Amendment Number 15 (16)
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; and
IV. Section VII. Attachments A – N (O).

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. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, A. Definitions*. The following defined terms are revised and restated as identified herein:

11. **Beneficiary:** An individual that is eligible to receive North Carolina Medicaid benefits but who may or may not be enrolled in the Medicaid Managed Care program.
26. **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. It does not include a claim from a provider who is suspended, 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.
38. **Cross-over Population:** Refers to North Carolina Medicaid beneficiaries that are enrolled in the Medicaid Fee-for-Service program and will transition to Medicaid Managed Care at a specific date determined by the Department.
48. **Eligibility:** A series of requirements that determine whether an individual is eligible for North Carolina Medicaid benefits.

51. **Enrollment:** The process through which a beneficiary selects or is auto-assigned to a PHP to receive North Carolina Medicaid benefits through the Medicaid Managed Care program.
55. **Family Member:** Any household member who is eligible for North Carolina Medicaid and included in Medicaid Manage Care.
87. **Medicaid Managed Care:** The name of the North Carolina managed care program for North Carolina Medicaid benefits; does not include LME/MCOs.
101. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department integrated case management system that provides eligibility and enrollment for Medicaid, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
102. **North Carolina Health Choice (NC Health Choice):** The Health Insurance Program for Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children. As authorized under Section 9D.15 of S.L. 2022-74, NC Health Choice transitioned to NC Medicaid on April 1, 2023.
130. **Provider Enrollment:** The process by which a provider is enrolled in North Carolina's Medicaid program, with credentialing as a component of enrollment. A provider who has enrolled in North Carolina's Medicaid program shall be referred to as a "Medicaid Enrolled provider" or an "Enrolled Medicaid provider".
137. **Redeterminations:** The annual review of beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid.
145. **Standard Plan:** A Medicaid managed care plan that will provide integrated physical health, behavioral health and pharmacy services to most North Carolina Medicaid beneficiaries and that are not BH IDD Tailored Plans as described in in Section 4.(10) of S.L. 2015-245, as amended by S.L. 2018-48.

b. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, A. Definitions*** **is revised to add the following newly define term:**

170. **Excluded Person:** A person or corporate entity who appears on one or more of the exclusion lists.

c. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, C. Contract Term, First Revised and Restated Section III. C. Table 1: Contract Term is*** **revised and restated as follows:**

1. The initial Contract Term will be from the Contract Effective Date through December 1, 2026, and shall include an implementation period and Contract Years 1 through 6 as follows:

Second Revised and Restated Section III. C. Table 1: Contract Term	
Contract Period	**Effective Dates**
Implementation Period	Contract Award through June 30, 2021
Contract Year 1	July 1, 2021 through June 30, 2022
Contract Year 2	July 1, 2022 through June 30, 2023
Contract Year 3	July 1, 2023 through June 30, 2024
Contract Year 4	July 1, 2024 through June 30, 2025
Contract Year 5	July 1, 2025 through June 30, 2026
Contract Year 6	July 1, 2026 through December 1, 2026

d. ***Section III. Definitions, Contract Terms, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 11. CONTRACT ADMINISTRATORS, Department's HIPAA and Policy Coordinator for all Federal, State, and Department privacy matters herein:*** **is revised and restated as follows:**

Name & Title	Andrew A. Albright, Privacy Officer
Address 1 Physical Address	1985 Umstead Drive, Kirby Building Raleigh, NC 27603
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7747
Email Address	Andrew.a.albright@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

e. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, a. Managed Care Payments, iv.*** **is revised and restated as follows:**

iv. Reserved;

f. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, i. Other Managed Care Payment Terms and Conditions*** **is revised and restated as follows:**

i. Payment will only be made for services provided and is contingent upon satisfactory performance by the Contractor of its responsibilities and obligations under the Contract.
ii. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other adjustments as described in *Section V.E. Quality Management and Quality Improvement* and *Section VI. Contract Performance* to any payment due to Contractor.
iii. The Contractor is responsible for all payments to subcontractors under the Contract. The Department shall not be liable for any purchases or subcontracts entered into by the Contractor or any subcontracted Provider in anticipation of funding.

iv. All payments shall be made by electronic funds transfers. Contractor shall set up the necessary bank accounts and provide written authorization to Medicaid's Fiscal Agent to generate and process monthly payments.
v. Contractor shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).
vi. Contractor shall maintain separate accounting for revenue and expenses for payments under this Contract in accordance with CMS requirements.

g. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT, k.*** **is revised and restated as follows:**

k. Reserved.

h. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 50. WAIVER*** **is revised and restated as follows:**

50. **WAIVER**: The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance. The Department reserves the right to waive any of the requirements in this Contract by providing written notice of such waiver to Contractor. In order to constitute a waiver, said waiver must be entitled "Waiver of Contract Requirements," list the specific requirement(s) being waived, the timeframe for such waiver, and be signed and dated by the Deputy Secretary for the Division of Health Benefits. For avoidance of doubt or dispute, there shall be no tacit, de facto, verbal, informal, or written waivers signed by anyone other than the Deputy Secretary for the Division of Health Benefits. Without such explicit written and signed "Waiver of Contract Requirements" document, the waiver is not effective.

i. ***Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections, F. Public Records and Trade Secrets Protections, 2.*** **is revised and restated as follows:**

2. Regardless of what Contractor may label as a trade secret, the determination of whether it is or is not entitled to protection will be made in accordance with N.C. Gen. Stat. § 132-1.2 and N.C. Gen. Stat. § 66-152(3). If any challenge, legal or otherwise, is made related to the confidential nature of information redacted by the Contractor, the Department will provide reasonable notice of such action to Contractor, and Contractor shall be responsible for the cost and defense of, or objection to, release of any material. The Department is not obligated to defend any challenges as to the confidential nature of information identified by the Contractor as being trade secret, proprietary, and otherwise confidential. The Department shall have no liability to Contractor with the respect to disclosure of Contractor's confidential information ordered by a court of competent authority pursuant to N.C. Gen. Stat. § 132-9 or other applicable law.

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, c.*** **is revised and restated as follows:**

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

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

o) Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide;

c. ***Section V.A. Administration and Management, 2. Entity Requirements, b. PLE Governance and Operations, i.*** **is revised and restated as follows:**

i. The majority of voting members on the governing body of each PLE shall be licensed in North Carolina as physicians, physician assistants, nurse practitioners or psychologists, and have treated beneficiaries of North Carolina Medicaid.

d. ***Section V.A. Administration and Management, 2. Entity Requirements, b. PLE Governance and Operations, vii.*** **is revised and restated as follows:**

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

e. ***Section V.A. Administration and Management, 3. National Committee for Quality Assurance (NCQA) Accreditation, a.- b.*** **are revised and restated as follows:**

a. The PHP shall achieve NCQA Health Plan Accreditation by the end of Contract Year 4.
b. The PHP shall achieve NCQA Health Equity Accreditation by the end of Contract Year 4.

f. ***Section V.B. Members, 2. Medicaid Managed Enrollment and Disenrollment, b.*** **is revised and restated as follows:**

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

g. ***Section V.B. Members, 2. Medicaid Managed Enrollment and Disenrollment, d.*** **is revised and restated as follows:**

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

h. ***Section V.B. Members, 2. Medicaid Managed Enrollment and Disenrollment, f.*** **is revised restated as follows:**

f. The PHP shall ensure automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid 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 eligibility for a period of ninety (90) Calendar 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.

i. ***Section V.B. Members, 2. Medicaid Managed Enrollment and Disenrollment, i. PHP auto-assignment, i.*** **is revised and restated as follows:**

i. Pursuant to 42 C.F.R. § 435.54, Members who do not select a PHP as part of the North Carolina Medicaid application process will be auto-assigned to a PHP.

j. ***Section V.B. Members, 3. Member Engagement, f. Member Services Website, ii.*** **is revised and restated as follows:**

ii. The PHP shall develop and maintain a dedicated, interactive North Carolina Medicaid Member services website that, at a minimum, has the functionality to allow the Member to search for in-network providers and search through the drug formulary.

k. ***Section V.B. Members, 3. Member Engagement, k. Member Welcome Packet, i., a)- b)*** **is revised and restated as follows:**

a) For Members who select a PHP during the Open Enrollment period through May 31, 2021, the PHP shall send the Welcome Packet no earlier than May 16, 2021, and no later than June 5, 2021. If the Member does not select a PCP, the PHP shall not send the Welcome Packet until the PHP receives confirmation of the Member's PCP selection from the Department on the 834 enrollment file or other standard eligibility and enrollment file. The PHP shall ensure a Member does not receive two Welcome Packets.

b) For all new Members enrolled after May 31, 2021, the PHP shall send the Welcome Packet within six (6) Calendar Days of receipt of a Member enrollment information with confirmation of the Member's PCP assignment on the 834 enrollment file or other standard eligibility and enrollment file.

l. ***Section V.B. Members, 3. Member Engagement, k. Member Welcome Packet, ii.*** **is revised and restated as follows:**

ii. The PHP shall include the following in the initial Member Welcome Packet:

m. ***Section V.B. Members, 3. Member Engagement, l. Member Identification Cards, i., a)*** **is revised and restated as follows:**

a) The Member's North Carolina Medicaid identification number.

n. ***Section V.B. Members, 3. Member Engagement, m. Member Handbook, i.*** **is revised and restated as follows:**

i. The PHP shall ensure that each Member is sent a Member Handbook, which serves as a summary of benefits and coverage, within six (6) Calendar Days after the PHP receives notice of the Member's enrollment in the PHP. 42 C.F.R. § 438.10(g)(1).

o. ***Section V.B. Members, 3. Member Engagement, m. Member Handbook, iv., k)*** **is revised and restated as follows:**

k) Cost sharing, if any, imposed on North Carolina Medicaid beneficiaries.

p. ***Section V.B. Members, 5. Member Rights and Responsibilities, i.*** **is revised and stated as follows:**

i. Reserved.

q. ***Section V.B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vi. Internal Plan Appeals, e)*** **is revised and restated as follows:**

e) The PHP shall provide Members and his or her authorized representative the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PHP (or at the direction of the PHP) in connection with the appeal. The PHP shall provide the information to the Member free of charge and within five (5) Calendar Days from the receipt of request for standard appeals and within two (2) Calendar Days from the receipt of request for expedited appeals. 42 C.F.R. § 438.406(b)(5).

r. ***Section V.B. Members, 6. Member Grievances and Appeals, h. NC Health Choice Member Grievances and Appeals*** **is revised and restated as follows:**

h. Reserved.

s. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, b., i.*** **is revised and restated as follows:**

i. Cover all services in the North Carolina Medicaid State Plan with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract.

t. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services, v.*** **is revised and restated as follows:**

v. The PHP shall adhere to the Department's Managed Care Clinical Supplemental Guidance, which references requirement for clinical coverage with supplement NC Medicaid clinical coverage policies.

u. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services, x., d)* is revised and restated as follows:

d) Reserved.

v. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services, xi.* is revised and restated as follows:

xi. Reserved.

w. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered services, i.* is revised and restated as follows:

i. The PHP shall cover all services as defined in the Medicaid State Plans with the exception of services carved out under Section 4.(4) of Session Law 2015-245, as amended;[7] as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid State Plan covered services is described in *Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Covered Services* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid State Plan);

x. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, Third Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services* is revised and restated as follows:

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 - Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; Meets the requirements for participation in Medicare as a hospital; and	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 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

[7] Ibid.

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66. Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to Subsection 1.1.1, above) may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a). Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid and NCHC beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals 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.	

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that— Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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
Nursing facility services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. § 440.40 42 C.F.R. § 440.140 42 C.F.R. § 440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
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.	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 Clinical Coverage Policy 3A

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 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.	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 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 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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) NC Clinical Coverage Policy 1B-2, Rituximab (Rituxan) NC Clinical Coverage Policy 1B-3, Intravenous Iron Therapy
Rural health clinic services	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 4; Att. 3.1-A, Page 1 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 Federally Qualified Health Centers and Rural Health Clinics
Federally qualified health center services	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;	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 Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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.	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 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
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 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 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) 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	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	NC Clinical Coverage Policy 1E-7, Family Planning Services
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 - 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. (b) 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 - i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services.	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a family nurse practice limited to providing primary health care to individuals and families.	
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
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 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 D, NC NEMT Policy
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program 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.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Clinical Coverage Policy 15
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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 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 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.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4
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	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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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.	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)
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive 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.	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 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 Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Limited inpatient and outpatient behavioral health	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
services defined in required clinical coverage policy	preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Please refer to NC Clinical Coverage Policies and services listed.	NC 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 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 Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Other diagnostic, screening, preventive and rehabilitative services	(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	(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 NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Optometry services	Medicaid 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 G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	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
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 Carolina Board	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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 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.	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)
Hospice services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 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.	North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services
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	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	8. Enteral nutrition equipment	
Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) 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 Clinical Coverage Policy 3H-1, Home Infusion Therapy
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems. *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
Inpatient psychiatric services for individuals under age 21	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	treatment for beneficiaries with acute psychiatric or substance use problems.	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 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 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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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 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
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
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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	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
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
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
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

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
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
Ophthalmological Services	General ophthalmologic services Include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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.	
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 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
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
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	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 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);	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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.	

y. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, d. Medical Necessity, i.* is revised and restated as follows:

i. For North Carolina Medicaid Members, the PHP shall cover all medically necessary services in accordance with *Section V.C. Benefits and Care Management*.

z. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, x., a)* is revised and restated as follows:

a) A chart of all North Carolina Medicaid clinical coverage policies is found in *Attachment B. First Revised and Restated Clinical Coverage Policy List.*

aa. *Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, xi.* is revised and restated as follows:

xi. For a limited number of services, the PHP shall incorporate existing North Carolina Medicaid Fee-for-Service clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with

State mandates, as described in *Second Revised and Restated Section V.C. Table 4: Required Clinical Coverage Policies*.

bb. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, xiii.*** **is revised to add the following:**

h) Nursing facility stays: After an initial approval of a nursing facility stay by the PHP, the PHP shall complete the health plan portion of the DHB-2039 (PHP Notification of Nursing Facility Level of Care) form and send the form to the nursing facility within one (1) Business Day of the Prior Approval.

cc. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, xv. UM Program Policy*** **is revised to add the following:**

e) No later than October 31, 2023, the PHP shall provide a publicly available prior authorization look-up tool for medical services to providers to support timely prior authorization requests from providers. The prior authorization look-up tool should include all medical/behavioral health prior authorization requirements and the tool should be accessible without any login from a provider.

dd. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, f. Telehealth, Virtual Patient Communications and Remote Patient Monitoring, i.*** **is revised and restated as follows:**

i. The PHP shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid beneficiaries as an alternative service delivery model, where clinically appropriate, in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. The services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).

ee. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services, i.*** **is revised and restated as follows:**

i. The PHP may use In Lieu of Services (ILOS), services or settings that are not covered under the North Carolina Medicaid State Plan, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)i-iv.

ff. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services, ii., b)*** **is revised and restated as follows:**

b) Prior to change, reduction, or removal, the PHP shall submit the Department's standardized ILOS Service Termination Form to the Department for approval. Upon approval of a change, reduction, or removal, the PHP shall notify all impacted Members

of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

gg. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, h. Value-Added Services, iii. b)*** **is revised and restated as follows:**

b) Prior to change, reduction, or removal of a Value-Added Service, the PHP shall submit the Department's standardized Value-Added Services Termination Form to the Department for approval. Upon approval of a change, reduction, or removal, the PHP shall notify all impacted Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

hh. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing, i.*** **is revised and restated as follows:**

i. The PHP shall impose the same cost-sharing amounts as specified in North Carolina's Medicaid State Plan.

ii. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing, v. Exceptions for cost sharing, a)*** **is revised and restated as follows:**

a) Reserved.

jj. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing, v. Exceptions for cost sharing, c)*** **is revised and restated as follows:**

c) Reserved.

kk. ***Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing*****, is revised to add the following:**

vi. Pursuant to Section 11405 of the Inflation Reduction Act (IRA), the PHP shall not apply cost sharing for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration effective October 1, 2023.

ll. ***Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, First Revised and Restated Section V.C. Table 5: Medicaid Managed Care Cost Sharing*** **is revised and restated as follows:**

Second Revised and Restated Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	**ANNUAL ENROLLMENT FEE**	**SERVICE**	**COPAY**
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency Visit in Hospital ER	$4/visit $4/visit $4/visit $4/script $4/visit $4/visit $4/visit $4/visit

mm. ***Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, j. Noticing Requirements, ii.*** **is revised and restated as follows:**

ii. The PHP shall provide written notice to Members of any Department-initiated changes to the Medicaid benefits package or cost sharing requirements.

nn. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, c. Drug Formulary and Preferred Drug List, iii., a)*** **is revised and restated as follows:**

a) All drugs included the North Carolina Medicaid Preferred Drug List (PDL) as posted on the Department's website. The PHP shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid PDL.

oo. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, c. Drug Formulary and Preferred Drug List, vii., a)*** **is revised and restated as follows:**

a. The PHP will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid PDL. The PHP shall update their pharmacy claim system within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.

pp. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, d. Utilization Management, ii.*** **is revised and restated as follows:**

ii. For pharmacy services, the PHP shall follow the existing Medicaid Fee-for-Service clinical coverage policies, prior authorization (PA) criteria, and clinical criteria into the UM Program as described in:

qq. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, d. Utilization Management, iv., j)*** **is revised and restated as follows:**

j) The PHP shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program or another PHP through the expiration date of the active service authorization.

rr. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, a)*** **is revised and restated as follows:**

a) The PHP shall reimburse pharmacies ingredient costs at the same rate at the Medicaid Fee-for-Service rate.

ss. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, g) Ingredient Costs for 340B, 1.*** **is revised and restated as follows:**

1. Traditional 340B drugs purchased through the 340B program shall be reimbursed by the PHP based on the Fee for Service reimbursement methodology for 340B drugs as defined in the State Plan and applied to the Medicaid Fee-for-Service program.

tt. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, h) Reimbursement for Drugs in Indian Health Services, 1., ii.*** **is revised and restated as follows:**

ii. For drugs with a calculated allowable amount equal to or greater than $1,000, the PHP shall reimburse the I/T/U utilizing the current Fee-for-Services reimbursement methodology as defined by the State Plan. The following is a list of exclusions to the I/T/U OMB encounter/ All Inclusive Rate (AIR):
    a. Drugs and vaccines procured free of charge,
    b. Emergency supply dispensation,
    c. Eyeglasses,
    d. Prosthetic devices and hearing aids,
    e. Diabetic testing supplies and continuous glucose monitors,
    f. Drug counseling or medication therapy management,
    g. 340B drugs,
    h. Medicare Part-B drugs,
    i. Reserved,
    j. Professional dispensing fees,
    k. Collection of rebates,
    l. Drug delivery or mailing, and
    m. Drugs dispensed to Members assigned to Family Planning Waiver benefit plans.

uu. ***Section V.C. Benefits and Management, 3. Pharmacy Benefits, i. Drug rebates, i.*** **is revised and restated as follows:**

i. The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid Program to a PHP. The PHP or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid Program.

If the PHP or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.

vv. ***Section V.C. Benefits and Management, 4. Transition of Care, e. Transition of Care for Members enrolled in the Healthy Opportunities Pilot, ii., a), 1., iii., d.*** **is revised and restated as follows:**

d. Date of Pilot enrollment; and
e. Payments made for Pilot services.

ww. ***Section V.C. Benefits and Care Management, 5. Non-Emergency Medical Transportation, a.*** **is revised and restated as follows:**

a. The PHP shall provide non-emergency medical transportation (NEMT) services to ensure that Members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid enrolled providers.

xx. ***Section V.C. Benefits and Care Management, 5. Non-Emergency Medical Transportation, c., iii.*** **is revised and restated as follows:**

iii. For a Medicaid covered service, including services carved out of Medicaid Managed Care, provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider).

yy. ***Section V.C. Benefits and Care Management, 5. Non-Emergency Medical Transportation, i.*** **is revised and restated as follows:**

i. The individuals included in *First Revised and Restated Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the PHP.

First Revised and Restated Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services	
Members in a nursing home	The facility is responsible for providing transportation to their patients.

zz. ***Section V.C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, v. Local Care Management Provided by Local Health Departments, a) General Requirements, 1.*** **is revised and restated as follows:**

1. In Contract Years 1-4, the PHP shall contract with each Local Health Department (LHD) in its Region(s) to provide care management services to High Risk Pregnant Women and At-Risk Children, to the extent that each LHD chooses to provide these services.

aaa. ***Section V.C. Benefits and Care Management, 7. Prevention and Population Health Management Programs, g. Tobacco Cessation Services*** **is revised to add the following:**

vi. The PHP's contract with the Quitline shall include coverage of the Quitline Behavioral Health protocol (seven (7) sessions and twelve (12) weeks of combination Nicotine Replacement Therapy).

bbb. ***Section V.C. Benefits and Care Management, 8. Opportunities for Health, g. Enhanced Case Management Pilot to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xii. Member Outreach and Identification of Potentially Pilot-Eligible Members, a)*** **is revised to add the following:**

2. The PHP shall incorporate the use of Department-developed outreach and marketing materials in the PHP's engagement with Providers and Members within the Pilot counties. This shall include, but is not limited to, flyers, handouts and talking points. The PHP shall submit to the Department for review and approval any modifications made to Department-developed outreach and marketing materials prior to distributing materials to Members and Providers.

ccc. ***Section V.C. Benefits and Care Management, 8. Opportunities for Health, g. Enhanced Case Management Pilot to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xii. Member Outreach and Identification of Potentially Pilot-Eligible Members*** **is revised to add the following:**

d) The PHP shall include a Healthy Opportunities Pilot indicator on the PHP's Patient Risk List sent to Delegated Pilot Care Management Entities indicating Members who are likely eligible for the Healthy Opportunities Pilot based on the population health management capabilities listed in *Section V.C.8.g.xii.c)* and using any Department-determined methodology. The PHP shall have at least ninety (90) Calendar Days' notice to implement any Department-determined methodology.

e) Expedited Enrollment. By a date to be identified by the Department with at least ninety (90) Calendar Days' notice, the PHP shall:

1. Identify potentially Pilot-eligible members for expedited enrollment into the Pilot. This shall include the use of population health management capabilities listed in *Section V.C.8.g.xii.c)* and any Department-determined methodology for the Patient Risk List listed in *Section V.C.8.g.xii.c)*.
2. Contact potentially Pilot-eligible members through a mechanism (e.g., text message, email) and with language to be determined by the Department. This outreach will notify the Member that they may be eligible for Pilot services and how to access Pilot services. Outreach shall have the ability to include one-time-use links to a Department-specified web portal and the ability for members to opt out of further communications. The PHP will not be responsible for developing the Department-specified portal.
3. Confirm the receipt of necessary HIPAA authorizations for Members enrolled in the Pilot through the expedited enrollment process.
4. Receive Pilot claims directly from HSOs and make payment for those claims to HSOs in accordance with the technology requirements to be established by the Department.
5. Use the receipt of expedited enrollment claims to trigger outreach to members with such a claim by a care manager. The care manager can be within the PHP or at a Delegated Pilot Care Management Entity. The care manager shall reach out to the member to document the member's Pilot eligibility in NCCARE360, assess the

member for additional non-medical needs, and connect the member to other Pilot or non-Pilot services, as appropriate.

6. Expedited enrollment activities may be exclusive to a subset of HSOs, services, PHPs, enrollees, or other criteria as indicated by the Department.

ddd. *Section V.C. Benefits and Care Management, 8. Opportunities for Health, g. Enhanced Case Management Pilot to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, xxxv. Healthy Opportunities Pilot Enrollee Communication Preferences* is revised and restated as follows:

xxxv. Healthy Opportunities Pilot Enrollee Communication Requirements

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

1. Its employed or contracted Care Managers obtain the Healthy Opportunities Pilot Enrollee's contact requirements from each Healthy Opportunities Pilot Enrollee assigned to them, which requirements 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 requirements 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 requirements, as outlined in the Healthy Opportunities Pilot IPV Protocol, prior to each instance of conducting outreach to such Enrollee.

(2) Healthy Opportunities Pilot Enrollee Opt-In/Opt-Out Communication Requirements

1. The PHP shall ensure that all individuals in PHP's employed and contracted workforce (including Care Managers) adhere to Healthy Opportunities Pilot Enrollees' requirements 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.*, 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 Requirements.*

eee. ***Section V.D. Providers, 1. Provider Network, a.*** **is revised and restated as follows:**

a. Providers are the backbone of North Carolina's Medicaid Program and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks PHPs which share and support that tradition.

fff. ***Section V.D. Providers, 1. Provider Network, g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207), i., d)*** **is revised and restated as follows:**

d) The Department will supply Member eligibility information that includes county of residence and residence zip code for the Medicaid beneficiary that is in the mandatory enrollment population as of the date of the report. The information will be provided to the Contractor after Contract Award, at a date to be defined by the Department for purposes of demonstrating compliance with the time and distance standards found in *Attachment F. Fourth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* during the Readiness Review, and at other times as needed as part of the network adequacy oversight.

ggg. ***Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, xxii.*** **is revised and restated as follows:**

xxii. For any provider subject to a rate floor as outlined in *Section V.D.4. Provider Payments*, a PHP may include a provision in the provider's contract that the PHP will pay the lesser of billed charges or the rate floor only if (i) *Section V.D.4. Provider Payments* specifies that the PHP may enter into an alternative reimbursement amount or methodology with the provider and (ii) the PHP and provider have to mutually agree to an alternative reimbursement amount or methodology which includes a "lesser than" provision. A PHP shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

hhh. ***Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, xxiii., a.*** **is revised and restated as follows:**

a. Any change to a standard provision required by *Attachment G., Sixth Revised and Restated Required Standard Provisions for PHP and Provider Contracts*, is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.u., 1.v., 1.w., 1.x., 1.cc, or 1.ee. which must be prior approved by the Department.

iii. ***Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, xxiv. Tobacco-free Policy*** **is revised and restated as follows:**

xxiv. Tobacco-free Policy

a. Starting April 1, 2024, the PHP shall require contracted Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the 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 products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

b. Starting April 1, 2024, the following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:
    1. Use of tobacco products is prohibited indoors when the building or home in which the provider operates is under the provider's control as owner or lessee.
    2. Outdoor areas of the property under the provider's control as owner or lessee must:
        a) Ensure access to common outdoor space(s) free from exposure to tobacco use; and
        b) Prohibit staff/employees from using tobacco products anywhere on the property.
        c) Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

c. Provider Monitoring
    1. Starting April 1, 2024, the PHP shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The PHP shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The PHP shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

jjj. ***Section V.D. Providers, 3. Provider Relations and Engagement, b. Provider Relations: Service Line; Provider Portal; Welcome Packet, iv.*** **is revised and restated as follows:**

iv. The PHP shall send a Welcome Packet and enrollment notice to providers within five (5) Calendar Days of executing a contract with the Provider for participation within its Medicaid Managed Care Network. The Welcome Packet must include orientation information and instructions on how to access the PHP's Provider Manual.

kkk. ***Section V.D. Providers, 4. Provider Payments, g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments*** **is revised to add the following:**

iii. The Department intends to submit a North Carolina State Plan Amendment (SPA) to CMS for their review and approval. These SPAs amend the reimbursement structure to FQHCs and RHCs respectively. The Department shall notify the PHP upon receipt of each SPA approval.

iv. Upon approval by CMS, the following shall occur within a timeline to be specified by the Department:

a) The PHP shall reimburse in network FQHCs and RHCs for Core Services visits (T1015) and Well Child visits at the respective North Carolina Medicaid Fee Schedule for FQHC and RHC Base Rates ("base reimbursement amount."). All ancillary services (i.e. radiology, etc.) shall be the based on the North Carolina Medicaid Physician Fee Schedule and shall follow established rules as described in the "Managed Care Billing Guidance to Health Plans."

b) The PHP shall issue FQHCs and RHCs a supplemental wraparound payment for covered Core Service visits (T1015) and Well Child Visits, which is equal to the difference between the provider specific Prospective Payment System (PPS)/Alternative Payment Methodology (APM) Rate from the North Carolina Medicaid PPS/APM Fee Schedule and the base reimbursement amount.

c) The PHP shall identify in the payment of the claim the base reimbursement amount and the supplemental wraparound amount totaling the provider specific PPS/APM Rate reimbursement pursuant to the "Managed Care Billing Guidance to Health Plans". Following implementation of PPS/APM Rate reimbursement by PHPs to the FQHC and RHC providers, the Department shall extract a report of paid FQHC and RHC encounters for Core Service and Well Child visits from EPS on a monthly basis and remit reimbursement to the PHPs for the supplemental wraparound payment.

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

ii. For Contract Years 1-4, the PHP shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.56 PMPM for all enrolled children ages 0-5). The Department reserves the right to further prescribe the Care Management for At-Risk Children reimbursement amount or methodology or to change the methodology in Contract Years after Contract Year 1.

mmm. ***Section V.D. Providers, 4. Provider Payments, i. Local Health Department (LHD) Payments, iv.*** **is revised and restated as follows:**

iv. For Contract Years 1-4, the PHP shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.96 PMPM for all enrolled women, ages 14 to 44). The Department reserves the right to further prescribe the Care Management for High Risk Pregnant Women reimbursement amount or methodology as allowed under 42 C.F.R. § 438.6(c) or to change the methodology in Contract Year 2 or Contract Year 3.

nnn. ***Section V.D. Providers, 4. Provider Payments, j. Public Ambulance Provider Payments, i.*** **is revised and restated as follows:**

i. The PHP shall reimburse in-network public ambulance providers no less than 100% of base rates specified in the Public Ambulance Managed Care Fee Schedule for Medicaid members (as allowed under 42 C.F.R. § 438.6(c)(iii)(B)), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

ooo. 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)), x., b) is revised and restated as follows:

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 average commercial rate determined by the Department multiplied by the actual utilization for the eligible professionals.

ppp. ***Section V.D. Providers, 4. Provider Payments, r. Out of Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services), v.*** **is revised and restated as follows:**

v. The PHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee-for-Service rates specified in State Plan Amendments 4.19-A and 4.19-B (Medicaid) when the services meet any of the following criteria:

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

ii. Electronic Visit Verification System (EVV)
  i. Beginning February 1, 2023, the PHP shall increase reimbursement to Home Health Care Services (HHCS) providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic.
  ii. This reimbursement rate increase applies to the following services:
    a) Physical Therapy.
    b) Physical Therapy evaluation.
    c) Occupational Therapy.
    d) Occupational Therapy evaluation.
    e) Speech-language Pathology services.

f) Speech-language Pathology services evaluation.
g) Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or sixty (60) Calendar Day re-assessment).
h) Skilled nursing: Treatment, teaching/training, observation/evaluation.
i) Skilled nursing: venipuncture.
j) Skilled nursing: Pre-filling insulin syringes/Medi-Planners.
k) Home Health Aide.

rrr. ***Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, i. Quality Measures, iv.*** **is revised and restated as follows:**

iv. Beginning on January 1, the Department will implement a withhold program. The initial withhold performance period shall begin January 1, 2024, and shall run through December 31, 2024, with funds initially being withheld on July 1, 2024. The performance measures subject to withholds will align with the State's Quality Strategy. Additional details on the Department's withhold program are provided in *Section VI.C. Withholds.*

sss. ***Section V.F. Stakeholder Engagement, 2. Engagement with Community and County Organizations, c.*** **is revised and restated as follows:**

c. The PHP shall establish an ongoing partnership with North Carolina County Agencies and CBOs that support North Carolina Medicaid Members, in the Region(s) that the PHP is contracted to cover.

ttt. ***Section V.G. Program Operation, 1. Service Lines, l.*** **is revised and restated as follows:**

l. The PHP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge on North Carolina Medicaid as defined within this Contract.

uuu. ***Section V.G. Program Operation, 1. Service Lines, n., ii., a)*** **is revised and restated as follows:**

a) Member Medicaid Managed Care resources, education and assistance to understand Medicaid benefits;

vvv. ***Section V.G. Program Operation, 1. Service Lines, o., ii.*** **is revised and restated as follows:**

ii. Medicaid identification number (preferred);

www. ***Section V G. Program Operation, 2. Staffing and Training, e., xx.-xxi.*** **is revised and restated as follows:**

xx. HIPAA and the Department's Privacy and Security requirements;
xxi. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention;

xxx. ***Section V.G. Program Operation, 2. Staffing and Training, e.*** **is revised to add the following:**

xxii. The Healthy Opportunities Pilot, including ensuring the following:

a) That Call Center supervisors are trained to have an in-depth knowledge of the Healthy Opportunities Pilot to allow them to act as a point of contact for escalations related to the Pilot; and

b) That Call Center supervisors attend refresher training hosted by the Department at least quarterly.

yyy. ***Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iii., b)*** **is revised and restated as follows:**

b) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid program, are subject to an out of state exception, or the Department or other investigatory agencies have not initiated a payment

zzz. ***Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iv., k)*** **is revised and restated as follows:**

d) 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.

aaaa. ***Section V.H. Claims and Encounter Management, 1. Claims d. Prompt Payment Standards, i., a), 1.*** **is revised and restated as follows:**

1. The PHP shall, within eighteen (18) Calendar Days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim. The PHP shall have the capability to receive additional information request via x12 275 Request for Additional Information EDI transaction, electronic means (including through a portal or email), and by mail. The PHP shall implement the capability for EDI x12 275 and electronic method (portal or email) no later than January 1, 2024. If an extension is needed, the PHP may submit a request to the Department's Contract Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.

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

iii. Claim Submission Timeframes:

a) For any claims with a date of service on or before June 30, 2023:

1. 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.

i. 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.

ii. 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.

b) For any claims with a date of service on or after July 1, 2023:

1. Consistent with N.C. Gen. Stat. § 58-3-225(f), 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 by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) 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 three hundred sixty-five (365) 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.

i. When a Member is retroactively enrolled, the PHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment.

cccc. ***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.

1. For fee schedule changes communicated within ninety (90) Calendar Days of the effective date, the PHP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates, including sending notification of overpayments, within an additional thirty (30) Calendar Days of implementing fee schedule changes.
2. For fee schedule changes communicated more than ninety (90) Calendar Days after the effective date, the PHP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates, including sending notification of overpayments, within an additional forty-five (45) Calendar Days of implementing fee schedule changes.
3. This standard is only applicable for NC DHB rate floor programs.
4. 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.

dddd. ***Section V.H. Claims and Encounter Management, 1. Claims, i. National Correct Coding Initiative (NCCI), ii.*** **is revised and restated as follows:**

ii. The PHP shall follow Medicaid NCCI policies to control improper coding that may lead to inappropriate payments to providers by the PHP.

eeee. ***Section V.H. Claims and Encounter Management, 1. Claims, i. National Correct Coding Initiative (NCCI), ii., a), 1.*** **is revised and restated as follows:**

1. Reserved.

ffff. ***Section V.H. Claims and Encounter Management, 1. Claims, i. National Correct Coding Initiative (NCCI), ii., c), 3.*** **is revised and restated as follows:**

3. The PHP shall submit the NCCI File Certification form by the fifteenth (15th) Calendar Day of the next month following the receipt of the Non-Public Medicaid NCCI Edit Files from the Department confirming the following:
   i. The PHP has received and downloaded the Non-Public Medicaid NCCI Edit Files from the Department; and
   ii. The PHP has loaded the Non-Public Medicaid NCCI Edit Files, as provided to the PHP by the Department, and are ready for use by the PHP by no later than 12:00 am on the first day of the calendar quarter in which the edit files apply.

gggg. ***Section V.I. Financial Requirements, 2. Medical Loss Ratio, b., iv., a), 1.*** **is revised to add the following:**

iii. Comply with the requirements under 42 C.F.R. § 438.8(e)(3).
iv. Are not expenditures made to any non-profit entity that is a subsidiary of, or otherwise legally affiliated with, the PHP. Any PHP expenditure to a non-profit entity that funds ongoing PHP operations is ineligible for inclusion in the Medical Loss Ratio under this subsection.

hhhh. ***Section V.I. Financial Requirements, 4. Risk Corridor, a., i-ii.*** **is revised and restated as follows:**

i. The Risk Corridor Measurement Periods shall be defined:
   a) For rating year one as July 1, 2021 to June 30, 2022.
   b) For rating year two as July 1, 2022 to June 30, 2023.
   c) For rating year three as July 1, 2023 to June 30, 2024.

ii. Reserved.

iiii. ***Section V.I. Financial Requirements, 4. Risk Corridor, a., v.*** **is revised and restated as follows:**

v. The Reported Services Ratio numerator shall be the PHP's expenses for the applicable Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care programs. The numerator shall be defined as the sum of:

jjjj. ***Section V.I. Financial Requirements, 4. Risk Corridor, a., xi., g)*** **is revised and restated as follows:**

g) The Department will provide the PHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section VI.A.e.vii.* of the Contract within thirty (30) Calendar Days of the notice by the Department to the PHP.

kkkk. ***Section V.I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, e.*** **is revised to add the following:**

iii. For the Risk Corridor Measurement Period for rating year three: ninety-five percent (95.0%) of the PCP Target Expenditure Percentage for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization based payments).

llll. ***Section V.J. Compliance, 2. Program Integrity, b., i. Validation of Exclusion List Status, a)*** **is revised and restated as follows:**

a) "Exclusion Lists" are the lists the PHP must check to ensure that the PHP does not pay federal funds to Excluded Persons, including:
   1. State Exclusion Provider List;
   2. U.S. Department of Health and Human Services,-Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
   3. The System of Award Management (SAM);
   4. The Social Security Administration Death Master File (SSADMF);
   5. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
   6. Office of Foreign Assets Control (OFAC).

mmmm. ***Section V.J. Compliance, 2. Program Integrity, b., i. Validation of Exclusion List Status, d)*** **is revised and restated as follows:**

d) The PHP shall take appropriate action upon identification that a person, agent, managing employee, delegated entities or subcontractor appears on one or more of the Exclusion

Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.

nnnn. ***Section V.J. Compliance, 2. Program Integrity, b., i. Validation of Exclusion List Status, e)*** **is revised and restated as follows:**

e) The PHP shall report to the Department within two (2) business days of identification of an Excluded Person the following information:
   1. The name(s) of the Excluded Person(s); and
   2. The amounts paid to the Excluded Person(s) over the previous twelve (12) months.

oooo. ***Section V.J. Compliance, 3. Fraud, Waste, and Abuse Prevention, e. Fraud Prevention Plan, iii., p)*** **is revised and restated as follows:**

p) Description of criminal background and exclusion screening processes for its owners, agents, delegated entities, employees~~, network providers~~ and subcontractors; and

pppp. ***Section V.J. Compliance, 4. Third Party Liability (TPL), b. Cost Avoidance Report, i., f)*** **is revised and restated as follows:**

f) Member Medicaid ID;

qqqq. ***Section V.J. Compliance, 4. Third Party Liability (TPL), i. Identification of Other Forms of Insurance*** **is revised to add the following:**

ix. The PHP shall ensure providers have the capability to verify other insurance information through the PHP's provider portal and Real-Time Eligibility Electronic Data Interchange (EDI) transactions 270/271. The PHP shall provide an operational timeline to the Department for review and approval on how the PHP will meet the requirements of this section September 1, 2023.

rrrr. ***Section V.J. Compliance, 4. Third Party Liability (TPL)*** **is revised to add the following:**

m. Bypass Third Party Liability Rules
   i. No later than October 1, 2023, the PHP shall adjudicate claims as the primary payer and bypass Third Party Liability edits for Medicaid covered services that commercial insurance does not typically cover based on criteria in the Managed Care Billing Guide (Section 3.27 Other Insurance and Third-Party Liability Bypass Guidance Document).

ssss. ***Section V.K. Technical Specifications, 1. Data Exchange Model, First Revised and Restated Data Exchange Description—For Informational Purposes*** **is revised and restated as follows:**

No.	Second Revised and Restated Data Exchange Description – For Informational Purposes
1.	The PHP will send the Department or its Vendors the following data: a) Encounter Data – Medical and pharmacy encounter data; b) AMH/PCP Assignment – The PHP will submit to the Department the Member's assigned AMH/PCP; c) Lock-in Data – Member lock-in data (including pharmacy and prescriber); d) Provider Network Data File; e) PHP Network File; f) Member Insurance Data; g) Member Enrollment – On request the PHP will send the Department its current, complete roster of Medicaid Managed Care Members; and h) PHP Assigned AMH Tiers – The Provider and updated AMH Tier assignment anytime the PHP changes the Provider Attested AMH tier including the reason for the change.
2.	The Department will send the PHP the following data: a) Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records; b) Managed Care Payments; c) Member Reconciliation Date – The Department will send weekly 834 files to be used by the PHP for reconciliation purposes; d) The Department will send a daily provider enrollment file; and e) The Department will send a daily affiliation file with provider data.
3.	The Department will send the Enrollment Broker the following data: a) The Department will send the Enrollment Broker a full list of all active and enrolled providers, including the Medicaid provider roster for inclusion in the Provider Directory; b) The Department will send the Enrollment Broker the provider affiliation file that includes all group practices and their affiliated doctors for a given location for the organization; c) The Department will send to the Enrollment Broker the PHP and Tribal Option network providers.
4a.	Real-time webservices between NC FAST and EB will be used to share beneficiary data from NC FAST to the EB and will also be used for the EB to send member PHP and PCP/AMH selections through that interface back to NC FAST.
5.	The PHP will send the following data to the AMH's: a) Member Assignments; b) Encounter / Claims Data; and c) Member Risk Stratification Data.
6.	The PHP and the Provider will exchange the following data: a) Claims Data – the contracted Providers will send claims data for payment to the PHP; and b) Payment Data – The PHP will send payments to the provider.
7.	The Provider enrolls in Medicaid and maintains provider data via the NCTracks Provider Portal.

tttt. ***Section V.K. Technical Specifications, 3. Enrollment and Reconciliation, c. Provider Enrollment and Credentialing, i.*** **is revised and restated as follows:**

i. The Department or a designated vendor will provide to the PHP a daily, full file including all North Carolina Medicaid enrolled providers, including relevant enrollment and credentialing information.

uuuu. ***Section V.K. Technical Specifications, 3. Enrollment and Reconciliation, c. Provider Enrollment and Credentialing, iii.*** **is revised and restated as follows:**

iii. Reserved.

vvvv. ***Section V.K. Technical Specifications, 5. Provider Directory, b. Consolidated Provider Directory Data Transmissions, ii.*** **is revised and restated as follows:**

ii. The PHP will create a successfully processed full Provider Network File (PNF) including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The PHP will deliver the file to the Department's designated vendor every Calendar Day by 5:00 pm. A successfully processed full PNF means that for each submission of the PNF by the PHP to the Department's vendor, the PHP has included all provider records from the PHP's network in the file submission and the PHP receives a Provider Network Response File (PNrF) from the Department's vendor in response to the PNF submission.

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

Specific subsections are modified as stated herein.

a. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, iv. Intermediate Sanctions, a), 5.*** **is revised and restated as follows:**

5. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 C.F.R. § 438.702(a)(5);

b. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance, Sixth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages*** **is revised and restated in its entirety as follows:**

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 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
7.	Reserved.	[redacted]
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.	[redacted]
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

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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
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.	[redacted]
25.	Reserved.	
26.	Reserved.	
27.	Reserved.	

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
28.	Reserved.	[redacted]
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.	[redacted]
34.	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.	Reserved.	[redacted]
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
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

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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: Third 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. Reporting Requirements.*	$2,000 per Calendar Day
46.	Failure to timely and accurately submit monthly financial reports in accordance with *Attachment J: Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per Calendar Day
47.	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: Reporting Requirements*	$250 per Calendar Day
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 *Section V.J.3. Fraud, Waste and Abuse Prevention* and *Attachment J: 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.

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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
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.

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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.*	$100 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
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.

Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 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
73.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.K. Technical Specifications*.	$1000 per occurrence

c. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, vi. Payment of Liquidated Damages and other Monetary Sanctions, a)*** **is revised and restated as follows:**

a) If the Contractor elects not to appeal the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within thirty-five (35) Calendar Days of the date on the written notice assessing the liquidated damages or other monetary sanctions.

d. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, vii. Dispute Resolution, a)*** **is revised and restated as follows:**

a) The Contractor shall exhaust the dispute processes as provided in the Contract to contest the imposition of intermediate sanctions, the assessment of liquidated damages, withholds, and/or for cause termination of the Contract pursuant to 42 C.F.R. § 438.708 by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.

e. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, vii. Dispute Resolution, b), 2.*** **is revised and restated as follows:**

2. To raise a dispute, the Contractor shall submit a written request for dispute resolution within thirty (30) Calendar Days of the date on the written notice imposing the Department's intended action. The Department may extend the Contractor's deadline to

request dispute resolution for good cause if the Contractor requests an extension within ten (10) Calendar Days of the date on the written notice.

f. Section VI. Contract Performance, A. Contract Violations and Noncompliance, e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages, vii. Dispute Resolution, b), 4.-5., are revised and restated as follows:

4. The Contractor waives any dispute not raised within thirty (30) Calendar Days of the date on the written notice imposing any proposed action by the Department (unless the Department grants an extension).
5. The Contractor also waives any arguments it fails to raise in writing within thirty (30) Calendar Days (unless the Department grants an extension) of the date on the written notice imposing the proposed action, and waives the right to use any materials, data, and information not contained in or accompanying the Contractor's written request for dispute resolution in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).

g. *Section VI. Contract Performance, B. Service Level Agreements, Fifth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements* is revised and restated in its entirety as follows:

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
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
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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$5,000 per month
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$100,000 per quarter
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
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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
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 encounters 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 encounter per Calendar Day

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
23.	Encounter Data Timeliness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy encounters 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 encounter 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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
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 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.	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
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)

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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
38.	Member Welcome Packet Timeliness – Single Mailing of	The PHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet)	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the PHP within the required timeframe divided by the total	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month

Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Entire Welcome Packet *Applies if the PHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	number of new Members enrolled in the PHP during the measurement period.		79.99% or less: $10,000 per month
39.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	The PHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the PHP within the required timeframe divided by the total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
40.	Member Welcome Packet Timeliness – Separate Mailing for Identification Card *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	The PHP shall meet or exceed ninety-nine percent (99%) of identification cards (mailed separately from welcome letters and Member handbooks) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	The number of identification cards (mailed separately from welcome letters and Member handbooks) mailed by the PHP within the required timeframe divided by total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
41.	Provider Welcome Packet Timeliness	The PHP shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in *Section V.D.3. Provider Relations and Engagement.*	The number of Provider Welcome Packet sent by the PHP within the required timeframe divided by the total number of new providers who have executed a contract with the PHP during the measurement period.	Quarterly	97.99% - 95%: $5,000 per quarter 94.99% - 80%: $7,500 per quarter 79.99% or less: $10,000 per quarter

h. *Section VI. Contract Performance, C. Withholds* is revised to add the following:

4. Prior to implementing a withhold pursuant to this Section and *Section III.D.32.i. Other Managed Care Payment Terms and Conditions,* the Department shall provide the PHP with written notice detailing the applicable withhold(s) and the performance period for the associated performance target(s), the amount being withheld, and the effective date in which the Department will begin withholding funds.
5. Notice of Withhold Determination
    i. Following the end of the applicable withhold performance period, the Department shall issue a written Notice of Withhold Determination to the PHP detailing the following:
        a) The Department's determination of whether the PHP fully met, partially met, or did not meet the applicable withhold performance targets during the performance period; and
        b) The method and timeframes by which the Contractor may dispute the Department's determination that the PHP partially met or did not meet the withhold performance targets.
6. Payment of any withheld amounts for which the Department determines that the PHP met the performance target(s) shall be made by the Department to the PHP by no later than sixty (60) Calendar Days of the date on the written Notice of Withhold Determination.
7. Disputes of the Withhold Determination
    i. If the PHP elects to dispute the Department's withhold determination, the PHP shall follow the process specified in *Section VI. A. e. vii. Dispute Resolution.*
    ii. If the Contractor elects to dispute the Department's withhold determination as provided in the Contract and the Department overturns its original decision, the Department shall pay the PHP any withheld amounts owed to the PHP by no later than sixty (60) Calendar Days of the date on the written notice of final decision. The PHP shall not be entitled to any interest or penalties from the Department for any disputed withheld amounts that were not paid by the Department during the pendency of the dispute resolution process.

IV. Modifications to Section VII. Attachments

Specific subsections are modified as stated herein.

1. *Attachment E. Second Revised and Restated Required PHP Quality Metrics* is revised and restated in its entirety as *Third Revised and Restated Required PHP Quality Metrics* and attached to this Amendment.

2. *Attachment G. Fifth Revised and Restated Required Standard Provisions for PHP and Provider Contracts* is revised and restated in its entirety as *Attachment G. Sixth Revised and Restated Required Standard Provisions for PHP and Provider Contracts* and attached to this Amendment.

3. ***Attachment J. Fifth Revised and Restated Reporting Requirements*** **is revised and restated in its entirety as** *Attachment J. Sixth Revised and Restated Reporting Requirements* and attached to this Amendment.

4. ***Attachment K. First Revised and Restated Risk Level Matrix*** **is revised and restated in its entirety as** *Attachment K. Second Revised and Restated Risk Level Matrix* and attached to this Amendment.

5. ***Attachment M. Policies, 1. First Revised and Restated North Carolina Medicaid Managed Care Enrollment Policy*** **is revised and restated in its entirety as** *Attachment M. Policies, 1. Second Revised and Restated North Carolina Medicaid Managed Care Enrollment Policy* and attached to this Amendment.

6. ***Attachment M. Policies, 6. Third Revised and Restated Uniform Credentialing and Re-credentialing Policy*** **is revised and restated in its entirety as** *Attachment M. Policies, 6. Fourth Revised and Restated Uniform Credentialing and Re-credentialing Policy* and attached to this Amendment.

7. ***Attachment M. Policies, 7. First Revised and Restated Management of Inborn Errors of Metabolism Policy*** **is revised and restated in its entirety as** *Attachment M. Policies, 7. Second Revised and Restated Management of Inborn Errors of Metabolism Policy* and attached to this Amendment.

8. ***Attachment M. Policies, 10. Approved <PHP NAME> In Lieu of Services*** **is revised and restated in its entirety as** *Attachment M. Policies, 10. First Revised and Restated Approved <PHP NAME> In Lieu of Services* and attached to this Amendment.

9. ***Attachment M. Policies, 14. Healthy Opportunities Interpersonal Violence (IPV)-Related Services: conditions, Requirements, and Standards*** **is revised and restated in its entirety as** *Attachment M. Policies, 14. First Revised and Restated Healthy Opportunities Interpersonal Violence (IPV)-Related Services: conditions, Requirements, and Standards* and attached to this Amendment.

V. ***Section VIII. Attachment O. Offeror's Proposal and Response: 7. First Revised and Restated Contractor's Contract Administrators*** is revised and restated in its entirety as *Section VIII. Attachment O. Offeror's Proposal and Response: 7. Second Revised and Restated Contractor's Contract Administrators* and attachment to this Amendment. (NOTE: For BCBS & CCH only)

VI. ***Section X. Seventh Revised and Restated Summary of Contractual Payment and Risk Sharing Terms*** shall remain in effect until State Fiscal Year 2024 rates are available and incorporated into the Contract by amendment.

VII. Effective Date

This Amendment is effective July 1, 2023, unless otherwise explicitly stated herein, subject to approval by CMS.

VIII. 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: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

PHP Name

_____ Date: _____

PHP Authorized Signature

Attachment E. Third Revised and Restated Required PHP Quality Metrics

Section VII. Third Revised and Restated Attachment E. Table 1: Survey Measures and General Measures lists the Department's quality and administrative measures that are meant to provide the Department with a complete picture of the PHP's processes and performance as described in *Section V.E. Quality and Value*. These Measures include a select set of Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

1. The PHP shall track all measures listed in *Section VII. Third Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*. The Department will monitor other measures that are not included in the table below and may engage with the PHP~~s~~ around these performance measures. An asterisk (*) indicates that the measure is calculated by the Department.

	Section VII. Third Revised and Restated Attachment E. Table 1. Survey and General Measures			
Reference #	Measure Steward	*NQF #*	*Measure Name*	*AMH Measure*
1.	NCQA	1516	Child and Adolescent Well-Care Visit (WCV)	x
2.	NCQA		Well-Child Visits in the First 30 Months of Life (W30)	x
3.			Reserved.	
4.	NCQA	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
5.	NCQA	0032	Cervical Cancer Screening (CCS)	x
6.	NCQA	0038	Childhood Immunization Status (Combination 10) (CIS 10)	x
7.	NCQA	0033	Chlamydia Screening in Women (CHL)	x
8.	NCQA	0059/0575	Hemoglobin A1c Control for Patients with Diabetes (HBD)	x
9.	NCQA	0018	Controlling High Blood Pressure (CBP)	x
10.	NCQA	0039	Flu Vaccinations for Adults (FVA)*	
11.	NCQA	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	
			7- Day Follow-up	
			30-Day Follow-up	
12.	NCQA	1517	Prenatal and Postpartum Care (PPC)	X
			Timeliness of Prenatal Care	

			Postpartum Care	
13.	NCQA	1407	Immunizations for Adolescents (Combination 2) (IMA 2)	x
14.	NCQA	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	
15.	DHHS	N/A	Low Birth weight[1]	
16.			Reserved.	
17.	PQA	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	
18.	DHHS	N/A	Rate of Screening for Pregnancy Risk*[2]	
19.	DHHS	N/A	Rate of Screening for Unmet Resource Needs*[3]	
20.	CMS	0418/0418e[4]	Screening for Depression and Follow-Up Plan (CDF)	x
21.			Reserved.	
22.	NCQA	1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	x
23.	Health Partners	N/A	Total Cost of Care*	x
24.	NCQA	1800	Asthma Medication Ratio (AMR)	
25.	NCQA	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	
26.	NCQA	0034	Colorectal Cancer Screening (COL)	
27.	NCQA	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	
28.	NCQA	N/A	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU)	

[1]The PHP shall submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure as described in *Attachment J. Sixth Revised and Restated Reporting Requirements.*

[2]The Department will work jointly with the PHP and CCNC to collect pregnancy risk screening data and report this measure.

[3] The Department is exploring potential adoption of HEDIS' new Social Needs Screening and Intervention (SNS-E) measure. In the interim, the PHP shall submit a quarterly operational report that includes beneficiary screening results that will be used to calculate this measure as described in *Attachment J. Sixth Revised and Restated Reporting Requirements.*

[4] The PHP shall report to the Department whether they are using the standard or electronic measure as described in *Attachment J. Sixth Revised and Restated Reporting Requirements.*

2. Updates to PHP Quality Metrics

   a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website and subsequently amend *Section VII. Third Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*, as necessary, to align with the annual January update.

   b. The PHP shall adopt the updated measures posted annually in January for the upcoming measurements years with reporting to be provided to the Department in June of the subsequent year.

   c. The PHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Section VII. Sixth Revised and Restated Attachment J. Table 1: Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the PHP would report the results in June 2024).

The remainder of this page is intentionally left blank.

Attachment G. Sixth 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; and*

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 for a date of service on or before June 30, 2023, 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. The [Provider] shall submit all claims with a date of service on or after July 1, 2023, to the [Company] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i. For Medical claims (including behavioral health):

1. The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to process the claim. The PHP shall have the capability to receive additional information request via 277 Request for Additional

Information EDI transaction, electronic means (including through a portal or email), and by mail. The PHP shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by the Department .

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) Calendar 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 percent (18%) 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) Calendar Days of receipt will result in the [Company] paying the [Provider] a penalty equal to one percent (1%) 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.

i. Providers who may Elect to Implement a Tobacco-Free Policy

Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings, or manufacturing sites that employ adults who receive group day services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy.

ii. Providers Subject to a Partial Tobacco-Free Policy

Starting April 1, 2024, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial 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. *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.*

2. *Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:*
   a) *Ensure access to common outdoor space(s) free from exposure to tobacco use.*
   b) *Prohibit staff/employees from using tobacco products anywhere on the property.*

Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

iii. Providers subject to Full Tobacco-Free Policy

Starting April 1, 2024, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

[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 products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on *[Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.*

The remainder of this page is intentionally left blank.

Attachment J: Sixth 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.

Sixth 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. Reserved.	
e. Reserved.	

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. Reserved.	
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. Reserved.	
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. Reserved.	
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. Reserved.	
s. Reserved.	
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. Reserved.	
c. Reserved.	
d. Reserved.	
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. Reserved.	
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. Reserved.	
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	
n. Provider Grievances, and Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
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. Reserved.	
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. Reserved.	
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	[redacted]
d. Reserved	
e. Reserved	
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Eligible Mothers for Low Birth Weight Extract	Quarterly update on eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.
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. Reserved.	[redacted]
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. Reserved.	
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. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. § 438.3(m).
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	Monthly 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. Reserved.	
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	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.

Invoice Monitoring Report	
d. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
e. Healthy Opportunities Pilot Care Management Assignment Report	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Pilot Enrolled Beneficiaries.-
f. Healthy Opportunities Pilot High-Priority Populations Report	Report that the PHP will submit in dual parts: (a) annually, the PHP will submit the Priority Populations Report outlining the PHP's plan for enrolling priority populations, to understand the PHP's enrollment plans and ensure inclusive representation of priority populations. (b) quarterly, the PHP will submit the report outlining aggregate enrollment data for these priority populations, to understand the PHP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a).

The remainder of this page is intentionally left blank.

Attachment K. Second Revised and Restated Risk Level Matrix

The PHP agrees and acknowledges that the Risk Level Matrix is intended to be an illustrative, non-exhaustive list of the types of acts, failures to act, behaviors, and/or practices that may be assigned to a specific level by the Department upon consideration of some or all of the factors described in the Contract.

If the PHP is found to be non-compliant with the terms, conditions, or requirements of the Contract or of any other violation by the Department, the PHP agrees and acknowledges that the Risk Level Matrix, as provided in the Contract, is for demonstrative purposes only, and the Department retains the sole discretion to assign an appropriate level to each type of noncompliance or violation by the PHP based on the nature of the noncompliance or violation as described in the Contract.

The PHP further agrees and acknowledges that the content included in the examples of noncompliant behavior and/or practices in the Risk Level Matrix are not the full scope of violations subject to a Risk Level assignment by the Department and that if a specific example of noncompliant behavior or practice identified in the Matrix occurs, the Department is not obligated to assign the noncompliant behavior or practice in accordance with the level provided in this Matrix.

Section VII. Attachment K. Second Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or the integrity of Medicaid Managed Care	Failure to substantially provide medically necessary covered services Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract Imposing on Members premiums or cost-sharing that are in excess of that permitted by the Department Failure to substantially meet minimum care management and care coordination requirements Failure to substantially meet minimum Transition of Care Policy requirements Failure to substantially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception) Denying coverage for out-of-network care when no reasonable access to an in-network provider is available Continuing failure to resolve Member and provider appeals and grievances within specified timeframes Failure to maintain PHP license in good standing with DOI Failure to timely submit accurate and/or complete encounter data in the required file format Misrepresenting or falsifying information that it furnishes to CMS or to the Department Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation

Section VII. Attachment K. Second Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to substantially comply with the claims processing requirements and standards Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) Failure to timely fulfil commitment to participate as a Qualified Health Plan (QHP) on the Federally Facilitated Marketplace in the individual health insurance market in North Carolina in QHP Plan Year 2022 as specified in *Section V.A.10. Marketplace Participation*. Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation One or more Level 2 violations within a Contract year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize Member(s) health, safety, and welfare or access to care	Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract Failure to comply with established rate floors and fee schedules as required under the Contract Failure to make additional directed payments to certain providers as required under the Contract EQRO or other program audit reports with substantial findings Failure to comply with Member services requirements (including hours of operation, call center, and online portal) Failure to maintain the privacy and/or security of data containing protected health information (PII) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PII Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation Two or more Level 3 violations within a Contract year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program	Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) Failure to notify the Department and Members of terminated network providers within required timeframes Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested

Section VII. Attachment K. Second Revised and Restated Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) Using unapproved Member notices, educational materials, and handbooks and marketing materials Engaging in prohibited marketing activities and practices Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation Three or more Level 4 violations within a Contract year
LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation the managed care program	Submission of a late, incorrect, or incomplete report or Deliverable (excludes encounter data and other financial reports) Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation Failure to comply with time frames for distributing (or providing access to) Member handbooks, identification cards, provider directories, and educational materials to Members (or potential Members) Failure to meet minimum requirements requiring coordination and cooperation with external entities EQRO or other program audit reports with non-substantia findings Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements) Failure to timely furnish a policy, handbook, directory, or manual upon request by a Member or potential Member as required under the Contract Failure to substantially comply with the Preferred Drug List requirements

Attachment M. Policies, 1. Second Revised and Restated North Carolina Medicaid Managed Care Enrollment Policy

a) **Background**

The Department will ensure that Medicaid beneficiaries, their families and caregivers are supported in the transition to Medicaid Managed Care throughout the enrollment process, including selecting a Prepaid Health Plan (PHP) and an advanced medical home (AMH) and/or primary care provider (PCP). The Department will ensure beneficiaries and their families have the tools and resources to access care and experience a smooth transition from Medicaid Fee-For-Service to Medicaid Managed Care, and throughout Medicaid Managed Care implementation.

The Department is planning to implement Medicaid Managed Care in two (2) phases based on Regions, with distinct open enrollment periods for each phase, for the initial transition of beneficiaries from Medicaid Fee-for-Service to Medicaid Managed Care to ensure successful implementation.

b) **Scope**

The North Carolina Medicaid Managed Care Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the PHPs in the enrollment of beneficiaries into Medicaid Managed Care. The intent of this Policy is not to replace any existing enrollment processes related to Medicaid Fee-For-Service and/or Local Management Entities/Managed Care Organizations (LME/MCOs).

c) **Populations Eligible for Medicaid Managed Care**

The Department is responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt, or mandatory at any point in time. The PHP must adhere to Medicaid Managed Care eligibility determinations made by the Department and enroll or disenroll beneficiaries in accordance with those determinations and this Policy. Populations to be excluded, exempt or mandatory in Medicaid Managed Care are defined in the Contract.

d) **Medicaid Managed Care Eligibility Determinations**

The Department is responsible for performing, managing and maintaining all Medicaid Managed Care enrollment and cost sharing eligibility determinations. It is the responsibility of the Enrollment Broker, the PHP and other partners of the Department operating within Medicaid Managed Care to adhere to the determinations made by the Department.

e) **Prepaid Health Plan Enrollment**

i. Consistent with 42 C.F.R. § 438.810, the Department will contract with an Enrollment Broker to provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives, who want to select a PHP and an AMH/PCP or have questions about Medicaid Managed Care.

ii. Crossover populations

1. Open enrollment

a. To support beneficiary choice, the Department will offer the crossover population a sixty (60) Calendar Day open enrollment period to select a PHP prior to the

scheduled transition date from Medicaid Fee-for-Service to Medicaid Managed Care.

b. During the open enrollment period, the Enrollment Broker will engage in proactive outreach that explains the Enrollment Broker's services, provides managed care education, and supports PHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care.

c. If a beneficiary selects a PHP during the open enrollment period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.

d. If a beneficiary does not select a PHP during the open enrollment period, the Department will auto-assign the beneficiary to a PHP based on the Department's defined auto-assignment algorithm. The Department will transmit PHP assignment to the PHP through an 834 eligibility file.

e. For a beneficiary in a crossover population who selects a PHP, or who is auto-assigned into a PHP, coverage by the PHP begins on the first day of the scheduled transition date to Medicaid Managed Care for the specific crossover population. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.

2. Choice period

a. After coverage by a PHP begins, the Member will have ninety (90) calendar days to change his or her PHP without cause.

b. During the choice period, the Enrollment Broker will continue to provide choice counseling and support the Member with PHP and AMH/PCP selection.

c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the member selected the PHP.

d. If a Member does not select a different PHP during the choice period, the Member will remain in his or her PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

iii. Ongoing enrollment (post Medicaid Managed Care implementation)

1. New Medicaid applicants eligible for Medicaid Managed Care

a. New Medicaid applicants will have an opportunity to select a PHP and AMH/PCP as part of the eligibility application process.

b. If an applicant selects a PHP during the eligibility application process, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.

c. If an applicant does not select a PHP as part of the eligibility application process, the applicant will be auto-assigned to a PHP based on the Department-defined auto-assignment algorithm described in Section 6.f.vi. The Department will

transmit the auto-assignment to the assigned PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.

d. For applicants determined Medicaid Managed Care eligible who select a PHP or who are auto-assigned into a PHP, coverage by the PHP begins on the first day of the month in which Medicaid eligibility is determined. However, the new Medicaid beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
e. Choice period
    i. After coverage by the PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
    ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.
    iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
    iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her previously selected or auto-assigned PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

2. New beneficiaries eligible for Medicaid Managed Care
    a. For a beneficiary determined eligible for Medicaid Managed Care after implementation, the beneficiary will be auto-assigned into a PHP based on the Department-defined auto-assignment algorithm.
    b. The Department will transmit the auto-assignment to the assigned PHP through an 834 eligibility file. Coverage by the assigned PHP will begin on the first day of the month in which the beneficiary is determined eligible for Medicaid Managed Care. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
    c. Choice period
        i. After coverage by a PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
        ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.
        iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
        iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her auto-assigned PHP until the Member's

annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section f.

iv. Medicaid eligibility redetermination

1. Upon receiving a notice from the Department of the Member's upcoming annual redetermination, the Member may contact the Enrollment Broker prior to the redetermination decision to select a different PHP for his or her upcoming eligibility year.
2. If a Member is redetermined eligible for Medicaid and has not selected a different PHP prior to the redetermination decision, the Department will auto-assign the Member into the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care. However, the Member will have an additional opportunity to select a different PHP during his or her annual choice period.
3. Annual choice period
   a. If a Member is redetermined eligible for Medicaid, the Member will receive a notice from the Department and will be offered ninety (90) Calendar Days to select a different PHP.
   b. During the choice period, the Enrollment Broker will provide choice counseling and support the Member in PHP and AMH/PCP selection.
   c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
   d. If a Member is redetermined eligible and has not selected a different PHP during the choice period, the Member will remain in the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care.
   e. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, the Member will receive his or her choice period, plus additional time added to the choice period equal to the number of calendar days the redetermination decision was delayed.
4. If a Member is determined to no longer be eligible for Medicaid, the Member will be notified and disenrolled from the PHP by the Department.

v. Special cases

1. Exempt populations
   a. The Enrollment Broker will provide choice counseling to exempt populations and support PHP/Medicaid Fee-For-Service/Tribal Option (as applicable) and AMH/PCP selection throughout the beneficiary's eligibility year.
   b. If a beneficiary in an exempt population selects a PHP, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.
   c. If a beneficiary in an exempt population selects a different PHP, or delivery system (such as Medicaid Fee-For-Service or Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by the new PHP or delivery

system begins on the first day of the next month in which the beneficiary selected the new PHP or delivery system.[1]

2. Deemed newborns
   a. If a Member is known to be pregnant, the PHP shall validate that the Member selects an AMH/PCP for the child prior to the birth.
   b. Upon delivery, a deemed newborn will be assigned to the mother's PHP, and the PHP will begin providing coverage to the newborn immediately. The PHP is responsible for the provision and payment of services for the deemed newborn in the hospital or birthing center, even if the deemed newborn has not appeared on the PHP's roster.
   c. If the PHP receives notification of birth prior to discharge, the PHP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.
   d. The PHP shall report the deemed newborn's birth to the Department within five (5) calendar days upon learning of the birth and, at a minimum, provide the Department with the mother's name, social security number, NC FAST case number, Member identification number, residing county, and the newborn's name, sex, and date of birth.
   e. If the PHP has not received confirmation of a deemed newborn's enrollment in the PHP through an 834 eligibility file following the deemed newborn's birth, the PHP shall notify the Department and the Enrollment Broker and send notification of the birth within sixty (60) Calendar Days from the date of delivery.
   f. If the newborn is enrolled in Medicaid, the PHP shall send a notification of the newborn's enrollment and issue a Member identification card for the newborn to the mother within fourteen (14) Calendar Days of learning of the birth. This notice must include information on how the mother or caregiver can access care for the newborn.

vi. PHP auto-assignment

1. In accordance with 42 C.F.R. § 438.54, the Department developed auto-assignment algorithms for every beneficiary determined Medicaid Managed Care eligible who does not select a PHP during their open enrollment period (for crossover populations only) or during the Medicaid eligibility application process. The Department may use the auto-assignment algorithm in other instances deemed appropriate by the Department and as required by North Carolina or federal law or regulation.
2. In its sole discretion, the Department may change the auto-assignment algorithm.
3. For the crossover population and for a new beneficiary enrolled into Medicaid Managed Care, the auto-assignment algorithm is defined according to the following components in this order:
   a. Beneficiary's geographic location;
   b. Whether the beneficiary is a member of a special population (e.g. member of a federally recognized tribe, or BH I/DD Tailored Plan eligible).

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

c. PHP/AMH selection upon application and PCP/AMH historic relationship.
d. Plan assignments for other family members.
e. Previous PHP enrollment during previous twelve (12) months (for those who have "churned" on/off Medicaid managed care).
f. Equitable plan distribution with enrollment subject to:
    i. PHP enrollment ceilings and floors, per PHP, to be used as guides.
    ii. Increases in a PHP's base formula relative to their contributions to health-related resources, as described herein.
    iii. Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment.

4. A PHP that voluntarily contributes at least one-tenth (0.1) percent of its annual capitation revenue in a Region to health-related resources and/or health equity initiative, approved by the Department may be awarded a preference in auto-assignment as defined in the Contract.
5. To promote an equitable distribution of Medicaid Managed Care enrollment among the PHPs, the Department will enforce an auto-assignment floor of ten percent (10%) and a ceiling of forty percent (40%) percent of Medicaid Managed Care Members per Region.
6. At redetermination after Medicaid Managed Care launch, the Member will be auto-assigned into the same PHP from the prior year, provided that the PHP continues to participate in Medicaid Managed Care and the Member does not request enrollment in a different PHP.
7. Auto-assignment may also be used in the following instances:
    a. For Medicaid Managed Care Members whose PHP has been discontinued. The Member will be auto-assigned using the same algorithm used for new beneficiaries.
    b. For beneficiaries who lose, but then regain, Medicaid eligibility. The beneficiary will be auto-assigned into the beneficiary's previous PHP, unless the PHP is no longer participating in Medicaid Managed Care or the beneficiary indicates that he or she wishes to enroll in another PHP. If the PHP is no longer participating in Medicaid Managed Care, the beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.
    c. For Members who have been disenrolled based upon the request of the PHP. The Member will be assigned to a new PHP based on the same auto-assignment algorithm used for new beneficiaries except that the Member will not be reassigned to the PHP that requested disenrollment.
    d. For beneficiaries who are determined Medicaid Managed Care mandatory or exempt who are discharged from a long-term stay in a nursing facility (including a state-owned Neuro-Medical Center or a DMVA-operated Veterans Home) after Medicaid Managed Care implementation. The beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.

f) **Prepaid Health Plan Disenrollment**

i. Member disenrollment from a PHP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from one PHP to be enrolled into a different PHP.

ii. Disenrollment requested by a Member

1. A Member may request disenrollment from a PHP "without cause" during the time periods specified in Section f.ii.4. or, at any time, for any of the "with cause" reason specified in Section f.ii.5.
2. A Member, or an authorized representative, may submit an oral or written request for disenrollment from the PHP to the Enrollment Broker by phone, mail, in-person, or electronically.
3. At the time of the disenrollment request, the Enrollment Broker will offer choice counseling to the Member, or his or her authorized representative, and capture the new PHP and AMH/PCP preference.
4. Without cause disenrollment requests
   a. Consistent with 42 C.F.R. § 438.56(c), a Member may change his or her PHP without cause at the following times:
      i. During the initial ninety (90) Calendar Days following the effective date or date of notice of new PHP enrollment (referred to as the choice period).
      ii. At least once every twelve (12) months that coincides with the Member's redetermination period.
      iii. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, during the period when the redetermination decision is delayed.
      iv. When the temporary loss of Medicaid eligibility has caused the Member to miss his or her annual disenrollment opportunity.
      v. If the Department imposes temporary management in accordance with 42 C.F.R. § 438.706, suspends new enrollment in accordance with 42 C.F.R. § 438.702(a)(4), or grants Members the right to terminate enrollment without cause in accordance with 42 § C.F.R. 438.702(a)(3) as intermediate sanctions against the PHP.[2]
   b. The following populations may disenroll from a PHP without cause at any time upon request to the Enrollment Broker:
      i. Members of federally recognized tribes.
      ii. Members receiving long-term services and supports (LTSS) in institutional or community-based settings.
   c. Unless otherwise notified by the Department of a without cause opportunity to disenroll from the PHP, to initiate a without cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.
   d. The Enrollment Broker will process without cause disenrollment requests in accordance with the following:
      i. The Enrollment Broker will evaluate the request and decide whether to approve or deny.
      ii. The Enrollment Broker will notify the Department of its decision by the next calendar day following receipt of the request.
   e. Notice of disenrollment determination

[2] If the Department imposes any of these intermediate sanctions against a PHP, the Department will notify the affected Members of their right to disenroll without cause.

i. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective date within seven (7) Calendar Days of receipt of the request by the Enrollment Broker.

ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[3]

5. With cause disenrollment requests

a. Consistent with 42 C.F.R. § 438.56(c)(1), a Member, or an authorized representative, may request disenrollment from his or her PHP with cause at any time.

b. The following are with cause reasons to request disenrollment from the PHP:

i. The Member moves out of the PHP Region(s).[4]

ii. The PHP does not, because of moral or religious objection, cover a service the Member seeks.[5]

iii. The Member needs concurrent, related services that are not all available within a PHP's provider network, and the Member's provider determines receiving services separately would subject the member to unnecessary risk.[6]

iv. A Member receiving LTSS would be required to change his or her residential, institutional or employment supports provider based on a change in status from in-network to out-of-network.[7]

v. The Member's complex medical condition(s) would be better served under a different PHP, or the Medicaid Fee-For-Service/LME/MCO delivery system in the case of a Medicaid Managed Care Member who meets BH I/DD Tailored Plan eligibility (including having a qualifying event, as defined by the Department) prior to launch of the BH I/DD Tailored Plans. A Member is considered to have a complex medical condition if the condition could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

vi. A family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the Member.

vii. Poor performance of the PHP, as determined by the Department, after evaluation of PHP performance.

[3] 42 C.F.R. § 438.56(e).
[4] 42 C.F.R. § 438.56(d)(2)(i).
[5] 42 C.F.R. § 438.56(d)(2)(ii).
[6] *See* 42 C.F.R. § 438.56(d)(2)(iii).
[7] *See* 42 C.F.R. § 438.56(d)(2)(iv).

viii. Other reasons, including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need, as defined by the Department.[8]

c. The existence of a with cause reason for disenrollment does not automatically disenroll a Member from the PHP. To initiate a with cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.

d. The Enrollment Broker will process with cause disenrollment requests in accordance with the following:

i. For clinical-related with cause disenrollment requests, including requests based on the need for concurrent related services, complex medical conditions, or urgent medical need, the Enrollment Broker will transmit clinical-related with cause requests to the Department for evaluation within twelve (12) hours of receipt. The Department will decide whether to approve or deny clinical-related disenrollment requests.

ii. For all other with cause disenrollment requests, the Enrollment Broker will evaluate the request and notify the Department of its decision to approve or deny within three (3) Calendar Days of receipt of the request.

e. Notice of disenrollment determination

i. The Department will notify the Member, or authorized representative, and the PHP of the denial or approval of the disenrollment request and, if approved, the disenrollment effective date within seven (7) Calendar Days of receipt of the request by the Enrollment Broker.

ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[9]

6. Expedited review of with cause requests for disenrollment

a. A Member, or an authorized representative, may request an expedited review of his or her with cause disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the PHP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

b. The Enrollment Broker will process requests for expedited review in accordance with the following:

i. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.

ii. The Department will evaluate and decide whether to approve or deny the request.

[8] 42 C.F.R. § 438.56(d)(2)(v).

[9] 42 C.F.R. § 438.56(e).

c. Notice of expedited disenrollment determination. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the expedited disenrollment request, and, if approved, the disenrollment effective date, will be within three (3) Calendar Days of receipt of the request by the Enrollment Broker.

iii. Disenrollment requested by a PHP

1. In accordance with 42 C.F.R. §§ 438.56(b)(2)-(3), the PHP is prohibited from requesting disenrollment of a Member because of an adverse change in the Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs.
2. The PHP may only submit requests for Member disenrollment if the following occurs:
   a. The Member's behavior seriously hinders the PHP's ability to care for the Member, or other Members of the PHP; and
   b. The PHP has documented efforts to resolve the Member's issues that form the basis of the request for disenrollment of the Member.
3. To initiate a disenrollment request, the PHP must contact the Enrollment Broker and provide the information required to support its request for disenrollment.
4. The Enrollment Broker will process requests for disenrollment received from the PHP in accordance with the following:
   a. The Enrollment Broker will transmit the request to Department for evaluation within three (3) calendar days of receipt of the request.
   b. The Department evaluate and decide whether to approve or deny the request.
5. Notice of disenrollment determination
   a. If the Department denies a disenrollment requests made by the PHP, the Department will notify the PHP of the decision within seven (7) Calendar Days of receipt of the request by the Enrollment Broker.
   b. If the Department approves a disenrollment requests made by the PHP, the Department will notify the PHP, the Member, or authorized representative, of the decision and the effective date of the disenrollment within seven (7) Calendar Days of receipt of the request by the Enrollment Broker.
   c. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the PHP requests disenrollment. If the Department fails to make a disenrollment determination within the timeframes specified in this subsection, the disenrollment is considered approved for the effective date that would have been established had the Department made a determination in the specified timeframe.[10]

iv. Disenrollment required by the Department

1. The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:
   a. Loss of eligibility
      i. If the Department determines that a member is no longer be eligible for Medicaid, the Member will be notified by the Department and the Member

[10] Id.

will be disenrolled from the PHP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.

ii. If a Member is disenrolled from a PHP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the PHP.[11]

b. Change in Medicaid eligibility category

c. Nursing facility long-term stays

i. A Member with a nursing facility stay that exceeds ninety (90) continuous Calendar Days will be disenrolled from Medicaid Managed Care on the first day of the next month following the ninetieth (90th) Calendar Day of stay and receive services through Medicaid Fee-For-Service.[12]

ii. The PHP will have a process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) Calendar Days.

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

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

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

iii. The Department will send the PHP and the Member, or authorized representative, a written notice of disenrollment at least fourteen (14) Calendar Days before the effective date of the Member's disenrollment from the PHP.

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

v. Coverage of the Member by the PHP will end on the effective date provided by the Department.

iv. Neuro-Medical Centers and Veterans Homes

i. A beneficiary, otherwise eligible for enrollment in Medicaid Managed Care, residing in a state-owned Neuro-Medical Center[13] or a DMVA-

[11] 42 C.F.R. § 438.56(g).

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

[13] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities.

operated Veterans Home[14] when the Department implements Medicaid Managed Care are excluded and will receive care in these facilities through Medicaid Fee-For-Service.

ii. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation will be disenrolled from the PHP by the Department.

1. The Neuro-Medical Center or Veterans Home will submit the Member's information including date of admission to the Department within fourteen (14) Calendar Days of admission.
2. The Department will notify the Member and the PHP of the disenrollment and the disenrollment effective date.
3. Coverage of the Member by the PHP will end on the effective date provided by the Department.

g) **Appeals**

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

h) **Managed Care Enrollment Policy Changes**

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

[14] Department of Military and Veterans Affairs, North Carolina State Veterans Homes: https://www.milvets.nc.gov/services/nc-state-veterans-homes.

Attachment M. Policies, 6. Fourth 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 program.
            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 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.

Attachment M. Policies, 7. Second Revised and Restated Management of Inborn Errors of Metabolism Policy

1. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.
2. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.
3. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that PHP cover the full cost of therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized care plan.
4. Once a client is established with a specialized treatment facility a nutrition care plan is developed and products prescribed. The current system of product coverage is four pronged:
    a. Clients with health insurance coverage fill their metabolic formula prescriptions through pharmacies or Durable Medical Equipment (DME) suppliers.
    b. Clients with Medicaid coverage are currently served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form, Prescription and Oral Nutrition Product Request Form (optional Medicaid form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product by IHC. The IHC will no longer serve Medicaid beneficiaries once they transition into managed care.
    c. Clients participating in WIC are served through the Nutrition Services Branch (NSB). Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main

office of the local WIC agency for pick-up by the client/family. WIC funds are used to pay the metabolic product invoices.

d. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

5. The PHP will need to establish working relationships with the NSB, Specialty Treatment Centers, and metabolic formula suppliers/manufacturers.

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

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

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

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

Attachment M. Policies, 10. First Revised and Restated Approved *PHP Name* In Lieu of Services'

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid State Plan or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.

The PHP may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows:

1. The Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute based on documentation provided to the Department by the PHP demonstrating such cost effectiveness and clinical effectiveness;
2. Members shall not be required by the PHP to use the alternative service or setting;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the PHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise. In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process.

In accordance with *Section V.C. Benefits and Care Management*, the following In Lieu of Services have been approved by the Department:

Attachment M.10. First Revised and Restated Approved AmeriHealth Caritas of North Carolina In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description**
1.	Institute for Mental Disease (IMD) for Mental Health Services for Members 22-64	0160	7/1/2021	Use of IMD settings for Members in need of psychiatric care provides the needed level of care and supervision for these adults while avoiding a more costly admission in an inpatient psychiatric unit. The added benefit is leaving the inpatient psychiatric bed open for individuals who need that level of care, and thereby reducing the incidence of Members in need of an inpatient psychiatric admission waiting for prolonged periods in the emergency room.
2.	Behavioral Health Urgent Care (BHUC)	T2016 U5	07/01/2021	A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Members receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.

Attachment M.10. First Revised and Restated Approved Blue Cross and Blue Shield of North Carolina In Lieu of Services				
No.	**Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description**
1.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	IMD 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 alternative placement for treatment for beneficiaries with acute psychiatric for no more than fifteen (15) Calendar Days within a calendar month.
2.	Behavioral Health (BH) Urgent Care	T2016 U5	7/1/2021	Diversion from Inpatient hospitalizations and long wait times/observation in emergency rooms for placement. Stabilization of condition and ability to return to community.
3.	Enhanced Personal Care Supports	T1019 U1	7/1/2021	This service will avoid costly institutional placement as well as support Member's independence and maintain their ability to live in their home community.
4.	Respite Care	S5150 U1	7/1/2021	This service will avoid costly institutional placement by offering family members in home respite services. Family members who have a break from caregiving are less overwhelmed and can take better care of themselves by staying healthy mentally and physically.
5.	Environmental Modifications	S5165	7/1/2021	This service will avoid costly institutional placement, emergency room, and inpatient readmissions by modifying or adapting the home to maintain the Member's health, safety, and welfare.
6.	Community Re-Integration Support	T2038 U1	7/1/2021	This service will avoid costly institutional placement and will ease some of the burden as a result of the transition and will enable Members to focus on their recovery.
7.	Enhanced Private Duty Nursing	T1000 UC	7/1/2021	The service will avoid costly institutional placement as well as support the Member's ability to remain in their home communities.

Attachment M.10. First Revised and Restated Approved Carolina Complete Health In Lieu of Services				
No.	**Service Name**	**Procedure Code**	**Approved**	**Description**
1.	Massage Therapy	97124, 97140	7/1/2021	Reduction in chronic pain and back pain without the use of opiate therapies.
2.	Inpatient psychiatric care/treatment in Institutes for Mental Disease (IMD)	0160	7/1/2021	Reduction in inappropriate emergency department stays, reduction in inpatient medical stays awaiting placement in inpatient behavioral health beds, increase in appropriate psychiatric utilization and placement.
3.	Behavioral Health Urgent Care (BHUC)	T2016 U5 (without Observation) T2016 U8 (with Observation)	07/01/2021	BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of Members experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning with the goal to reduce inappropriate utilization of the Emergency Department for BH specific needs and assisting Members by linking them to more clinically appropriate community based services and decreasing the recurrence of crisis needs.

Attachment M.10. First Revised and Restated Approved UnitedHealthcare of North Carolina In Lieu of Services				
No.	**Service Name**	**Procedure Code**	**Approved**	**Description**
1.	Behavioral Health Urgent Care (BHUC)	T2016 U5	7/1/2021	A designated intervention/treatment location, known as a BHUC, that is an alternative to any community hospital emergency department where members with urgent primary behavioral health needs will receive triage and referral. The behavioral health urgent care location must include the ability to initiate the involuntary commitment petition via first-level evaluations (Clinician Petition), medical screening, case management and referrals.
2.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	Increasing access to IMD acute beds for Members in behavioral health crisis can lead to better outcomes and fewer exacerbations of serious behavioral health crises. Use of IMD beds, in conjunction with other diversion based length of stay (BHUC where available), along with robust Care Management and ancillary supports such as Peer Supportwill help to ensure Members have access to the right care at the right time for their specific needs – as well as for well-managed lengths of stay.

Attachment M.10. First Revised and Restated Approved WellCare of North Carolina In Lieu of Services				
No.	**Service Name**	**Procedure Code**	**Approved**	**Description**
1.	Intensive Outpatient (IOP) for Mental Health	S9480 with Rev Code 905	7/1/2021	IOPs are more cost effective than hospitalization while delivering invaluable group therapy in a setting of supportive professional care, including peer support by those with lived experience to support positive change. Group-based therapy offers Members an opportunity to participate in a community setting to witness the success of those around them and inspire others within the group as they further their own therapy, knowledge of their psychiatric conditions and steps toward sustained recovery. IOPs for treatment of mental health conditions offer services and support programs that operate on a small scale and do not require the intensity associated with hospitalization or residential services characteristic of larger, broader-based treatment centers.
2.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to fifteen (15) Calendar Days per calendar month in an IMD.
3.	Behavioral Health Urgent Care (BHUC)	T2016 U5	7/1/2021	Provide crisis stabilization for Members experiencing acute mental health episodes in an urgent care setting in order to decreased crisis/emergency department utilization, decrease inpatient hospital stays, and improve crisis stabilization.
4.	Programs for High Risk Populations	H0046HK	7/1/2021	Specialized therapeutic in-home service is a flexible in-home support service designed for children at risk of foster care, ages 5 through 17, who are at risk for or stepping down from inpatient services. Services are delivered by a team led by a licensed clinician and a targeted case manager, a Master's-level therapist, and a psychiatric nurse as a means to decreased inpatient and crisis utilization and decrease crisis/emergency department utilization.

Attachment M. Policies, 14. First Revised and Restated 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. Reserved.
        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 Requirements
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 Requirements* 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 requirements as provided for in the Care Manager IPV-Related Trainings.

5. Member Opt-In/Opt-Out Requirements

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 Requirements 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 VIII. Attachment O. Offeror's Proposal and Response: 7. Second Revised and Restate Contractor's Contract Administrators

7. Second Revised and Restated Contractor's Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Email Address	

Contract Administrator regarding day to day activities herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Email Address	

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Email Address	