy Secretary

PHP Name

_____ Date: _____

PHP Authorized Signature

Attachment 1

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

Third Revised and Restated 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	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 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	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 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	YES	YES

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

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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
	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			
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) 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	YES	NO
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	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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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			
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 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.	SSA, Title XIX, Section 1905(a)(7) 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	YES	YES
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.	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	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. 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-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 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		

Third Revised and Restated 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-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision		

Third Revised and Restated 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-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 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		

Third Revised and Restated 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-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-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)		

Third Revised and Restated 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 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 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;	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 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	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	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; 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.	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 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	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY MEDICAID	COVERED BY NCHC
		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 NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing	YES	YES

Third Revised and Restated 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-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 practitioner services	(a) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section. If the State specifies qualifications for pediatric nurse practitioners, the practitioner must -	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a	YES	YES

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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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 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	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	transport via ground and air medical ambulance for a NCHC beneficiary.			
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 Drug Management	YES	YES

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

Third Revised and Restated 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,	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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	including identification, assessment, intervention, adaptation of the environment, and selection of assistive 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	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically	North Carolina Medicaid State Plan Att. 3.1-A.1,	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
outpatient behavioral health services defined in required clinical coverage policy	necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Please refer to NC Clinical Coverage Policies and services listed.	Pages 12b, 15-A.1-A.5, 15a-15a.35 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 Withdrawal Management Without Extended On-Site Monitoring Ambulatory Withdrawal Management With Extended On-Site Monitoring Medically Monitored Inpatient Withdrawal Services Outpatient Opioid Treatment NC Clinical Coverage Policy 8C: Outpatient Behavioral Health		

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

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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY MEDICAID	COVERED BY NCHC
		NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care		
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. Opticians may dispense 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 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	YES	YES
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	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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	requirements as outlined in 42 C.F.R. § 410.21.			
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 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	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 Nursing for Beneficiaries Under 21 years of Age	YES	NO

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.			
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 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	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)	YES	NO

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

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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: 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	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 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	YES	YES
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.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.	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		
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) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy	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
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. *IMD exclusion is waived for Medicaid beneficiaries receiving treatment for substance use disorders.	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	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are	SSA, Title XIX, Section 1905(a)(16)	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
individuals under age 21	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.	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		
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 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	YES	YES

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

Third Revised and Restated 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 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 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		

Third Revised and Restated 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 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
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:	North Carolina Medicaid State Plan, Att. 3.1-A,	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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	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)		
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement	YES	YES
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment	YES	YES

Third Revised and Restated 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 1G-2, Skin Substitutes		
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound	YES	YES
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES	YES
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES	YES
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention	YES	NO

Third Revised and Restated 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 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		
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 NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home	YES	NO
Ophthalmological Services	General ophthalmologic services include	NC Clinical Coverage Policy 1T-1, General	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	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.	Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services		
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 NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administration Procedures	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY MEDICAID	COVERED BY NCHC
		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 NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21	YES	YES
Telehealth, Virtual Patient Communications and Remote Patient	Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual patient communications is the use of	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and	YES	YES

Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
Monitoring Services	technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.	Remote Patient Monitoring		

Attachment 2

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

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

Second Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff	These individuals will carry out the implementation and readiness review terms of the contract.	• 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 • Pharmacists must be registered, with current NC Pharmacist license.
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

Second Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
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 • 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

Second Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
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
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

Second Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
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 compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice or have at least three (3) years of relevant experience.
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
22. InCK Integration Consultant	This individual will support care teams in implementing InCK by providing consultations to support Family Navigators on topics including but not limited to resource navigation across core child service areas, trainings, and connections to help InCK participant meet goals of Shared Action Plan. The Integration Consultant also advises InCK leadership on key components of the model.	• Must reside in North Carolina • 1.0 FTE required per PHP • Must have clinical experience (e.g. Care Manager, RN, BSW, LPN, MSW). • Must be selected through collaborative process with NC InCK Managing Director and Operations and Strategy Director
23. InCK Family Navigator	This individual will be a designated care team member assigned to support an InCK member's (assigned to SIL 2 and SIL 3) care integration needs.	• Must reside in North Carolina • Must have clinical experience (e.g. Care Manager, RN, MSW, LPN, BSW)

Attachment 3

Attachment F: Fourth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards

This *Attachment F: Fourth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* is effective April 1, 2023.

At a minimum, Contractor's network shall consist of hospitals, physicians, advanced practice nurses, SUD 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 sufficientlyavailable 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. The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all members have timely access to all covered health care services, Contractor shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Certain service types are not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

For purposes of network adequacy standards physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.

For purposes of network adequacy standards for behavioral health providers/services, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who

is less than 18 years of age.

Section VII. Attachment F. Third Revised and Restated Table 1: PHP Time/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 atleast 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
5	Obstetrics[1]	≥ 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 SpeechTherapists*	≥ 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 HealthServices	• ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles ofresidence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles ofresidence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*
8	Location-Based Services (BehavioralHealth)	≥ 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 atleast 95% of Members
12	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 inevery county; providers are not required to live in the same county in which they provide services.
13	Nursing Facilities*	PHP must have at least 1 nursing facility acceptingnew patients in every county.	PHP must have at least 1 nursing facility acceptingnew patients in every county.

[1] Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included to satisfy OB access requirements.

The PHP is required to use the definitions of service categories for Behavioral Health time/distance standards found in behavioral health service types in *Section VII. Attachment F. Third Revised and Restated – Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. ~~Third~~ Fourth Revised and Restated – Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards*.

Section VII. Attachment F. Fourth Revised and Restated Table 2: Definition of Service Category forBehavioral Health Time/Distance Standards		
ReferenceNumber	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers(adults and children) • Diagnostic Assessment • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (OTP) (adult)
3.	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult • Facility-based crisis services for children and adolescents • Ambulatory withdrawal management, without extended on-site monitoring ~~detoxification~~ • Ambulatory withdrawal management, with extended on-site monitoring • Medically Monitored Inpatient Withdrawal Services
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Withdrawal Management Services beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Services beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent/child Medically Managed Intensive Inpatient Services beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

PHP 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. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age andolder	Care provided to prevent illness or injury; examples include, but are notlimited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar Days
1a	Preventive Care Services – child, birth through 20 yearsof 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 of age and older.
2	Urgent Care Services	Care provided for a non-emergent illnessor 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 withoutSymptoms	Non-symptomatic visits for routinehealth check-up.	Within thirty (30) Calendar Days

4	After-Hours Access – Emergent and Urgent	Care requested after normal businessoffice hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care			
5	Initial Appointment – 1st or 2ndTrimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, suchas 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 illnessor 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 withoutSymptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
8	After-Hours Access – Emergent and Urgent	Care requested after normal businessoffice 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.: First Revised and Restated BehavioralHealth Service Definition Policy*	Within two (2) hours
10	Urgent Care Services for Mental Health	Refer to *Attachment M. 8.: First Revised and Restated BehavioralHealth Service Definition Policy*	Within twenty-four (24) hours
11	Urgent Care Services for SUDs	Refer to *Attachment M. 8.: First Revised and Restated BehavioralHealth Service Definition Policy*	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to *Attachment M. 8.: First Revised and Restated BehavioralHealth Service Definition Policy*	Within fourteen (14) Calendar Days
13	Routine Services for SUDs	Refer to *Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy*	Within forty-eight (48) hours
14	Emergency Services forMental Health	Refer to *Attachment M. 8.: First Revised and Restated 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.: First Revised and Restated BehavioralHealth Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

The remainder of this page is intentionally left blank.

Attachment 4

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

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

1. **Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following**:
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
    e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the PHP's insolvency the contract must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.

ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:

1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.

h. Member Billing: The contract must address the following:

i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and

ii. Any provider's responsibility to collect applicable Member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

i. Provider Accessibility. The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the PHP's standards for provider accessibility.

j. Eligibility Verification. The contract must address the PHP's obligation to provide a mechanism that allows providers to verify Member eligibility, based on current information held by the PHP, before rendering health care services.

k. Medical Records. The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:

i. Maintain confidentiality of Member medical records and personal information and other health records as required by law;

ii. Maintain adequate medical and other health records according to industry and PHP standards; and

iii. Make copies of such records available to the PHP and the Department in conjunction with its regulation of the PHP. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Member Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the Member in regard to Member appeals and grievance procedures.

m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).

n. Data to the Provider: The contract must address the PHP's obligations to provide data and information to the provider, such as:
    i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
    ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
    iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.

o. Utilization Management: The contract must address the provider's obligations to comply with the PHP's utilization management programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

p. Provider Directory: The provider's authorization and the PHP's obligation to include the name of the provider or the provider group in the provider directory distributed to Members.

q. Dispute Resolution: Any process to be followed to resolve contractual differences between the PHP and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.D.5. Provider Grievances and Appeals*.

r. Assignment: Provisions on assignment of the contract must include that:
    i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.
    ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

s. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.

t. Interpreting and Translation Services: The contract must have provisions that indicate:
    i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
    ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
    iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

u. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements

consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.

w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
   i. G. S. 58-3-200(c).
   ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
   iii. G.S. 58-50-270(1), (2), and (3a).
   iv. G.S. 58-50-275 (a) and (b).
   v. G.S. 58-50-280 (a) through (d).
   vi. G.S. 58-50-285 (a) and (b).
   vii. G.S. 58-51-37 (d) and (e).

y. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in Section V.D.4. of the PHP Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the PHP shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Attachment H. Third Revised and Restated Medicaid Managed Care Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the PHP and provider have mutually agreed to an alternative reimbursement arrangement. When a PHP and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

z. Clinical Records Requests for Claims Processing: the contract shall indicate that the PHP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).

aa. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the PHP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

bb. Physician Advisor Use in Claims Dispute: The contract must indicate that the PHP shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:

i. The Designated Pilot Care Management Entity shall:
   a) Utilize NCCARE360 for functions outlined in PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.
   b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*
   c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.
   d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot*.
   e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals, i. Provider Complaints related to the Healthy Opportunities Pilot.*
   f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*

ii. The PHP shall:
   a) Make Pilot care management payments to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined in *Section III.D.32.e.iii. Pilot Care Management Payments*.
   b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.

iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.

dd. Healthy Opportunities Network Leads: The PHP must contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as noted in Section V.D.1.c.vi, using a Department-standardized PHP-Network Lead model contract, to access the Network Lead's network of Pilot providers, also referred to as Human Service Organizations (HSOs).

ee. Advanced Medical Home InCK: For all Advanced Medical Homes participating in the InCK program, a provision that outlines the InCK model and requirements that is consistent with the Advanced Medical Home Manual. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's InCK Program.

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

a. Attachment M. 2. First Revised and Restated Advanced Medical Home Program Policy

b. Attachment M. 3. Pregnancy Management Program Policy

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

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

e. Advanced Medical Home Manual

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

a. Compliance with State and Federal Laws

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

b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to provider records

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

i. *The United States Department of Health and Human Services or its designee;*
ii. *The Comptroller General of the United States or its designee;*
iii. *The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee*
iv. *The Office of Inspector General*
v. *North Carolina Department of Justice Medicaid Investigations Division*
vi. *Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;*
vii. *The North Carolina Office of State Auditor, or its designee*
viii. *A state or federal law enforcement agency.*
ix. *And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.*

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

Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and

Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

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

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

The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later), except for pharmacy point of sale claims which shall be submitted within three hundred sixty-five (365) *Calendar Days of the date of the provision of care. 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.*

h. Contract Effective Date.

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

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

i. Tobacco-Free Policy.

The contract with a provider shall at a minimum include the following in relation to the implementation of a tobacco-free policy unless the provider is a residential provider facility described below.

[Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting [Provider] from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients [Provider] serves.

Contracts with facilities that are owned or controlled by the provider, and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required*:*

[Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

1. *Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].*
2. *For outdoor areas of campus, [PROVIDER] shall ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and prohibit staff/employees from using tobacco products anywhere on campus.*

Attachment 5

Attachment J: Fifth Revised and Restated Reporting Requirements

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

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

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

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

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

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

k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management payments.
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. AMH Integration Contracting Report	Monthly AMH Tier 3 practices contracting and integration status report
p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. High Needs Members Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members.
s. Crossover-Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.
t. Quarterly Admission and Readmission Report	Quarterly summary report of admission and readmission trends.
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
y. UM and Clinical Coverage Report	Ad Hoc report outlining analysis of compliance with attestation upon request.

4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.
c. Network Adequacy Exceptions Narrative Report	Quarterly narrative report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with PRV001-J Network Adequacy Exceptions Report
d. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy.
e. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Provider Contracting Determinations and Activities Narrative Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with PRV005-J: Provider Contracting Determinations and Activities Narrative Report.
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.

h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Essential Provider Alternate Arrangements Narrative Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy. To be submitted with the Essential Alternate Arrangements Report.
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. Reserved	Reserved
n. Provider Grievances, Appeals, and Litigated Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.
p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function

	effectiveness and recommendations for engagement/education approach adjustments based on survey results.
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Suspended and Terminated Providers Report	Monthly report showing suspended claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. PHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Referenced in Sections V.D.2.j.i.a / V.D.2.j.i.b.

y. UNC Vidant Hospital Directed Payment Report Data –Outpatient	Quarterly report to collect claims data to support outpatient directed payments to UNC / Vidant Hospitals.
z. UNC Vidant Hospital Directed Payment Report Data – Inpatient	Quarterly report to collect claims data to support inpatient directed payments to UNC / Vidant Hospitals.
5. ***Quality and Value***	
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	Reserved
d. Reserved	Reserved
e. Reserved	Reserved
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
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	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).

d. Secondary Call Center Service Line Report	Monthly secondary call center service line utilization and statistics.
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.
b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
g. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. (Section IV.4.d.)

9. ***Financial Requirements***	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template.
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.
d. NC PHP Claims Monitoring Report	Weekly summary of the volume and dollar amount of claims that were paid, denied, and rejected during the reporting period, and current inventory of pended claims by professional, institutional, and pharmacy. Top 10 denial reasons by volume and dollar amount.
10. *Healthy Opportunities Pilot*	
a. Healthy Opportunities Pilot Key Metrics Report	Quarterly report of Healthy Opportunities Pilot key metrics including, at a minimum, Members served, services used, total service delivery costs, and member cost and utilization metrics related to the Healthy Opportunities Pilots.
b. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PHP may submit if the Department notifies the PHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PHP's anticipated spending through the remainder of the Pilot service delivery year.
c. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of PHP Pilot service delivery spending.
d. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
e. Healthy Opportunities Pilot Care Management Payment Report	Monthly report of PHP spending on care management payments.
f. Healthy Opportunities Pilot Directing Pilot Services to High-Priority Populations Report	Quarterly report beginning in Pilot Service Delivery Year 2 on Pilot enrollment and how the PHP has directed Pilot services to high-priority populations.

Attachment 6

Attachment M. Policies

6. Third Revised and Restated 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 based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled provider.

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 relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Recredentialing Policy.

   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 North Carolina's Medicaid or NC Health Choice programs (or both).
            1. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
            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 or NC Health Choice 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 applicable_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.

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

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-Servic*e* 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 outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the PHP will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.

g) The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers.

1. A PHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

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

i. The PHP shall develop and implement, as part of its Credentialing and Re-credentialing Policy, through written policies and procedures for the selection and retention of network providers based upon the Department's Uniform Credentialing and Re-credentialing Policy. The PHP's 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) Reserved.
f) Reserved.
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.
k) Reserved.
l) Reserved.
m) Reserved.
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.
o) PHP shall evaluate a provider's continued eligibility 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 a statement that the current policy and all previous versions will be published on the PHP's website and include the Policy effective dates of each version.

ii. PHP shall follow this Policy when making a network 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 network contracting decisions consistent with this Department 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. The PHP shall make the Credentialing/Recredentialing Policy available, within ten (10) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

The remained of this page is intentionally left blank.

Attachment 7

Attachment M. Policies

8. First Revised and Restated Behavioral Health Service Definitions

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. Medically Monitored Inpatient Withdrawal Services: a crisis service for the purpose of network adequacy standards.
   e. Reserved.
   f. Reserved.
   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 (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.
   j. Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): 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. 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.

The remainder of this page is intentionally left blank.

Attachment 8

Attachment M. Policies

14. Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services: Conditions, Requirements and Standards

All capitalized terms used in this Attachment not otherwise defined herein shall have the meanings ascribed to them as set forth in the Contract.

1. Access to IPV-Related Information
    a. The PHP shall consider any authorizations, Services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member as "*IPV-Related Service Data*."
    b. The PHP shall ensure that all members of the PHP's workforce (which term, as used in this Attachment, includes PHP's employees and contractors, whether or not they are Care Managers) with access to Pilot-related data, including from NCCARE360, complete IPV-Related Data Training prior to IPV service launch, including :
        i. IPV-Related Services;
        ii. Handling of, privacy of, security of, and access to IPV-Related Service Data;
        iii. All such other trainings as required by the Contract and by the Department in its sole discretion. The Department shall provide at least ninety (90) Calendar days notice of any changes to the Healthy Opportunities Pilot IPV Protocol.
    c. Upon a PHP workforce member's completion of such trainings, the PHP may designate such individual as an "*IPV-Trained Individual*."
    d. The PHP shall keep current records of each IPV-Trained Individual's completion of IPV-Related Data Training for as long as such IPV-Trained Individual is employed or contracted by the PHP and, following termination or expiration of such individual's employment or contract, for the greater of any period of time as required by applicable law or one (1) year following such termination or expiration.
    e. The PHP shall ensure that only IPV-Trained Individuals are authorized to access and view IPV-Related Service Data. The PHP shall ensure that any PHP workforce member or Care Manager who is not an IPV-Trained Individual does not have authorization to access and may not access any IPV-Related Service Data.

2. IPV-Related Data Standards
    a. The PHP agrees to conduct routine and ongoing monitoring of IPV-Related Service Data, which monitoring shall include at a minimum:
        i. the maintenance of a regularly updated IPV-Related Service Data access log, which access log shall include the employee or contractor name, employee or contractor identification number, time and date that each record is accessed, and types of actions taken with respect to each record (e.g., viewing, downloading, printing, modifying records) and the periodic auditing of such access logs;
        ii. internal auditing of the PHP's adherence to the IPV-Related Data Policies (as referenced in Section 6 of this Attachment and reporting to the Department on the same, such auditing and reporting each occurring no less than annually or as frequently as otherwise directed by the Department in its sole discretion;

iii. reporting to the Department within the timeframes specified in *Section III.E.11. Privacy and Security Incidents and Breaches* of identifying any incident or breaches of IPV-Related Service Data in the custody of or maintained by the PHP or its contractors; and

iv. reporting to the Department within one (1) Business Day upon identification of any material non-compliance with any of the PHP's IPV-Related Data Policies.

b. In the event that the PHP discovers an incident or breach of IPV-Related Service Data, the PHP shall send written notice to each Care Manager within one (1) Business Day (as defined in Section 3 of this Attachment and HSO whose IPV-Related Service Data was or may have been affected by the incident or breach, informing the Care Manager and HSO of the nature and extent of the unauthorized access or breach, and providing the Care Manager and HSO with a list of Members whose data was or may have been affected by the unauthorized access or breach.

c. The PHP shall ensure that all of its PHP workforce members and Care Managers who have Healthy Opportunities Pilot responsibilities complete required Pilot-related training on privacy, security, and access controls related to IPV-Related Service Data and on relevant PHP policies and procedures relating to usage, storage and sharing of IPV-Related Service Data, including but not limited to the PHP's IPV-Related Data Policies (as referenced in Section 6 of this Attachment) prior to IPV service launch and annually thereafter.

3. Care Manager Training

a. The PHP shall ensure that Care Managers with Healthy Opportunities Pilot responsibilities are designated as IPV-Trained Individuals and receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment , including but not limited to the below trainings:

i. IPV-Related Data Training;
ii. Working with IPV survivors;
iii. Trauma-informed care delivery;
iv. Cultural Humility and/or Competency training;
v. The Healthy Opportunities Pilot consent process, including how to communicate to Members that while an initial Pilot consent is obtained by the Care Manager, HSOs may request that the Member execute additional consents depending on the services the HSO furnishes to the Member or the services that the Member may be eligible to access or receive.

4. Health Opportunities Pilot Enrollee Contact Preferences

The PHP shall ensure that:

a. When obtaining and recording a Member's contact preferences pursuant to *Section V.C.8.g.xxxv Healthy Opportunities Pilot Enrollee Communication Preferences* of the Contract, and such Member is authorized to receive, has received, or is currently receiving IPV-Related Services, Care Managers shall adhere to Department standard's as defined in the IPV-Related Data Training with respect to the level of specificity in recording Member contact preferences as provided for in the Care Manager IPV-Related Trainings.

5. Member Opt-In/Opt-Out Preferences
    a. In all communications with Members who are authorized to receive, have received, or are currently receiving IPV-Related Services, the PHP shall, and shall cause Care Managers and individuals in the PHP's workforce to, properly consider IPV survivor safety guidelines as set forth in the IPV-Related Data Training and the Care Manager IPV-Related Trainings.
    b. The PHP shall ensure that no member-facing materials targeting individuals who may be, or are currently, experiencing IPV are distributed without Department review and approval.
    c. When communicating with a Member pursuant to *Section V.C.8.g.xxxv Healthy Opportunities Pilot Enrollee Communication Preferences o*f the Contract and the Member in question is authorized to receive, has received, or is currently receiving IPV-Related Services, Care Managers and individuals in the PHP's workforce may send such communications only if adhering to the requirements set forth in Section 4 of this Attachment and taking all care necessary as directed by the Care Manager IPV-Related Trainings.
6. IPV-Related Policies and Enforcement
    a. The PHP shall develop a Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services Policy (IPV Policy) for review by the Department by March 15, 2023, and at the Department's request. The IPV Policy shall include all of the requirements of the PHP as defined in the Contract.

The remainder of this page is intentionally left blank.

Section X. Sixth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms

Blue Cross and Blue Shield of NC has an individual *Section X. Sixth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms* that is specific to BCBS as it contains a Part 1 for July 1, 2022 – Novebmer 30, 2022 rate period and a Part 2: December 1. 2022 – June 30, 2023 rate period.

AmeriHealth Caritas of NC, Carolina Complete Health, UnitedHealthcare of NC and WellCare of NC, have a *Section X. Sixth Revised and Restated Summary of Contractual Payment and Risk Sharing Terms* that contains the December 1, 2022 – June 30, 2023 rate period only.

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

This *Section X.* of Contract #30-190029-DHB Prepaid Health Plans Blue Cross and Blue Shield of North Carolina includes two (2) separate parts for Contractor (Healthy Blue) that summarizes the capitation payment and risk sharing terms and figures for the periods spanning July 1, 2022 – November 30, 2022, and December 1, 2022 – June 30, 2023.

Part 1: July 1, 2022 – November 30, 2022

This *Section X. Part 1: July 1, 2022 – November 30, 2022,* summarizes capitation payment and risk sharing terms and figures included elsewhere in the Standard Plan Rate Book for State Fiscal Year 2023 dated July 29, 2022, with capitation add-on rates for Healthy Blue applicable for the period spanning July 1, 2022 – November 30, 2022. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates, excluding the capitation add-on rates for Healthy Blue, will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model. The capitation add-on rates for Healthy Blue will be added to the risk adjusted rates.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,682.70	$1,601.73	$1,858.52	$1,701.82	$1,536.52	$1,532.32
TANF, Newborns (<1)	$1,027.18	$831.15	$924.50	$865.21	$828.49	$866.10
TANF, Children (1–20)	$183.73	$162.03	$174.11	$160.48	$162.78	$157.99
TANF, Adults (21+)	$404.84	$412.59	$422.13	$407.58	$431.61	$406.60
Maternity Event	$11,515.44	$10,862.95	$12,417.16	$11,257.89	$10,782.66	$11,805.50

PMPM Capitation Add-on Rates by Region and COA for PHE Related Rate Increases

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$7.31	$13.20	$20.77	$15.61	$13.09	$14.18
TANF, Newborns (<1)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF, Children (1–20)	$0.00	$0.01	$0.01	$0.00	$0.00	$0.00
TANF, Adults (21+)	$0.02	$0.27	$0.34	$0.24	$0.28	$0.21
Maternity Event	$0.00	$0.00	$0.00	$0.00	$0.28	$0.00

PMPM Capitation Add-on Rates by Region and COA for Healthy Blue July – November 2022

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$17.05	$16.89	$19.64	$18.03	$16.62	$16.00
TANF, Newborns (<1)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF, Children (1–20)	$6.92	$6.05	$6.61	$5.94	$6.03	$5.94
TANF, Adults (21+)	$9.41	$9.87	$10.24	$9.98	$10.41	$9.96
Maternity Event	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	91.7%	91.0%	91.5%	90.9%	91.3%	91.3%
TANF, Newborns (<1)	91.1%	90.3%	90.8%	90.0%	90.5%	90.6%
TANF, Children (1–20)	88.2%	87.6%	87.8%	85.8%	87.2%	87.7%
TANF, Adults (21+)	89.9%	89.4%	89.7%	89.1%	89.5%	89.6%
Maternity Event	94.5%	94.0%	94.3%	94.0%	94.2%	94.2%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.5%	4.8%	4.7%	4.5%	5.4%	4.8%
TANF, Newborns (<1)	11.2%	15.2%	14.2%	13.7%	15.4%	13.3%
TANF, Children (1–20)	17.9%	19.1%	18.6%	17.9%	18.4%	17.6%
TANF, Adults (21+)	8.9%	8.9%	9.3%	9.2%	10.3%	9.0%
Maternity Event	15.3%	16.1%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.2%	88.8%	85.8%	88.1%	92.3%	88.0%

Part 2: December 1, 2022 – June 30, 2023

This *Section X. Part 2: December 1, 2022 – June 30, 2023,* summarizes capitation payment and risk sharing terms and figures included in the Standard Plan Rate Book for State Fiscal Year 2023 dated November 17, 2022, and effective as of December 1, 2022. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model. The capitation add-on rates for Healthy Blue will be added to the risk adjusted rates for the December 1, 2022 through January 31, 2023 time period.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,687.80	$1,603.68	$1,865.66	$1,713.16	$1,536.90	$1,544.19
TANF, Newborns (<1)	$1,021.84	$829.84	$923.65	$863.94	$827.35	$865.09
TANF, Children (1–20)	$185.15	$163.03	$175.27	$161.56	$163.77	$158.98
TANF, Adults (21+)	$415.89	$422.76	$432.28	$417.82	$443.02	$415.64
Maternity Event	$11,637.04	$10,925.24	$12,479.93	$11,329.20	$10,835.91	$11,874.72

PMPM Capitation Add-on Rates by Region and COA for PHE Related Rate Increases

Category of Aid	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$8.29	$14.13	$22.07	$16.65	$13.68	$14.98
TANF, Newborns (<1)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF, Children (1–20)	$0.00	$0.01	$0.01	$0.00	$0.00	$0.00
TANF, Adults (21+)	$0.02	$0.28	$0.37	$0.25	$0.29	$0.22
Maternity Event	$0.00	$0.00	$0.00	$0.00	$0.28	$0.00

PMPM Capitation Add-on Rates by Region and COA for Healthy Blue December 2022 – January 2023

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$17.05	$16.89	$19.64	$18.03	$16.62	$16.00
TANF, Newborns (<1)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF, Children (1–20)	$6.92	$6.05	$6.61	$5.94	$6.03	$5.94
TANF, Adults (21+)	$9.41	$9.87	$10.24	$9.98	$10.41	$9.96
Maternity Event	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	91.8%	91.1%	91.6%	91.1%	91.4%	91.4%
TANF, Newborns (<1)	91.2%	90.4%	90.9%	90.1%	90.6%	90.7%
TANF, Children (1–20)	88.3%	87.8%	88.0%	86.0%	87.4%	87.8%
TANF, Adults (21+)	90.0%	89.6%	89.9%	89.3%	89.7%	89.7%
Maternity Event	94.5%	94.1%	94.4%	94.0%	94.3%	94.3%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.5%	4.9%	4.7%	4.5%	5.4%	4.7%
TANF, Newborns (<1)	11.3%	15.3%	14.2%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.9%	19.1%	18.5%	17.8%	18.4%	17.5%
TANF, Adults (21+)	8.9%	8.9%	9.2%	9.1%	10.2%	8.9%
Maternity Event	15.4%	16.0%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.2%	88.8%	85.8%	88.1%	92.2%	88.0%

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

(Applies to AmeriHealth Caritas, Carolina Complete Health, UnitedHealthcare and WellCare.)

This *Section X.* summarizes capitation payment and risk sharing terms and figures included in the Standard Plan Rate Book for State Fiscal Year 2023 dated November 17, 2022, and effective as of December 1, 2022. The ABD, TANF and Other Related Children ages 1-20, and TANF and other Related Adults ages 21+ rates will be risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk adjustment model.

Base Capitation Rates by Region and COA

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$1,687.80	$1,603.68	$1,865.66	$1,713.16	$1,536.90	$1,544.19
TANF, Newborns (<1)	$1,021.84	$829.84	$923.65	$863.94	$827.35	$865.09
TANF, Children (1–20)	$185.15	$163.03	$175.27	$161.56	$163.77	$158.98
TANF, Adults (21+)	$415.89	$422.76	$432.28	$417.82	$443.02	$415.64
Maternity Event	$11,637.04	$10,925.24	$12,479.93	$11,329.20	$10,835.91	$11,874.72

PMPM Add-on by Region and COA

Category of Aid	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	$8.29	$14.13	$22.07	$16.65	$13.68	$14.98
TANF, Newborns (<1)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TANF, Children (1–20)	$0.00	$0.01	$0.01	$0.00	$0.00	$0.00
TANF, Adults (21+)	$0.02	$0.28	$0.37	$0.25	$0.29	$0.22
Maternity Event	$0.00	$0.00	$0.00	$0.00	$0.28	$0.00

Target Service Ratio Underlying Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	91.8%	91.1%	91.6%	91.1%	91.4%	91.4%
TANF, Newborns (<1)	91.2%	90.4%	90.9%	90.1%	90.6%	90.7%
TANF, Children (1–20)	88.3%	87.8%	88.0%	86.0%	87.4%	87.8%
TANF, Adults (21+)	90.0%	89.6%	89.9%	89.3%	89.7%	89.7%
Maternity Event	94.5%	94.1%	94.4%	94.0%	94.3%	94.3%

Minimum PCP Expenditures as a Percentage of Base Capitation Rates

COA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ABD	4.5%	4.9%	4.7%	4.5%	5.4%	4.7%
TANF, Newborns (<1)	11.3%	15.3%	14.2%	13.8%	15.4%	13.4%
TANF, Children (1–20)	17.9%	19.1%	18.5%	17.8%	18.4%	17.5%
TANF, Adults (21+)	8.9%	8.9%	9.2%	9.1%	10.2%	8.9%
Maternity Event	15.4%	16.0%	15.5%	15.5%	16.8%	16.5%

Contractual Minimum MLR Thresholds by Rating Group

ABD	TANF, Newborn (<1)	TANF, Child (1-20)	TANF, Adult (21+)	Maternity Event	Total Standard Plan
89.2%	88.8%	85.8%	88.1%	92.2%	88.0%