Amendment Number 29 (30)
#30-190029-DHB-# Standard Plan – PHP Name

This Amendment to Contract #30-190029-DHB-# Standard Plan – PHP (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. Contract Number and Title;
II. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
III. Section V. Scope of Services;
IV. Section VI. Contract Performance;
V. Section VII. Attachments; and
VI. Section VIII. Attachment O.13. Business Associate Agreement.

The Parties agree as follows:

I. Modifications to the Contract Number and Title

The Contract Number and Title are revised and restated in its entirety as follows:

#30-190029-DHB-1 Standard Plan – AMHC

#30-190029-DHB-2 Standard Plan – BCBS

#30-190029-DHB-3 Standard Plan – WCHP

#30-190029-DHB-4 Standard Plan – UNHC

#30-190029-DHB-5 Standard Plan – CCH

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

a. Section III.A. Definitions, 6. Auto-Assignment is revised and restated as follows:

6. **Auto-enrollment**: Automated process by which the Department enrolls a beneficiary who has not actively selected a PHP during open enrollment or at application. Maybe also be referred to as auto-assignment.

b. *Section III.A. Definitions* is revised to add the following:

190. **Children and Families Specialty Plan (CFSP):** A statewide capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of Chapter 108D, including the requirements pertaining to the Children and Families (CAF) specialty plan, but excluding the requirements only pertaining to BH I/DD tailored plans.

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

223. CFSP: Children and Families Specialty Plan

d. ***Section III.D. Terms and Conditions, 11. CONTRACT ADMINISTRATORS: For the Department*** **is revised and restated in its entirety as follows:**

For the Department

Contract Administrator for all contractual issues:

Name & Title	Kimberley Kilpatrick, Associate Director, Managed Care Contracting
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	(919) 527-7015
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Contract Administrator regarding day-to-day activities:

Name & Title	Cassandra McFadden Deputy Director of Standard Plans
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7040
Email Address	Cassandra.McFadden@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Department's Federal, State and the Department Compliance Coordinator for all security matters:

Name & Title	Pyreddy Reddy, DHHS CISO
Address	1915 Health Services Way Raleigh, NC 27607
Telephone Number	(919) 855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Department's HIPAA and Policy Coordinator for all Federal, State, and Department privacy matters:

Name & Title	John Thompson Chief Compliance Officer
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7701
Email Address	John.e.thompson@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

III. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. ***Section V.A. Administration and Management, 6. Readiness Requirements, g.*** **is revised and restated in its entirety as follows:**

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

b. ***Section V.B. Members, 2. Medicaid Managed Care Enrollment and Disenrollment, h., ii.*** **is revised and rested in its entirety as follows:**

ii. PHP auto-enrollment algorithm.

c. ***Section V.B. Members, 2. Medicaid Managed Care Enrollment and Disenrollment, i. PHP auto-assignment:*** **is revised and rested in its entirety as follows:**

i. PHP auto-enrollment:
   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-enrolled to a PHP.
   ii. The PHP shall adhere to the PHP auto-enrollment logic as defined by the Department.
      a) The Department will share the auto-enrollment logic with the PHP annually and any time there is a material change to the logic methodology.
      b) The Department, at its sole discretion, may choose to modify or choose to not use the auto-enrollment algorithm.

d. ***Section V.B. Members, 6. Member Grievances and Appeals, b. Member Grievance and Appeals General Requirements, vi.*** **is revised and restated in its entirety as follows:**

vi. The PHP shall allow an authorized representative (including providers) or legal guardian, with the Member's written consent, to request an appeal or file a grievance on behalf of a Member. 42 C.F.R.§ 438.402(c)(1)(ii)**.**

e. ***Section V.B. Members, 6. Member Grievances and Appeals, i. Appeals and Grievances Recordkeeping and Reporting, v. Appeals and Grievance Reporting, b), iii.*** **revised and restated in its entirety as follows:**

iii. Each Clearinghouse upload should include English ~~version~~ and the primary language of the Member (if the Notice is sent in a language other than English); and

f. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered Services, Sixth Revised and Restated Section V.C. Table 1 Summary of Medicaid Services*** **is revised and restated in its entirety as follows:**

Seventh 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 - (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R.§ 482.66. Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may 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	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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. 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
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	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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	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. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is	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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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.	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 NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography 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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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 Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program
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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC 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
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, Telehealth, Virtual Communications and Remote Patient Monitoring
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-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1S-9, Genetic Testing for Diagnosis and Treatment NC Clinical Coverage Policy 1S-10, Genetic Testing for Carrier and Prenatal

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 1S-11, Genetic Testing - Gene Expression NC Clinical Coverage Policy 1S-12, Genetic Testing - Next Generation Sequencing (NGS) NC Clinical Coverage Policy 1S-13, Cell and Gene Therapies 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
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 supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC 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. (c) 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.	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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. 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, Page 1-4 Non-Emergency Medical Transportation Managed Care 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-

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		A, Page 5; Att. 3.1-A.1, Pages 14-14h 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
Clinical 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 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
Physical therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional	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, 13e NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 10A, Outpatient Specialized Therapies
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, 13e NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Audiology Therapy	Services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for the rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use, and evaluation. These services must be provided by an Audiologist. As defined in 42 CFR § 440.110, an Audiologist who has a valid license issued by the NC 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, Page 7c.15 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
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, 13e NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policy	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Please refer to NC Clinical Coverage Policies and services listed.	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35, Page 15a.12, Page 15a. 11b, Page 15a. 12-B. Page 15a.12-A: NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): Mobile Crisis Management Partial Hospitalization Professional Treatment Services in Facility-based Crisis NC Clinical Coverage Policy 8A-2: Facility- based crisis services for children and adolescents NC Clinical Coverage Policy 8A-5: Diagnostic assessment NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-9: Opioid Treatment Program NC Clinical Coverage Policy 8A-10: Clinically Managed Residential Withdrawal Services (Social Setting Detox) NC Clinical Coverage Policy 8A-11: Medically Monitored Inpatient Withdrawal Management Services (Non-hospital medical detoxification) NC Clinical Coverage Policy 8A-12: Substance abuse intensive outpatient program (SAIOP) NC Clinical Coverage Policy 8A-13: Substance abuse comprehensive outpatient treatment program (SACOT) NC Clinical Coverage Policy 8B: Inpatient behavioral health services NC Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F: Research-based Behavioral Health Treatment NC Clinical Coverage Policy 8G: Peer Support Services
Respiratory care	Respiratory therapy services as defined in 1902(e)(9)(A) of	SSA, Title XIX, Section 1905(a)(20)

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
services	the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	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; (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.	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 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 musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services
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 of Nursing and employed by a licensed home care agency.	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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 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.	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.	
Durable medical equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: 1. Inexpensive or routinely purchased items 2. Capped rental/purchased equipment 3. Equipment requiring frequent and substantial servicing 4. Oxygen and oxygen equipment 5. Related medical supplies 6. Service and repair 7. Other individually priced items 8. Enteral nutrition equipment	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
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 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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 treatment for beneficiaries with acute psychiatric or substance use problems.	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC 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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		Stem- Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy 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 NC Clinical Coverage Policy 11B-9, Thymus Tissue Implantation

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 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. The clinical management of various fluid, electrolyte, and metabolic disturbances.	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
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	NC Clinical Coverage Policy 1R-1, Phase II Outpatient

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	restore beneficiaries with cardiovascular heart disease to active and productive lives.	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
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

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Ophthalmological Services	General ophthalmologic services Include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
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 NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
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 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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); 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. 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.	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring
Cell and Gene Therapies	Medicaid covers Cell and Gene Therapies for beneficiaries who meet specific criteria. The therapy must: • Have U.S. Food and Drug Administration (FDA) approval. • Meet the definition of a covered outpatient drug as defined in 42 CFR § 447.502. • Come from a manufacturer enrolled in the Medicaid Drug Rebate Program. • Be administered in accordance with FDA-approved guidelines, including: ○ Indications and usage. ○ Dosage and administration. ○ Dosage forms and strengths. ○ Warnings and precautions. • Be provided at a Qualified Treatment Center (QTC) or Authorized Treatment Center (ATC) approved for administering the therapy, as	NC Clinical Covery Policy 1S-13, Cell and Gene Therapies

Seventh Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	applicable • In some cases, the State will publish PA criteria for a specific therapy. In this case, the PA criteria will take precedence over the FDA label. In addition, Medicaid covers Non-Emergency Medical Transportation (NEMT) to assist beneficiaries with transportation to medical appointments. Medicaid does not cover Cell and Gene Therapies under the following circumstances: • The therapy has not received FDA approval. • The therapy is administered outside FDA guidelines, including: ○ Indications and usage. ○ Dosage and administration. ○ Dosage forms and strengths. • The therapy is provided at an unapproved facility. • The beneficiary is receiving repeat treatment with the same or another Cell or Gene Therapy. • Psychosocial or non-compliance issues prevent adherence to pre- and post-infusion medical care. Additional exclusions include: • Fertility preservation services associated with Cell and Gene Therapy administration. • NEMT services for fertility preservation appointments. While Medicaid does not cover fertility preservation services, the Centers for Medicare and Medicaid Services (CMS) requires participating manufacturers to fund these services for therapies provided under the CGT Access Model.	

g. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered Services, Second Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plan and BH I/DD Tailored Plans*** **is revised, renamed as** ***Third Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plan, BH I/DD Tailored Plans, and CFSP[10]*****, and restated in its entirety as follows:**

Third Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plans, BH I/DD Tailored Plans, and the CFSP[10]		
BH, TBI and I/DD Services Covered by Both SPs, BH I/DD TPs, and the CFSP	**BH, I/DD and TBI Services Covered by BH I/DD TPs and the CFSP**	**BH, I/DD and TBI Services Covered Exclusively by BH I/DD TPs (or LME-MCOs Prior To Launch)**
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Peer Support Services • Partial hospitalization • Mobile crisis management • Facility-based crisis services for children and adolescents • Professional treatment services in facility- based crisis program • Outpatient opioid treatment • Ambulatory Withdrawal Management without Extended On-Site Monitoring (Ambulatory detox) • Ambulatory Withdrawal Management with Extended On-Site Monitoring (Ambulatory detox) • Research-based Behavioral Health Treatment • Diagnostic assessment • Medically Monitored Inpatient Withdrawal Management Services (Non-hospital medical detoxification) • Substance abuse intensive outpatient program (SAIOP) • Substance abuse comprehensive outpatient treatment program (SACOT) • Clinically Managed Residential Withdrawal Services (Social Setting Detox) **EPSDT**	**State Plan BH and I/DD Services** • Residential treatment facility services • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities (PRTFs) • Assertive community treatment (ACT) • Community support team (CST) • Psychosocial rehabilitation • Clinically managed low-intensity residential treatment* • Clinically managed population-specific high intensity residential program* • Clinically managed residential treatment services (Substance abuse non-medical community residential treatment) • Medically monitored intensive inpatient services (Substance abuse medically monitored residential treatment) • 1915(i) services	**State Plan BH and I/DD Services** • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded BH and I/DD Services** **State-Funded TBI Services** **Respite services through TRACK at Murdoch**

*Coverage to be applied on the effective date approved by CMS.

[10]G.S. 108D-35.

h. ***Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered Services, x., c)*** **is revised and restated in its entirety as follows:**

c) Vaccines provided for children enrolled in Medicaid shall go through the VFC when the VFC program includes the vaccine, unless an exception is made by the Department.

i. ***Section V.C. Benefits and Care Management, 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*** **is revised to add the following:**

x. The PHP shall submit their plan specific annual CMS-416 data, based off the prior Federal Fiscal Year (October 1st – September 30th), to the Department each year before June 1st. The PHP shall also submit quarterly CMS-416 data to the Department no later than the 15th day of the month following the end of the previous quarter.

j. ***Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, d. Utilization Management, iv., g)*** **is revised and restated in its entirety as follows:**

g) The PHP shall reimburse the pharmacy for dispensing the emergency supply of medication, including dispensing fee and ingredient cost, for each fill.

k. ***Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement; i. Dispensing Fees, b)*** **is revised and restated in its entirety as follows:**

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

l. ***Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement; i. Dispensing Fees, f)*** **revised and restated in its entirety as follows:**

f) For 340B Hemophilia and Non-340B Hemophilia drugs, the dispensing fee is paid based on the number of units dispensed, utilizing a multiplier of $0.04 per unit for Hemophilia Treatment Center (HTC) pharmacies and $0.025 per unit for all other pharmacies.

m. ***Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement; ii. Ingredient Costs, a)*** **revised and restated in its entirety as follows:**

a) The PHP shall reimburse pharmacies ingredient costs at the same rate as the Medicaid Fee-for-Service rate as defined in the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1).

n. ***Section V.C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement; ii. Ingredient Costs, f), 2., ii.*** **is revised and restated in its entirety as follows:**

ii. Under the State Plan, the dispensing fee for blood clotting factor products used to treat hemophilia is paid based on the quantity of units dispensed. The per unit professional dispensing fee is $0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is $0.025/unit for all other non-hemophilia treatment center pharmacies.

o. ***Section V.C. Benefits and Care Management, 6. Care management, b. Local Care Management and Related Programs, iv. Advance Medical Home Contracting, c), 1.*** **revised and restated in its entirety as follows:**

1. In cases where the Department establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department in the latest version of the Advance Medical Home data specifications guidance documents found at https://medicaid.ncdhhs.gov/advanced-medical-home-data-specification-guidance.

p. ***Section V.G. Program Operations, 1. Service Lines, j.*** **is revised and restated in its entirety as follows:**

j. The PHP shall digitally record and store one hundred percent (100%) of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months from the date of the call including Subcontractors.

q. ***Section V.I. Financial Requirements, 2. Medical Loss Ratio*** **is revised to add the following:**

j. Medical Loss Ratio Reporting for Risk-Bearing PHP Subcontractors

i. Starting January 1, 2026, the PHP shall require any risk-bearing Subcontractor, as defined by the Department, to calculate and report the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8(b). The first MLR reporting year for vendors will be January 1, 2026 – June 30, 2026 and aligned with the PHP's rating period thereafter.

a) The PHP shall require risk-bearing Subcontractors to calculate and report MLR consistent with the Department's requirements in 42 C.F.R. § 438.8(d) and 42 C.F.R. § 438.8(k) on an aggregate basis combining experience for Medicaid Expansion Eligible Members and non-Medicaid Expansion populations.

b) The PHP's Subcontractor shall apply a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3) using the CMS published credibility factors.

c) The PHP's Subcontractor's report shall be submitted to the PHP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year.

d) The PHP may require that all classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity be submitted to the PHP for review and approval, but only the activities that the PHP requests to include in the PHP MLR calculations must be submitted to the Department.

e) The PHP shall report the outcome of Subcontractor MLR calculations in the MLR templates and associated instructions to be provided by the Department.

IV. Modifications to Section VI. Contract Performance

Specific subsections are modified as stated herein.

a. ***Section VI. Contract Performance, A. Contract Violations and Noncompliance,*** **Seventh Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective July 1, 2023) is revised and restated in its entirety as follows:**

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
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 drug ingredient cost reimbursement rates 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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
24.	Reserved.	[redacted]
25.	Reserved.	
26.	Reserved.	
27.	Reserved.	
28.	Reserved.	
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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.
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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.

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
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

Eighth Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages (Effective January 1, 2026)		
No.	**PROGRAM ISSUES**	**DAMAGES**
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.
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

b. ***Section VI. Contract Performance, B. Services Level Agreements, Eighth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2025)*** **is revised and restated in its entirety as follows:**

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
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
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	Quarterly	$100,000 per quarter

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.		
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 by a live operator 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
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	Monthly	$15,000 per month

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			divided by the total number of calls received by the service line.		
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 by a live operator 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	Monthly	$10,000 per month

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.		
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 by a live operator 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 by a live operator 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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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; and monthly medical home and care management fees and value-based payments as specified in the Encounters Submission Guide.*	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
23.	Encounter Data Timeliness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy encounters within seven (7) Calendar Days after	The number of unique transactions submitted divided by the number of unique transactions which should have been	Weekly	$100 per encounter per Calendar Day

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		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.*	submitted to the Department as an encounter.		
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; and monthly medical home and care management fees and value-based payments as specified in the Encounters Submission Guide.*	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. *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	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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		reported on financial reports within one hundred twenty (120) Calendar Days.			
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)
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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 by a live operator 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
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 by a live operator 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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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.	Individual Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the PHP utilizes a single*	The PHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	For individual member mailing, the number of Member Welcome Packets 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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)				79.99% or less: $10,000 per month
39.	Individual 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.*	For individual member mailing, the number of welcome letters and Member handbooks 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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
42.	Non-Emergency Medical Transportation – Approved Trips	The PHP shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the PHP minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-J-SP operational report, divided by the total number of NEMT trips approved by the PHP. *NEMT trips for hospital discharges will not be included in determining compliance with this SLA.*	Monthly	99.25%-99.49% = $15,000 per month 99.01%-99.24% = $20,000 per month 99% or less = $25,000 per month
43.	Head of Household Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the PHP sends separate mailings to the Head of Household and individual Member and if the PHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	The PHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	For Head of Household mailing, the number of household Member Welcome Packets mailed by the PHP within the required timeframe, divided by the total number of households, with newly enrolled members 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

Ninth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective January 1, 2026)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
44.	Head of Household Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PHP sends separate mailings to the Head of Household and individual Member and 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.*	For Head of Household mailing, the number of household Member Welcome Packets mailed by the PHP within the required timeframe, divided by the total number of households, with newly enrolled members 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

V. <u>Modifications to Section VII. Attachments</u>

Specific Attachments are modified or added as stated herein.

a. *Attachment F. Sixth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* is revised and restated in its entirety as *Attachment F. Seventh Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* and attached to this Amendment.

b. *Attachment J. Tenth Revised and Restated Reporting Requirements* is revised and restated in its entirety as *Attachment J. Eleventh Revised and Restated Reporting Requirements* and attached to this Amendment.

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

d. *Attachment M.8. First Revised and Restated Behavioral Health Services Definition Policy* is revised and restated in its entirety as *Attachment M.8. Second Revised and Restated Behavioral Health Services Definition Policy* and attached to this Amendment.

e. ***Attachment M.10. Third Revised and Restated Approved PHP Name In Lieu of Services*** **is revised and restated in its entirety as *Attachment M.10. Fourth Revised and Restated Approved PHP Name In Lieu of Services* and attached to this Amendment.**

VI. Modifications to Section VIII. Attachment O.

Attachment O.13. Business Associate Agreement **is revised and restated in its entirety as *Attachment O.13. First Revised and Restated Business Associate Agreement* and attached to this Amendment.**

VII. Effective Date

This Amendment is effective January 1, 2026, 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, Division of Health Benefits

_____ Date: _____

Melanie Bush, Interim Deputy Secretary
NC Medicaid

Plan Name

_____ Date: _____

Plan Signature Authority

Attachment F. Seventh Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards

At a minimum, Contractor's network shall consist of hospitals, physicians, advanced practice nurses, SUD and behavioral health treatment providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficientlyavailable as described in Section V.D.1. Provider Network.

For the purposes of this attachment and the Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

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

For purposes of network adequacy standards physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.
For purposes of network adequacy standards for behavioral health providers/services, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

Section VII. Attachment F. Fourth Revised and Restated Table 1: PHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
5	Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
7	Outpatient Behavioral Health Services	• ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members • *Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard*
8	Location-Based Services (Behavioral Health)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
9	Crisis Services (Behavioral Health)	≥ 1 provider of each crisis service within each PHP Region	
10	Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP Region	

11	Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members
12	All State Plan LTSS(except nursing facilities)*	PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.
13	Nursing Facilities*	PHP must have at least 1 nursing facility accepting new patients in every county.

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

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

Section VII. Attachment F. Seventh Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (OTP) (adult) • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program
3.	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult) • Facility-based crisis services for children and adolescents • Ambulatory withdrawal management, without extended on-site monitoring • Ambulatory withdrawal management, with extended on-site monitoring • Medically Monitored Inpatient Withdrawal Management Services • Clinically Managed Residential Withdrawal Services (Social Setting Detox)

Section VII. Attachment F. Seventh Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		• Mobile Crisis Management
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Withdrawal Management Services beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Services beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent/child Medically Managed Intensive Inpatient Services beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

PHP is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by thetype of service:

Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service –adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations,	Within thirty (30) Calendar Days

Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
1a	Preventive Care Services – child, birth through 20 years of age	immunizations, mammograms and pap smears	Within fourteen (14) Calendar Days for Member less than six (6) months of age Within thirty (30) Calendar Days for Members six (6) months of age and older.
2	Urgent Care Services	Care provided for a non- emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar Days
4	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar Days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar Days
Specialty Care			
6	Urgent Care Services	Care provided for a non- emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours

Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
8	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Behavioral Health Care			
9	Mobile Crisis Management Services	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within two (2) hours
10	Urgent Care Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within twenty-four (24) hours
11	Urgent Care Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within fourteen (14) Calendar Days
13	Routine Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within forty-eight (48) hours
14	Emergency Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
15	Emergency Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

The PHP is required to use the following provider types as "specialty care" providers for purposes of *Section VII. Attachment F. Second Revised and Restated Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. Second Revised and Restated Table 3: PHP Appointment Wait Time Standards* as found in this attachment:

Section VII. Attachment F. Second Revised and Restated. Table 4: Specialty Care Providers	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
8a.	Gynecology [2]
9.	Infectious Disease
10.	Hematology
11.	Nephrology
12.	Neurology
13.	Oncology
14.	Ophthalmology
15.	Optometry
16.	Orthopedic Surgery
17.	Pain Management (Board Certified)
18.	Psychiatry
19.	Pulmonology
20.	Radiology
21.	Rheumatology
22.	Urology

[2] Measured on members who are female and age 14 or older.

Attachment J. Eleventh 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.

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
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.	

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
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	Every other week summary of members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
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.	[redacted]
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. Reserved.	[redacted]
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.

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
r. Reserved.	[redacted]
s. Reserved.	
t. Reserved.	
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.
z. PCP Operational Monitoring Report	Monthly report on PCP assignment, changes and panel limits.
aa. Clinically Integrated Networks (CIN) Contracting Report	Monthly report that identifies contracting status between the PHP and Clinically Integrated Networks (CIN) and their affiliated AMH Tier 3 practices.
bb. NC Select Drug Report	Quarterly report on requesting drugs on the NC Select Drug List, the status of PA requests, status of paid claims, time to complete PA reviews, and single case provider agreements.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Reserved.	[redacted]
c. Reserved.	
d. Reserved.	

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
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.

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
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. Reserved.	
z. Reserved.	
5. ***Quality and Value***	
a. Reserved.	
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	
d. Reserved	
e. Reserved	

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Reserved	[redacted]
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	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
Report	
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.)
i. Recipient Explanation of Medical Benefit (REOMB) Report	The PHP is responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The PHP sends REOMBs to a random sample of Members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the Member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The PHP is required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.
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	Monthly summary of the volume and dollar amount of claims that were paid,

Eleventh Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements (Effective January 1, 2026)	
PHP Report Name	**PHP Report Description**
Report	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
e. TPL Recovery Match Report	A monthly report detailing those claims upon which the PHP has been unable to effectuate recovery within one (1) year of the date of service.
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 Invoice Monitoring Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.
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).

Attachment M.1. Third 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-enroll the beneficiary to a PHP based on the Department's defined auto-enrollment 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-enrolled 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 choice period, 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. 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-enrolled to a PHP based on the Department-defined auto-enrollment algorithm described in Section 6.f.vi. The Department will transmit the auto-enrollment 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-enrolled 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-enrolled PHP until the Member's annual choice period, 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-enrolled into a PHP based on the Department-defined auto-enrollment algorithm.
    b. The Department will transmit the auto-enrollment 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-enrolled PHP until the Member's annual choice period, unless otherwise disenrolled from the PHP for reasons specified in Section f.

iv. Medicaid eligibility redetermination
1. Reserved.
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-enroll the Member into the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care. Members have an opportunity to select a different PHP during his or her annual choice period.
3. Annual choice period
    a. Once a year, 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-enrollment

1. In accordance with 42 C.F.R. § 438.54, the Department developed auto-enrollment 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-enrollment 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-enrollment algorithm.
3. For the crossover population and for a new beneficiary enrolled into Medicaid Managed Care, the auto-enrollment algorithm is defined according to the following components in this order:
   a. Beneficiary's geographic location;
   b. Whether the beneficiary is a member of a special population (e.g. member of a federally recognized tribe, or BH I/DD Tailored Plan eligible).
   c. PHP/AMH selection upon application and PCP/AMH historic relationship.
   d. Plan assignments for other family members.

[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.

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-enrollment 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-enrollment 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-enrolled 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-enrollment may also be used in the following instances:
    a. For Medicaid Managed Care Members whose PHP has been discontinued. The Member will be auto-enrolled using the same algorithm used for new beneficiaries.
    b. For beneficiaries who lose, but then regain, Medicaid eligibility. The beneficiary will be auto-enrolled 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-enrolled 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-enrollment 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-enrolled 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, 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 during the annual choice 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 he 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
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]

[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.
[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).

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.

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

[6] *See* 42 C.F.R. § 438.56(d)(2)(iii).
[7] *See* 42 C.F.R. § 438.56(d)(2)(iv).
[8] 42 C.F.R. § 438.56(d)(2)(v).

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 twenty-four (24) hours of receipt of the decisions to the Department.
   ii. Reserved.

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 evaluates and decides whether to approve or deny the request.
   c. Reserved.
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

[10] Id.

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

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

[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.

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

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.

Attachment M.8. Second Revised and Restated Behavioral Health Service Definition Policy

1. **Background**

   The Behavioral Health Service Definition Policy provides the Prepaid Health Plans (PHPs) a detailed description of the Department's definitions of required Behavioral Health Service for the purpose of appointment wait time standards and routine, urgent and emergent care.

2. **Behavioral Health Services Definitions**

   a. Opioid treatment (adults only): a location-based service for the purpose of network adequacy standards.
   b. Adult Facility-Based Crisis Services: a crisis service for the purpose of network adequacy standards.
   c. Child Facility-Based Crisis Services: a crisis service for the purpose of network adequacy standards.
   d. Medically Monitored Inpatient Withdrawal Management Services: a crisis service for the purpose of network adequacy standards.
   e. Reserved.
   f. Reserved.
   g. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
   h. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
   i. Medically Managed Intensive Inpatient Services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4): inpatient BH services for the purpose of network adequacy standards.
   j. Medically Managed Intensive Inpatient Withdrawal Management Services (Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standards.
   k. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
   l. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
   m. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
   n. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
   o. Acute Care Hospitals with Child Inpatient Psychiatric Beds as inpatient BH services for the purpose of network adequacy standards.
   p. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
   q. Specialized Services: as partial hospitalization for children and adults for the purposes of the network adequacy standards.
   r. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.
   s. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

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

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

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

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

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

y. Clinically Managed Residential Withdrawal Services (Social Setting Detoxification): a Medicaid crisis service for the purpose of network adequacy standards.

z. Hospitals with Adult Inpatient Substance Use Beds (ASAM Level 4 and ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standards.

Attachment M.8. Fourth 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 or NC Health Choice State Plans 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. The PHP shall ensure that Members are provided the rights outlined in *Section V.C.1.g. In Lieu of Services* for all approved In Lieu of Services;
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. Fourth Revised and Restated Approved AmeriHealth Caritas of North Carolina In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Institute for Mental Disease (IMD) for Mental Health Services for Members 21-64	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.	Mental Health IP-Acute Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160	07/01/2021
Behavioral Health Urgent Care (BHUC)	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.	Emergency Department-Acute Inpatient Hospital	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. (Episode of Care) Per Person 1-Unit/1-2 days.	T2016 U5	07/01/2021

Attachment M.10. Fourth Revised and Restated Approved Blue Cross and Blue Shield of North Carolina In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Institute for Mental Disease (IMD) for Mental Health Services for Members 22- 64	IMD hospital treatment in a hospital setting twentyfour (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.	Inpatient Psychiatric bed Facility	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160	07/01/2021
Behavioral Health Urgent Care (BHUC)	Diversion from Inpatient hospitalizations and long wait times/observation in emergency rooms for placement. Stabilization of condition and ability to return to community.	Emergency Room Observation Inpatient Acute Hospitalization	Target Population includes members, aged 4 and older experiencing a BH crisis, psychological, or biological dysfunction and functional impairment, which are consistent and associated with DSM-5 diagnosis. (Episode of Care) 1 Unit=Per Diem per 1-Day.	T2016 U5	07/01/2021
Enhanced Personal Care Supports	To provide an additional 24 hours of personal care services in the home per year to support members independence and avoid costly institutional placement to supplement personal care services provided by state plan benefits.	Nursing Home Facility	LTSS Members currently receiving personal care services, and members who require facility based care (such as nursing home or assisted living) that could benefit from a combination of in lieu of services to support community living. (Episode of Care) 1 unit=15 minutes (Not to exceed 24 hours yearly per member	T1019 U1	07/01/2021-10/01/2023
Respite Care	To provide up to 24 hours per year of in-home Respite Care Services to members in order to relieve the strain of caregivers providing services in the home. The Respite Care services will be non- institutional respite services provided by homecare agencies licensed by the State of North Carolina.	Nursing Home Facility	Members currently receiving LTSS state plan benefits. Members who require facility-based care (such as nursing home or assisted living) that could benefit from a combination of in lieu of services to support community living. (Episode of Care) 1 unit=15 minutes (24 hours of in-home respite care for eligible members each year.	S5150 U1	07/01/2021-10/01/2023

Environmental Modifications	Eligible members will receive up to $2,500 for environmental modifications for their place of residence to include pest extermination, mold remediation, temporary housing and external physical adaptations. Eligible members assessed to need environmental modifications will be referred to a contracted vendor to provide the requested service.	Emergency Room Nursing Home Facility	LTSS Members currently residing in their own home or other private residence. Members currently receiving LTSS state plan benefits. Length of service will depend on type of modification required. Utilization is limited to $2,500 every 365 days.	S5165	07/01/2021-01/01/2025
Community Reintegration Support	Eligible members will receive up to $2,500 per member per nursing facility admission episode of 30 days or more to help pay for the cost of moving back to a community setting. Funds can be used for security and utility deposits, household furnishings and moving costs.	Nursing Home Facility	Members who need LTSS or at risk of needing LTSS. Members who require facility based care (such as nursing home or assisted living) that could benefit from a combination of in lieu of services to support community living. Length of Service as needed for eligible members who transition from an institution to the community	T2038 U1	07/01/2021-10/01/2023
Enhanced Private Duty Nursing	To provide Enhanced Private Duty Nursing Services for eligible members in need of skilled nursing services in the home for up to 24 hours per day.	Private Duty Nursing Nursing Home Facility	Current adult PDN members who are at the maximum legislature PDN hour units at risk of being institutionalized. (Episode of Care) 1 unit=15 minutes (Up to 32 units per day not to exceed a total of 448 units per week in combination with PDN received via state plan benefits.	T1000 UC	07/01/2021-10/01/2023

Attachment M.10. Fourth Revised and Restated Approved Carolina Complete Health In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Massage Therapy	Alternative pain management via message therapy provided by a licensed practitioner in Lieu of pharmaceutical pain management with Schedule II narcotics. Reduction in chronic pain and back pain without the use of opiate therapies.	Injection, Hydromorphone Injection, methadone HCl Injection, meperidine hydrochloride Injection, fentanyl citrate Codeine phosphate	Target Population includes adult members that have documented history of chronic pain (Episode of Care) One Unit=15 minutes/ 40 per fiscal year	97124, 97140	07/01/2021
Institute for Mental Disease (IMD) for Mental Health Services for Members 22- 64	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.	Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160	07/01/2021
Behavioral Health Urgent Care (BHUC)	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.	Emergency Care Inpatient Hospital	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. (Episode of Care) Per Person 1 unit/Per event	T2016 U5 (without Observation) T2016 U8 (with Observation)	07/01/2021

Attachment M.10. Fourth Revised and Restated Approved United Healthcare of North Carolina In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Behavioral Health Urgent Care (BHUC)	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.	Inpatient Hospital	Target Population includes children aged 4 to 20 and adults with mental health, substance use disorder, or co-occurring disorders. Also, people experiencing behavioral health crisis meeting urgent triage standards. (Episode of Care) Per Person 1-Unit per Diem	T2016 U5	07/01/2021
Institute for Mental Disease (IMD) for Acute Psychiatric Care	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 Support will 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	Inpatient Hospital	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160	07/01/2021

Attachment M.10. Fourth Revised and Restated Approved WellCare of North Carolina In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Intensive Outpatient (IOP) for Mental Health	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	Partial Hospitalization	Target Population includes members with a behavioral health diagnosis needing more intensive care, but not inpatient treatment; members discharging from inpatient care who need more than outpatient support. The duration of service is per diem, 4-hours per day, 4-5 days per week, with length of service 4-6 months.	S9480 with Rev Code 905	07/01/2021
Institute for Mental Disease (IMD) for Acute Psychiatric care	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 ages 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.	Inpatient Stay-Initial Hospital Care	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	0160	07/01/2021
Behavioral Health Urgent Care (BHUC)	Provide crisis stabilization for Members experiencing acute mental health episodes in an urgent care setting in order to decreased crisis/emergency department utilization, decrease	Emergency Room Visit Inpatient Stay-Initial Hospital Care	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or	T2016 U5	07/01/2021

	inpatient hospital stays, and improve crisis stabilization.		urgent triage standards. The duration of service is per 1 unit per event (2 hours per episode)		
Specialized Therapeutic In-Home Service Programs for High Risk Populations	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	Inpatient Hospital Stay	Target Population includes beneficiaries with complex medical and behavioral health conditions and unmet social needs. The duration of service is 1 visit per diem (max 1 day per week) Based on Medical necessity up to 120 days.	H0046 HK	07/01/2021-07/01/2025

Attachment O.13. First Revised and Restated Business Associate Agreement

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made between North Carolina Department of Health and Human Services, Division of Health Benefits ("DHB" and "Covered Entity") and PHP NAME ("Business Associate") (collectively the "Parties").

1. **BACKGROUND**
   a. Covered Entity and Business Associate are Parties to an agreement entitled Contract #30-190029-DHB-# Standard Plan – Plan ("Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
   b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
   c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.
   d. The Parties enter into this Business Associate Agreement as an attachment to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose Protected Health Information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. **DEFINITIONS**
   Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:
   a. "Electronic protected health information" or "ePHI" shall have the same meaning as the term "Electronic protected health information" in 45 C.F.R. § 160.103.
   b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
   c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a Person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
   d. "Person" shall have the same meaning as the term "person" in 45 C.F.R. § 160.103 and shall include a human being that is born alive, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.
   e. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
   f. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information compiled, created, or received by Business Associate from or on behalf of Covered Entity.
   g. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.
   h. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the Person to whom the authority involved has been delegated.
   i. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subpart C.

j. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

3. **OBLIGATIONS OF BUSINESS ASSOCIATE**
   a. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.
   b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the ePHI other than as provided for by this Agreement.
   c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
   d. Business Associate agrees to comply with all applicable requirements of the Security Rule (45 C.F.R. Part 164, Subparts A and C) with respect to electronic protected health information.
   e. Business Associate shall implement physical, administrative and technical safeguards that reasonably protect the confidentiality, integrity and availability of any ePHI that it creates, receives, maintains or transmits on behalf of the NC DHHS.
   f. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410.
   g. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
   h. Business Associate agrees to make available PHI as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
   i. Business Associate agrees to make available PHI for amendment and incorporate any amendment(s) to PHI in accordance with 45 C.F.R. § 164.526.
   j. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
   k. Business Associate agrees to make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

4. **PERMITTED USES AND DISCLOSURES**
   a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
      1) Would not violate the Privacy Rule if done by Covered Entity; or
      2) Would not violate the minimum necessary policies and procedures of the Covered Entity.
   b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
      1) The disclosures are Required By Law; and

2) Business Associate obtains reasonable assurances from the Person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the Person, and the Person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate shall not use or disclose PHI if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. **Term**. This Agreement shall be effective as of the effective date of the Contract and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1) Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or

3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

1) Except as provided in paragraph (2) of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. **GENERAL TERMS AND CONDITIONS**

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. In the event that a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

IN WITNESS WHEREOF, Business Associate agrees to and executes this Agreement as of the Effective Date of the Contract.

PHP NAME

_____ _____

PHP POC Date
POC Title

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

_____ _____

Melanie Bush Date
Interim Deputy Secretary, NC Medicaid