AMENDMENT NUMBER 2

CONTRACT #30-2024-001-DHB
CHILDREN AND FAMILIES SPECIALITY PLAN

BETWEEN

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

AND

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

THIS Amendment to Contract #30-2024-001-DHB (Contract), which was made effective August 15, 2024 as subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Department"), and Blue Cross and Blue Shield of North Carolina ("Contractor"). Department and Contractor may be individually referred to as "Party" and collectively as the "Parties."

Background

The Children and Families Specialty Plan (CFSP) is an integrated Medicaid Managed Care plan that covers services specified to address a spectrum of Member needs, including those related to physical health, behavioral Health, I/DD, LTSS, and pharmacy services and unmet health-related resource needs. Intended to meet the unique health care needs of children, youth and families currently and formerly served by the child welfare system, the CFSP operates statewide, enabling Members to access a broad range of physical health and behavioral health services and maintain treatment plans when their geographic locations change.

The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract as follows:

1. Modify requirements in *Section II. General Procurement Information and Notice to Offerors*
2. Modify requirements in *Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections*.
3. Modify requirements in *Section V. Scope of Services*.
4. Modify *Section VII. Attachments* as specified herein.

The Parties agree as follows:

1. Modifications to *Section II. General Procurement Information and Notice to Offerors*

a. ***Section II. E. Submission of Proposal and Offeror's Response*** **is revised and restated in its entirety as follows:**

E. Reserved.

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

Specific subsections of the Contact are modified as follows:

a. *Section III. A. Definitions* is revised to add the following newly defined term:

211. Health Care Clearinghouse: Has the same meaning as Health care Clearinghouse as defined in 45 C.F.R. § 160.103.

b. *Section III. D. Terms and Conditions, 35. MEDIA CONTACT APPROVAL AND DISCLOSURE,* is revised and restated in its entirety as follows:

35. MEDIA CONTACT APPROVAL AND DISCLOSURE:

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

b. Media Interviews: Contractor shall not agree to participate in a media request for planned an interview related to the terms of this Contract prior to obtaining prior approval from the Department which approval shall not be unreasonably withheld. Upon receipt of a request for an interview, Contractor shall provide the information outlined in the Health Plan Media Interview Request Instructions for Health Plans to the Department for review.

3. Modifications to *Section V. Scope of Services*

Specific subsections of the Contract are modified as follows:

a. *Section V.A. Administration and Management, 2. Entity Requirements, c. Ownership and Control and CFSP Operating Plan, iii.,* is revised and restated in its entirety as follows:

iii. The CFSP shall develop and maintain an up-to-date CFSP Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core

Medicaid operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care services.

1) Core Medicaid Operations shall include but are not limited to:
   a) Managing Medicaid Managed Care Beneficiary lives (including Member services and the administration of clinical benefits and services);
   b) Provider network management;
   c) Performing care management and care coordination functions;
   d) Performing quality management and data reporting;
   e) Processing and paying claims;
   f) Assuming risk through a capitated contract;
   g) Entities acting as a TPA;
   h) Entities acting NEMT vendors; and
   i) Entities acting as Pharmacy.

b. Section V.A. Administration and Management, 5. Implementation, f. ii., is revised and restated in its entirety as follows:

ii. End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting. The Department, if deemed necessary for the project execution, shall develop and provide an End-to-End test plan aligned with specific requirements for the program that includes all systems part of End-to-End testing. At a minimum, the End-to-End testing Plan shall include:
   (1) High level description of the End-to-End Testing scope;
   (2) High level overall End-to-End Testing duration;
   (3) Applications or systems that are part of the End-to-End testing; and
   (4) Integrations that are part of the End-to-End

c. *Section V.A. Administration and Management, 9. Staffing and Facilities, k. Organization Roles and Positions, vi.,* is revised and restated in its entirety as follows:

vi. The CFSP shall provide staffing levels, hiring, layoff activity, and plans upon request by the Department.

d. *Section V.A. Administration and Management, 9. Staffing and Facilities, l. Physical Presence in North Carolina, iv.,* is revised and restated in its entirety as follows:

iv. Additionally, the following personnel and roles, at a minimum, shall be located in and operate from within the State of North Carolina unless otherwise noted (as found in *Section VII. Attachment A. CFSP Organization Roles and Positions*):
   1) Care Managers and Supervisors;
   2) Certified Family Peer Specialist(s);
   3) System of Care Outreach Coordinator(s);
   4) System of Care Manager;
   5) Member Appeal Coordinator;

6) Member Complaint and Grievance Coordinator;
7) Full-Time Member Services and Service Line Staff;
8) Provider Relations and Service Line Staff;
9) Provider Complaint, Grievance, and Appeal Coordinator;
10) Pharmacy Director and Pharmacy Service Line Staff;
11) Full-Time Utilization Management Staff;
12) Tribal Provider Contracting Specialist;
13) Liaison between the Department and the North Carolina Attorney General's MID;
14) Regional Liaisons to County DSS; and
15) I/DD and TBI Clinical Director
16) Care Management Housing Specialist(s)

e. *Section V.B. Members, 3. Transitions of Care Across Plans and Delivery Systems, a. Ongoing Requirements, iv., 1),* is revised and restated in its entirety as follows:

1) Identify enrolling or disenrolling Members, as defined in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy*, who are transitioning from or to a BH I/DD Tailored Plan, Standard Plan, PIHP, Tribal Option, or other delivery system such as NC Medicaid Direct. Protocols shall be made available to the Department, upon request.

f. Section *V.B. Members, 3. Transitions of Care Across Plans and Delivery Systems, a. Ongoing Requirements, vii.,* is revised and restated in its entirety as follows:

vii. In instances in which a Member transitions into the CFSP from NC Medicaid Direct, a Standard Plan, a BH I/DD Tailored Plan, PIHP, Tribal Option or another type of health insurance coverage, and the Member is in an Ongoing Course of Treatment or has an Ongoing Special Condition, the CFSP shall permit the Member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, in accordance with NCGS § 58-67-88(d)-(g), and as otherwise required by the Contract. In lieu of the transitional period established in NCGS § 58-67-88 (d), the CFSP shall honor a transitional period of one hundred eighty (180) Calendar Days for all out-of-network providers serving a transitioning CFSP Member at the time of transition, treating out-of-network providers the same as in-network providers regarding both reimbursement and prior authorization requirements.

g. Section *V.B. Members, 3. Transitions of Care Across Plans and Delivery Systems, b. Cross-over Population, v.,* is revised and restated in its entirety as follows:

v. The CFSP shall participate in Member-specific knowledge transfer sessions known as "Warm Handoffs" for beneficiaries transitioning to the CFSP as identified by CCNC, a BH I/DD Tailored Plan, a Standard Plan, PIHP, County DSS, the State and other transition entities as identified

h. *Section V.B. Members, 4. Member Engagement, i. Written and Verbal Member Materials, ii., 4), a),* is revised and restated in its entirety as follows:

a) Taglines are required on materials that are critical for potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d). For all materials requiring a tagline, the PHP shall use the Department-developed Auxiliary Aids and Interpreter Services Taglines Template.

i. Section *V.B. Members, 4. Member Engagement, l. Member Welcome Packet, ii., 1),* is revised and restated in its entirety as follows:

1) A welcome letter that notifies the Member of their enrollment in the CFSP and provides:
   a) The effective date from which the CFSP shall assume health coverage for the Member;
   b) Information on how to access the online Provider directory and how to request a hardcopy of the provider directory;
   c) Information on how to change to a Standard Plan, BH I/DD Tailored Plan, Tribal Option, or NC Medicaid Direct;
   d) The toll-free service line numbers which a Member may call for the Member Service Line, Behavioral Health Crisis Line, NEMT Member Service Line, Nurse Line and Pharmacy Service Line;
   e) Information on how to inquire about accessing Care Management services, including background on CFSP Care Management, first and last name of assigned Care Manager, or care management entity, if delegated, and how to change a care manager;
   f) The role of a PCP in Medicaid Managed Care:
      i) How to select or change a PCP; and
      ii) Why a Member might be auto-assigned a PCP;
   g) How to arrange for NEMT;
   h) An offer of assistance in arranging initial visit to his or her PCP;
   i) Contact information for the Ombudsman Program;
   j) The CFSP website address;
   k) Circumstances under which Member information will be disclosed to third parties; and
   l) The availability of the Grievance and Appeals process as described in Section V.B.7. Member Grievances and Appeals.

j. *Section V.B. Members, 5. Marketing, k. Marketing Materials and Activities, ii., 11),* is revised and restated in its entirety as follows:

11) Reserved.

k. *Section V.B. Members, 5. Marketing, k. Marketing Materials and Activities, iv., 2), c),* is revised and restated in its entirety as follows:

c) The gifts are distributed via events (e.g., community events, virtual events).

l. ***Section V.B. Members, 5. Marketing, l. Department Approval of Marketing Materials, i.,*** **is revised and restated in its entirety as follows:**

i. The CFSP shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.

m. ***Section V.B. Members, 8. Advanced Medical Home (AMHs) as Primary Care Providers (PCPs), b. AMH/PCP Choice and Assignment, ii.,*** **is revised and restated in its entirety as follows:**

ii. The CFSP shall, in instances in which a Member does not select an AMH/PCP at the time of enrollment, assign the Member to an AMH/PCP within twenty-four (24) hours of effectuation date of enrollment in CFSP. The CFSP shall allow AMH/PCPs to set limits on panel size and shall have a process for AMH/PCPs to do so. The CFSP shall abide by the panel limits outlined in CFSP Contracts with AMH and PCP providers.
   1) The CFSP's methodology for assigning Members to an AMH/PCP shall include the following components, as defined by the Department and shared requirements for PCP Auto Assignment as outlined in NCMT CFSPPCP AA Requirements Document.
   2) Reserved.
   3) Reserved.
   4) Reserved.
   5) Reserved.
   6) Reserved.
   7) Reserved.
   8) Reserved.

n. ***Section V.D. Care Management, 2. CFSP Care Management, d. Eligibility for CFSP Care Management, i.,*** **is revised and restated in its entirety as follows:**

i. All Members are eligible for CFSP Care Management. The Department reserves the right to determine if services are duplicative of CFSP Care Management, which may impact eligibility for CFSP Care Management.
   1) Reserved.
   2) Reserved.

o. ***Section V.D. Care Management, 2. CFSP Care Management, d. Eligibility for CFSP Care Management, iv.,*** **is revised and restated in its entirety as follows:**

iv. CFSP shall ensure Members who do not engage in CFSP Care Management (including Members who are not reachable or decline CFSP Care Management), receive Care Coordination services, as described in *Section V.D.3. Care Coordination and Care Transitions for All Members*.

p. ***Section V.D. Care Management, 2. CFSP Care Management, e. Initiation of Care Management,*** **is revised and restated in its entirety as follows:**

e. Initiation of Care Management

i. The CFSP shall ensure that all Members are assigned a care manager within twenty-four (24) hours of the CFSP receiving notification of the Member's enrollment.

ii. The CFSP shall submit to the Department its methodology for assigning Members to a care manager.

iii. The CFSP shall make best efforts to prioritize the following factors, in order, when assigning each Member to a care manager:
   1) Member's request for a specific care manager;
   2) The specialized needs of individual Members (e.g., care manager has experience managing Members of a similar age and/or those with similar clinical and social needs);
   3) Reserved;
   4) The same care manager is assigned to family members enrolled in the CFSP (e.g., child in Foster Care is assigned to the same care manager as their Parent(s), Guardian(s), or Custodian(s) who is also enrolled in the CFSP);
   5) The care manager is based out of the same County DSS as the Member's assigned County Child Welfare Worker; and
   6) Geographic proximity (if the care manager is not staffed to the same County DSS as the Member's assigned County Child Welfare Worker).

iv. The CFSP shall have discretion to modify the prioritization of care manager assignment factors based on care manager availability and existing caseloads.

v. The CFSP shall permit Members to request a change in their assigned care manager at any time and without limit.

vi. Reserved.

vii. Reserved.

viii. Reserved.

ix. In instances where a Member has relocated permanently, the CFSP may, with the Member's consent, re-assign the Member to a care manager located closer to the Member's place of residence. "Relocated permanently" for this requirement means when a Member moves from one place to another without expecting to return to their original or previous location.

x. Members must not be assigned to a care manager who is related by blood or who serves as the Member's Parent, Guardian or Custodian.

xi. The CFSP shall submit its policies and procedures for care manager assignment as part of its Care Management Policy (Section V.D.5. Care Management Policy).

xii. Consolidation of Medical Records
   1) The CFSP shall be responsible for consolidating relevant medical records for enrolled Members within thirty (30) Calendar Days of enrollment.
   2) The care manager or other plan staff shall work with each Member's assigned PCP and other healthcare providers, as appropriate, to gather and compile relevant records.
   3) The consolidated medical record shall be made available to the Member or Authorized Representative, care manager, the Member's PCP, other members of

the care team, and other healthcare providers, as appropriate, in a format of their choosing, including electronic or hard copy.

q. ***Section V.D. Care Management, 2. CFSP Care Management, o. Care Management Requirements for Members Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody and Members Who Lose Medicaid Eligibility, ii., 9),*** **is revised to add the following:**

d) In the event the Member has a legal guardian, the CFSP shall provide the Health Passport to the Member and the legal guardian.

r. ***Section V.D. Care Management, 2. CFSP Care Management, u. CFSP Care Management Payments, iii., 5), b),*** **is revised and restated in its entirety as follows:**

b) The Department reserves the right to identify additional services that are duplicative of CFSP Care Management.

s. ***Section V.D. Care Management, 3. Care Coordination and Care Transitions for All Members,*** **is revised to add the following:**

i. The CFSP shall have a housing specialist on staff or on contract who can assist individuals who are experiencing homelessness in securing housing.

t. ***Section V.D. Care Management, 4. Other Care Management Programs, f. Members Obtaining ACT,*** **is revised and restated in its entirety as follows:**

f. Reserved.

u. ***Section V.D. Care Management, 9. Healthy Opportunities, c., iii.,*** **is revised and restated in its entirety as follows:**

iii. Reserved.

v. ***Section V.D. Care Management, 9. Healthy Opportunities, f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs, ii.,*** **is revised and restated in its entirety as follows:**

ii. Through a competitive procurement process, the Department established the Healthy Opportunities Pilot in three (3) areas of the State to provide a subset of high-need, high-risk, and emerging-risk Medicaid Members with information, services and benefits targeted to measurably improve health and lower costs. Pending CMS' approval of the Department's 1115 waiver renewal, Healthy Opportunities Pilot services will be expanded statewide during the 2024-2029 timeframe, with potential modifications to the Healthy Opportunities Pilot Service Fee Schedule and service offerings. The Healthy Opportunities Pilot will employ evidence-based interventions addressing Members' needs in housing, food, transportation, and interpersonal safety/toxic stress. The CFSP shall play a key role in executing the Healthy Opportunities Pilot in accordance with the roles and responsibilities enumerated below.

w. ***Section V.D. Care Management, 9. Healthy Opportunities, f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs, xii., 1), d),*** **is revised and restated in its entirety as follows:**

d) Qualifying Physical/Behavioral Health (BH) and social risk factors supporting Healthy Opportunities Pilot program eligibility;

x. *Section V.D. Care Management, 9. Healthy Opportunities, f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs, xxi. IPV-Related Services,* is revised and restated in its entirety as follows:

xxi. Interpersonal Violence (IPV)-Related Services

1) The CFSP shall adhere to those certain conditions, requirements, and standards regarding IPV-Related Services, data referencing or regarding IPV-Related Services and Members receiving such services, and communications to Members receiving IPV-Related services, collectively as set forth in *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards*.

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

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

y. *Section V.D. Care Management, 9. Healthy Opportunities, f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs, xxii. Healthy Opportunities Pilot Enrollee Communication Requirements,* is revised and restated in its entirety as follows:

xxii. Healthy Opportunities Pilot Enrollee Communication Requirements

1) Healthy Opportunities Pilot Enrollee Contact Requirements. The CFSP shall ensure that:
    a) Its contracted or employed care managers obtain the Healthy Opportunities Pilot Enrollee's contact requirements from each Healthy Opportunities Pilot Enrollee assigned to them, which requirements care managers shall record in NCCARE360 using the greatest degree of specificity possible. At a minimum, care managers shall obtain from, and record for, each Healthy Opportunities Pilot Enrollee assigned to them such Enrollee's:
        i) Preferred dates or days of the week for being contacted, time of day at which to be contacted, and modality of contact (e.g., calls vs. texts, use of voicemail, email, postal mail, etc.);
        ii) Whether any other days of the week, times of day, or modalities for contact must not be used; and
        iii) Whether it is acceptable to leave a message for the Healthy Opportunities Pilot Enrollee using their preferred modality of contact.
    b) Upon request by a Healthy Opportunities Pilot Enrollee, the care manager shall update such Enrollee's contact preferences in NCCARE360 within one (1) Business Day.
    c) Each individual in the CFSP's employed or contracted workforce who, as part of their role or function, is expected to or does conduct direct outreach to Healthy Opportunities Pilot Enrollees, including but not limited to care managers, reviews and adheres to a Healthy Opportunities Pilot Enrollee's recorded contact requirements, as outlined in the Healthy Opportunities Pilot IPV Protocol, prior to each instance of conducting outreach to such Enrollee.
2) Healthy Opportunities Pilot Enrollee Opt-In/Opt-Out Communication Preferences
    a) The CFSP shall ensure that all individuals in CFSP's employed and contracted workforce (including care managers) adhere to Healthy Opportunities Pilot Enrollees' requirements for either opting-in or opting-out of Healthy Opportunities Pilot-specific communications from Healthy Opportunities Pilot entities, as selected by Healthy Opportunities Pilot Enrollees during their initial Healthy Opportunities Pilot assessment with their respective care managers and as amended from time to time thereafter in the Healthy Opportunities Pilot Enrollee's sole discretion.
    b) Notwithstanding *Section V.D.9.f.xxii.1.b. Healthy Opportunities Pilot Enrollee Opt-In/Opt-Out Communications Preferences* above, if a care manager or individual in the CFSP's workforce needs to communicate with a Healthy Opportunities Pilot Enrollee, including but not limited to, regarding a three-month Healthy Opportunities Pilot service mix review and/or a six-month eligibility reassessment, or related to automated notifications from NCCARE360 (e.g., for notice of an accepted referral), such care manager or individual in the CFSP's workforce may send such communications only if adhering to the requirements

set forth in *Section V.D.9.f.xxii. Healthy Opportunities Pilot Enrollee Communication Requirements*.

3) IPV-Related Policies and Enforcement
   a) The CFSP shall develop a Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services Policy (IPV Policy) for review by the Department, and at the Department's request. The IPV Policy shall include all the requirements of the CFSP as defined in the Contract.

z. ***Section V.D. Care Management, 9. Healthy Opportunities f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs,*** **is revised to add the following:**

xxiii. Care Manager Training
1) The CFSP shall ensure that care managers with Healthy Opportunities Pilot responsibilities are designated as IPV-trained individuals and receive and complete relevant trainings annually, as provided or approved in advance by the Department prior to such care manager initiating a Member contact or an initial Healthy Opportunities Pilot assessment, including but not limited to the below topics:
   a) IPV-Related Data Training;
   b) Working with IPV survivors;
   c) Trauma-informed care delivery;
   d) Cultural humility and/or competency training; and
   e) The Healthy Opportunities Pilot consent process, including how to communicate to Members that Members might execute additional consents depending on the services the HSO furnishes to the Member or the services that the Member may be eligible to access or receive.

aa. ***Section V.D. Care Management, 9. Healthy Opportunities f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs,*** **is revised to add the following:**

xxiv. IPV-Related Data Standards
1) The CFSP agrees to conduct routine and ongoing monitoring of IPV-Related Service Data, which monitoring shall include at a minimum:
   a) Internal auditing of the CFSP's adherence to the IPV-Related Data Policies (as referenced in Section f of this Attachment and reporting to the Department on the same, such auditing and reporting each occurring no less than annually or as frequently as otherwise directed by the Department in its sole discretion;
   b) Reporting to the Department within the timeframes specified in Section III.E.5.D. Duty to Report, identifying any incident or breaches of IPV-Related Service Data in the custody of or maintained by the CFSP or its contractors; and
   c) Reporting to the Department within one (1) Business Day upon identification of any material non-compliance with any of the CFSP's IPV-Related Data Policies.
      i) In the event that the CFSP discovers an incident or breach of IPV-Related Service Data, the CFSP shall send written notice to each care manager within one (1) Business Day (as defined in Section c of this Attachment and HSO

whose IPV-Related Service Data was or may have been affected by the incident or breach, informing the care manager and HSO of the nature and extent of the unauthorized access or breach, and providing the care manager and HSO with a list of Members whose data was or may have been affected by the unauthorized access or breach.

ii) The CFSP shall ensure that all of its CFSP workforce members and care managers who have Healthy Opportunities Pilot responsibilities complete required Healthy Opportunities Pilot related training on privacy, security, and access controls related to IPV-Related Service Data and on relevant CFSP policies and procedures relating to usage, storage and sharing of IPV Related Service Data, including but not limited to the CFSP's IPV-Related Data Policies prior to IPV service launch and annually thereafter.

bb. ***Section V.E. Providers, 2. Provider Network Management, c. Provider Contracting, xi.,*** **is revised and restated in its entirety as follows:**

xi. The CFSP shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the Provider payment requirements herein. For Provider payment requirements that refer to Medicaid Direct rates:

1) The CFSP shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change applicable to rate floor programs as prescribed by the Department.
2) The CFSP shall implement applicable rate changes to the rate floor programs within timelines prescribed by the Department. Payments made to Providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable Provider.

cc. ***Section V.E. Providers, 2. Provider Network Management, c. Provider Contracting, xxix. Tobacco-free Policy,*** **is revised and restated in its entirety as follows:**

1) Starting January 1, 2027, the CFSP shall require contracted Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who

receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

2) Provider Monitoring
    a) Starting January 1, 2027, the CFSP shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The CFSP shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The CFSP shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

dd. ***Section V.E. Providers, 2. Provider Network Management, c. Provider Contracting,*** **is revised to add the following:**

xxx. Additional Provider information shall be collected during contracting, including:
1) Populations served by the Provider, including whether a BH Provider is serving children and adolescents;
2) Whether Provider has completed Trauma-Informed Care training; and
3) Treatment modalities that the Provider is certified to provide (e.g., individual therapy, group therapy).

ee. ***Section V. E. Providers, 2. Provider Network Management, h. Credentialing and Re-credentialing Process, v., 2),*** **is revised and restated in its entirety as follows:**

2) After the Provider Credentialing Transition Period, the CFSP shall evaluate a contracted Provider's continued eligibility for contracting by confirming the appearance of the Provider on the daily Provider Enrollment File. The CFSP's process shall occur every five (5) years consistent with Department policy and procedure, unless otherwise notified by the Department.

ff. ***Section V. E. Providers, 2. Provider Network Management, h. Credentialing and Re-credentialing Process, vii.,*** **is revised and restated in its entirety as follows:**

vii. The CFSP shall meet with the Department, or designated Department vendor as requested regarding the Credentialing and Network contracting process.

gg. ***Section V. E. Providers, 2. Provider Network Management, i. Network Provider System Requirements, i., 3),*** **is revised and restated in its entirety as follows:**

3) Change in existing Contract terms within fifteen (15) Business Days of the effective date after the change.

hh. ***Section V.E. Providers, 2. Provider Network Management, j. Network Provider Credentialing and Re-credentialing Policy,*** **is revised and restated in its entirety as follows:**

j. Network Provider Credentialing and Re-credentialing Policy

i. The CFSP shall establish and follow written policies and procedures for Network Provider selection and retention in accordance with 42 C.F.R. § 438.12(a)(2). The CFSP shall apply these criteria consistently to all Providers. The CFSP shall follow the Department's Uniform Credentialing and Re-credentialing Policy.
ii. Reserved.
iii. Reserved.
iv. Reserved.

ii. ***Section V.E. Providers, 2. Provider Network Management, k. Provider Disenrollment and Termination, ii., 4),*** **is revised and restated in its entirety as follows:**

4) The CFSP shall address payment suspension in its Provider Manual.

jj. ***Section V.E. Providers, 2. Provider Network Management, m. Provider Directory, vi.,*** **is revised and restated in its entirety as follows:**

vi. All consumer-facing Provider directories must comply with 42 C.F.R. § 438.10(h)(1) and shall include the following information, at a minimum:
1) Department provided data elements from the Department:
a) Provider name;
b) Provider demographics (first, middle, and last name, gender);
c) Reserved.
d) Provider DBA Name;
e) Provider Service Location Name;
f) Provider mailing address;
g) Provider type (PCP, etc.);
h) Provider type effective date;
i) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
j) Street address(as) of service location(s);
k) Count(ies) of service location(s);
l) Telephone number(s) at each location;
m) After hours telephone number(s) at each location;
n) Website URL as applicable;
o) Provider specialty (Taxonomy Codes) by location;
p) Whether Provider is accepting new beneficiaries;
q) Provider's cultural and linguistic capabilities, i.e., languages (including American Sign Language) offered by Provider or a skilled medical interpreter at Provider's office;
r) Whether provider has completed cultural competency training, including description of training;
s) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
t) A telephone number at the CFSP where a Member can call to confirm the information in the directory;

u) Reserved.
v) Essential provider indicator;
w) IHCP indicator;
x) Reserved; and
y) Whether the provider offers telehealth services.

2) Reserved.

kk. ***Section V.E. Providers, 2. Provider Network Management, m. Provider Directory, vii.,*** **is revised and restated in its entirety as follows:**

vii. In no case shall a Provider be loaded into the Provider directory which cannot receive payment on the CFSP's current payment cycle. This provision does not apply to Providers suspended by the Department.

ll. ***Section V.E. Providers, 2. Provider Network Management, m. Provider Directory, viii.,*** **is revised and restated in its entirety as follows:**

viii. Reserved.

mm. ***Section V.E. Providers, 4. Provider Payments, g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs),*** **is revised and restated in its entirety as follows:**

g. Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments
   i. The CFSP shall reimburse FQHCs and RHCs for covered services at no less than the following rates:
      1) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
      2) All core services shall be based on each FQHC or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.
   ii. Reserved.
   iii. CMS has approved State Plan Amendments (SPAs) which amend the reimbursement structure to FQHCs and RHCs respectively.
   iv. The following shall occur within a timeline to be specified by the Department:
      1) The CFSP shall reimburse in network FQHCs and RHCs for Core Services visits (T1015) and Well Child visits at the respective North Carolina Medicaid Fee Schedule for FQHC and RHC Base Rates ("base reimbursement amount."). All ancillary services (i.e. radiology, etc.) shall be the based on the North Carolina Medicaid Physician Fee Schedule and shall follow established rules as described in the "Managed Care Billing Guidance to Health Plans";
      2) The CFSP shall issue FQHCs and RHCs a supplemental wraparound payment for covered Core Service visits (T1015) and Well Child Visits, which is equal to the difference between the provider specific Prospective Payment System (PPS)/Alternative Payment Methodology (APM) Rate from the North Carolina Medicaid PPS/APM Fee Schedule and the base reimbursement amount; and

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

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

v. Reserved.

oo. ***Section V.E. Providers, 4. Provider Payments, l. Additional Directed Payments for Certain Providers (as allowed under 42.C.F.R. § 438.6(c)(1)(iii)(B)), viii.,*** **is revised and restated in its entirety as follows:**

viii. Interest and Penalties

1) The CFSP shall pay interest to the Provider on the portion of the directed payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid or was underpaid as specified in the Contract.
2) Reserved.
3) All references to a penalty related to late directed payments to Providers are hereby stricken as of July 1, 2024.

pp. ***Section V.E. Providers, 4. Provider Payments, p. Payments of Medical Home Fees to AMH, ii.,*** **is revised and restated in its entirety as follows:**

ii. The CFSP shall pay Medical Home Fees to AMH practices for any month in which the CFSP Member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH practices shall be no less than $5 PMPM.

qq. ***Section V.E. Providers, 4. Provider Payments, y. HCBS Direct Care Worker Wage, ii.,*** **is revised and restated in its entirety as follows:**

ii. The Department shall maintain and share with the CFSP a list of HCBS services and codes that the rate increase will apply to through the PCDU and the Service Now fee schedule portal.

rr. ***Section V.E. Providers, 4. Provider Payments, bb. Healthy Opportunities Pilot Payments, iii., 1), f),*** **is revised and restated in its entirety as follows:**

f) At a minimum, include the following information on the Remittance Advice (RA) to the HSOs:

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

ss. ***Section V.E. Providers, 4. Provider Payments, dd.,*** **is revised and restated in its entirety as follows:**

dd. The CFSP shall develop and maintain a Reimbursement Policy consistent with NCGS § 58-3-227(a)(5). The CFSP shall provide the Policy to the Department upon request, for review. The CFSP shall monitor the Department website and other Department communication mechanisms daily for changes to the Medicaid FFS rates to ensure compliance with the Provider payment requirements herein. For Provider payment requirements that refer to Medicaid FFS rates:
i. The CFSP shall make retroactive payment adjustments to the effective date of the Medicaid FFS rate change applicable to rate floor programs as prescribed by the Department; and
ii. The CFSP shall implement applicable rate changes to the rate floor programs within timelines prescribed by the Department. Payments made to Providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable Provider.

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

ff. For dates of service on or after December 1, 2025, the CFSP shall reimburse in-network providers of substance use disorder (SUD) services at no less than one hundred percent (100%) of the Enhanced Mental Health Medicaid Fee-for-Service Fee Schedule rate, as set by the Department, unless the CFSP and provider have mutually agreed to an alternative reimbursement arrangement established on or after December 1, 2025. For any claims that the CFSP is required to reprocess to comply with this Section, the CFSP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of V.E.4.l.viii.

uu. ***Section V.G. Engagement with Federally Recognized Tribes, 2. Engagement with Community and County Organizations, d.,*** **is revised and restated in its entirety as follows:**

d. The CFSP shall develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with county and community organizations and builds partnerships at the local level to improve the health of its Members.

vv. ***Section V.G. Engagement with Federally Recognized Tribes, 2. Engagement with Community and County Organizations, e.,*** **is revised and restated in its entirety as follows:**

e. The Local Community Collaboration and Engagement Strategy shall address how the CFSP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, Member engagement, and local continuums of care.
   i. The Strategy shall include:
      1) Approach to understand the unique needs of the communities the CFSP is serving;
      2) Methods of collaborative outreach with county agencies, CBOs, and community partners;
      3) Measures of successful engagement and collaboration across county lines;
      4) Reporting of outcomes to county agencies, CBOs, and other community partners; and
      5) Information on how the CFSP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.
   ii. The Local Community Collaboration and Engagement Strategy shall be submitted to the Department for review and approval no later than ninety (90) Calendar Days after Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.

ww. Section V.H. Program Operations, 1. Service Lines, t. Behavioral Health Crisis Line, iv., is revised and restated in its entirety as follows:

iv. The CFSP Behavioral Health Crisis Line must have warm transfer capabilities to crisis emergency services lines, including (but not necessarily limited to) 911, 988, and mobile crisis teams. In instances where there is immediate danger to self or others, the CFSP Plan shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
   1) The CFSP Behavioral Health Crisis Line must have warm transfer capabilities to the NC peer warm line (1- 855-PEERS NC).

xx. *Section V.H. Program Operations, 2. Staff Training, h., xxx., 2),* is revised and restated in its entirety as follows:

2) That call center supervisors attend refresher training hosted by the Department at least annually.

yy. *Section V.H. Program Operations, 2. Staff Training, m.,* is revised and restated in its entirety as follows:

m. The CFSP shall be responsible for ensuring training directed towards key personnel as identified in Section V.A.9.: Table 1. CFSP Key Personnel Requirements include but are not limited to:
   i. Overall understanding of:

1) The unique and complex needs of Members served by the CFSP, including the impact of trauma and ACEs; and
2) Overall understanding of the critical importance of closely coordinating with County DSS to support permanency planning for Members served by the CFSP.

zz. *Section V. I. Claims and Encounter Management, 1. Claims, c. Claims and Processing Standards, i.,* is revised and restated in its entirety as follows:

i. The CFSP shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when Department decisions warrant reprocessing (i.e. Member retrospective eligibility determinations or plan enrollment changes). The CFSP, and any Subcontractors who process claims on behalf of the CFSP, shall have the capability to accept and process claims through an industry-standard Health Care Clearinghouse in standard HIPAA transaction formats (ASC X12, NCPDP, 837P and 837I).

aaa. *Section V. I. Claims and Encounter Management, 1. Claims, c. Claims and Processing Standards, iv., 2)* is revised and restated in its entirety as follow:

2) The CFSP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes. The CFSP, and any Subcontractors who process claims on behalf of the CFSP, shall implement Health Care Clearinghouse integration.

bbb. *Section V.I. Claims and Encounter Management, 1. Claims, d., i., 1), a),* is revised and restated in its entirety as follows:

a) The CSFP shall, within eighteen (18) Calendar Days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim. The CFSP shall have the capability to receive additional information request via ASC X12, 275 Request for Additional Information EDI transaction, electronic means (including through a portal or email), and by mail. The CFSP shall pay or deny a clean Medical Claim within thirty (30) Calendar Days of receipt of the claim.

ccc. *Section V.I. Claims and Encounter Management, 1. Claims, d., iv., 2),* is revised and restated in its entirety as follows:

2) Reserved.

ddd. *Section V.J. Financial Requirements, 1. Capitation Payments, g.,* is revised and restated in its entirety as follows:

g. The Department will reimburse CFSP for additional directed payments to providers as required under Section V.E.4. Provider Payments (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). CFSP is required to make these payments to certain providers, but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments.

eee. ***Section V.L. Technical Specifications, 2. Electronic Data Submissions, v.,*** **is revised and restated in its entirety as follows:**

v. TECHOPS Partner Expectations

1) NCMT Technology Operations is designed to support State business owners, State technology owners, and technology operations partners through proactive interface monitoring, incident, problem and change management, along with release and maintenance calendar management, specific to Medicaid Transformation. This team also supports a 24x7 P1 incident support line. Technology Operations Partners will continue to capture issues using their existing call centers, helpdesks, and operational teams, funnel Medicaid Transformation Managed Care Program impacting issues to NCMT Technology Operations team daily as follows:
   a) Provide Integration Monitoring status data.
   b) Report new and updates to incidents, problems and changes to the Tech Ops Team in ServiceNow in accordance to Section V.L. Table 1.
   c) Participate in NCMT Daily Technology Operations Meeting.
   d) Provide Root Cause Analysis for problems.
   e) Provide estimates and targeted production dates to resolve problems.
   f) Resolve production incidents and problems (as needed per assignment and schedule).
   g) Provide target release scope to Tech Ops team forty-five (45) Calendar Days ahead of release.
   h) Inform NCMT Release Management at NCMT.ReleaseMgmt@dhhs.nc.gov of scheduled and ad hoc production releases and system maintenance activities that either will or may impact the NC Managed Care Program. This includes impacts to regular file delivery and processing, report delivery, and production application and system availability.
   i) For release or maintenance activity that impacts NC Managed Care Program, partners should send an email to the Release Management NCMT.ReleaseMgmt@dhhs.nc.gov. If reporting release or maintenance activity is less than one (1) business day in advance, partners should call the Technology Operations Support Line at (919) 283-2787.
   j) Confirm release contents are tested and ready for release.
   k) Deploy the release to production only after NCMT leadership approval.
   l) Confirm release outcome.
   m) Provide on-call 24x7 support to report, respond to, and resolve P1 cross-partner incidents.

2) Below is *Section V.L. Table 1: Production Incident & Problem Resolution Turnaround* times based on criteria:

 ncident & Problem Resolution Turnaround

Priority	Report Time	Tech Ops Response Time	State Business and Tech Owner Response Time	BTRM Response Time	Suggested CFSP Operations Response Time	Suggested CFSP Operations Incident Resolution Time	Suggested CFSP Operations Problem Resolution Time
1- Critical	Within one (1) hour	On call resource should answer phone immediately, if call is missed, call to be returned within thirty (30) minutes from time of report. Ticket will be logged within thirty (30) minutes of end of P1 incident call.	Thirty (30) minutes from time of Tech Ops Escalation via phone call & text.	N/A	Thirty (30) minutes from time of Tech Ops Escalation via phone call & text.	Twelve (12) hours, updates every two (2) hours or at next agreed upon interval Note: Environment down/availability will require 24/7 response and resolution	Twelve (12) hours to fix or to provide State accepted work around, updates every two (2) hours or at next agreed upon interval until service restoration. Note: Environment down/availability will require 24/7 response and resolution.
2- High	Log within four (4) business hours or by 7 AM from previous day through daily incident reporting.	Escalate to appropriate stakeholder group by 9 AM daily after incident is reported. Complete follow-up within four (4) hours of assignment.	Confirm impact, urgency and priority within twenty-four (24) hours of assignment. Complete any follow-up outside of priority confirmation within four (4) business hours of assignment.	Complete follow-up within four (4) business hours of assignment.	Follow-up within four (4) business hours of assignment.	Forty-eight (48) Hours from time of report.	Should be slated to a release within one (1) week of problem creation, fixed in two (2) weeks from problem creation.
3- Medium	Log within four (4) business hours or by 7 AM from previous day through daily incident reporting.	Escalate to appropriate stakeholder group by 9 AM daily after incident is reported. Complete follow-up within three (3) Business Days of assignment.	Confirm impact, urgency and priority within twenty-four (24) hours of assignment. Complete any follow-up outside of priority confirmation within three (3) Business Days of assignment.	Complete follow-up within three (3) Business Days of assignment.	Follow-up within three (3) Business Days of assignment.	Four (4) Business Days from time of report.	Should be slated to a release within two (2) weeks of problem creation, fixed in four (4) weeks from problem creation.

Section V.L. Table 1: Production Incident & Problem Resolution Turnaround							
Priority	**Report Time**	**Tech Ops Response Time**	**State Business and Tech Owner Response Time**	**BTRM Response Time**	**Suggested CFSP Operations Response Time**	**Suggested CFSP Operations Incident Resolution Time**	**Suggested CFSP Operations Problem Resolution Time**
4- Low	Log within four (4) business hours or by 7 AM from previous day through daily incident reporting.	Escalate to appropriate stakeholder group by 9 AM daily after incident is reported. Complete follow-up within four (4) days of assignment.	Confirm impact, urgency and priority within twenty-four (24) hours of assignment. Complete any follow-up outside of priority confirmation within four (4) Business Days of assignment.	Complete follow-up within four (4) Business Days of assignment.	Follow-up within four (4) business days of assignment.	Ten (10) Business Days from time of report.	None. Fix to be deployed based on priority during CFSP's regularly scheduled maintenance period.

fff. ***Section V.L. Technical Specifications, 6. Provider Identification Numbers (NPIs, APIs), a. Provider Directory, i.,*** **is revised and restated in its entirety as follows:**

i. The CFSP shall develop a Provider Directory in accordance with Section V.E.1 Provider Network. The Department's designated vendor is responsible for integrating the Provider Directory information to supply with a Consolidated Provider Directory to support CFSP Choice Counseling and selection. During the Provider Credentialing Transition Period, the information will be provided on a daily basis, in a format and transmission protocol to be defined by the Department.

ggg. ***Section V.L. Technical Specifications, 7. Technology Documents*** **is revised and restated in its entirety as follows:**

7. Technology Documents

a. The CFSP shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Award. The Department may request additional information or documents be made available or developed if the documentation is not satisfactory.

b. Security Documentation: The CFSP must comply with all State and DHHS security policy as outlined in the State and DHHS Security manuals. These manuals are available here: https://it.nc.gov/documents/statewide-information-security-manual and https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security.

In compliance with this policy, the DHHS Privacy and Security Office and the Department of Information Technology require, at a minimum, three (3) documents to be submitted by the CFSP. Two of the three documents detailed below must be submitted using the State's templates.

i. Vendor Readiness Assessment Report (VRAR) - The CFSP shall provide the Vendor Readiness Assessment Report to the Department for review and approval at least sixty (60) Calendar Days after Contract Award OR sixty (60) Calendar Days before any production data are required to be used in any lower environments. This report will be required for resubmission yearly and must be done before or on the anniversary date of the go-live of the project. The Department may request additional information or documents to be made available or developed if the documentation is not satisfactory. The template for the VRAR can be accessed here: https://it.nc.gov/documents/vendor-readiness-assessment-report.

ii. System Security Plan (SSP): The CFSP shall provide the System Security Plan (SSP) to the Department for review and approval at least sixty (60) Calendar Days after Contract Award or sixty (60) Calendar Days before any production data are required to be used in any lower environments. This report will be required for resubmission yearly and must be done before or on the anniversary date of the go-live of the project. The Department may request additional information or documents to be made available or developed if the documentation is not satisfactory. The full template will be provided by the Contracts office and shared with the vendor once the contract has been awarded. This will be provided as part of the outbound deliverables. The System Security Plan (SSP) must be updated and submitted annually. The SSP must include at a minimum:
    1) Approach to customer and Member data protection including internal programs and policies;
    2) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
    3) Approach to complying with HITECH and HIPAA;
    4) Approach to risk analysis and assessment associate with NIST;
    5) Processes for monitoring for security vulnerabilities including the use of external organization such as US CERT;
    6) Processes and plans for vulnerability and breach management including response processes; and
    7) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).

iii. SOC 2 Type 2 Report – The CFSP shall provide the Soc 2 Type II to the Department for review and approval at least sixty (60) Calendar Days after Contract Award OR if the system has been in production for a minimum of one hundred eighty (180) Calendars Days of production activity. This report will be required for yearly resubmission and must be done before or on the anniversary date of the go-live of the project. The Department may request additional information or documents be made available or developed if the documentation is not satisfactory.

1) If the system is new and does not have 180 days of production activity then the Contractor must submit a Self-Assessment, External Penetration Test and Engagement Letter but must be performed on the technology platform and submitted in lieu of the SOC II Type 2, HITRUST, ISO 27001, FedRAMP, etc. This can only be done for the first year.
    a) The Self-Assessment, External Penetration Test and Engagement letter must be done sixty (60) Calendar Days before the go-live of the project. The templates provided by the DHHS Privacy and Security Office must be used for these (two) reports.

iv. NIST 800-53 Self-Assessment – The NIST 800-53 Self-Assessment (Security Audit Report) must be provided to the Department for review and approval at least sixty (60) Calendar Days after Contract Award or sixty (60) Calendar Days before any production data are required to be used in any lower environment.
    1) This report must include either an Electronic Data Processing (EDP) systems audit using SSAE - 18 at a minimum level service organization control (SOC) 2 Type II or current NIST 800-53 assessment at a "moderate" system risk control level.
    2) The Security Audit Report can only be submitted once per Contract, on the 2nd year of the Contract, the Soc 02 Type II report must be provided.

v. External Penetration Test – For the External Pentation Test Report (EPT), the Contractor shall provide an independent third party to perform penetration testing and submit the results to the Department for review and approval at least sixty (60) Calendar Days after Contract Award or sixty (60) Calendar Days before any production data are required to be used in any lower environment.
    1) Penetration testing must be performed by an independent third party when additions or changes to functionality impact the security framework, architecture or when a new vulnerability exists. Penetration Test Report results shall be supplied to the Department and any major or critical vulnerabilities mitigated.
    2) The External Pentation Test Report (EPT) should only be submitted once per contract, unless these additions, changes were made then resubmission must be done at least sixty (60) Calendar Days prior to go-live of the project.

c. Encounter Implementation Approach. The CFSP shall provide a plan that shows how the CFSP will implement their encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
    i. Approach to meeting performance, accuracy, and timeliness requirements;
    ii. Operating model including staffing and technology to process and submit encounters;
    iii. Reference data management process including how NC DHHS's reference data (if applicable) will be integrated into the encounter management process;
    iv. Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
    v. QA and Process improvement processes including how errors detected by NC DHHS's Encounter Processing System are addressed by the CFSP, as well as how continuous improvement is integrated into the overall process. This section should also include

how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Offeror's processes; and

vi. The plan should include distinctions for medical and Pharmacy Encounter management.

d. System Interface Design. The CFSP shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:

i. Detailed design by interface showing the Offeror's approach to meeting the requirements defined by the State;
ii. Approach to managing EDI transactions including technology;
iii. Technical integration architecture including the Offerors technical approach to integrating multiple internal systems with external partners;
iv. Operating model around interface and batch management including staffing and technical architecture. This section should include the processes for managing failures in transmissions; and
v. Software and platform testing processes for new interfaces including the data management approach.

hhh. *Section V.L. Technical Specifications, 8. Testing, d.,* is revised and restated in its entirety as follows:

d. The CFSP will participate in all End-to-End testing with other Department partners as directed by the Department. This will include End to End testing prior to launch and may include periodic End to End testing as other technical processes and systems are modified or brought online. The Department, if deemed necessary for project execution, shall develop and provide an End-to-End test plan aligned with specific requirements to CFSP and all systems part of End-to-End testing. End to End testing schedule shall include:

i. High level description of the scope;
ii. High level overall End-to-End duration;
iii. Applications or Systems that are part of the testing; and
iv. Integrations that are part of the testing.

4. **Modifications to Section VII. Attachments:** Specific Contract Attachments are modified as follows:

a. *First Revised and Restated Attachment A: CFSP Organization Roles and Positions* is revised and restated in its entirety and renamed *Section VII. Second Revised and Restated Attachment A: CFSP Organization Roles and Positions* and attached to this Amendment.

b. *First Revised and Restated Attachment C: Anticipated Contract Implementation Schedule* is revised and restated in its entirety and renamed *Second Revised and Restated Attachment C: Anticipated Contract Implementation Schedule* and attached to this Amendment.

c. *First Revised and Restated Attachment F: Required Standard Provisions for CFSP and Provider Contracts* is revised and restated in its entirety and renamed *Second Revised and Restated*

Attachment F: Required Standard Provisions for CFSP and Provider Contracts and attached to this Amendment.

d. *First Revised and Restated Attachment L. Policies* is revised and restated in its entirety and renamed *Second Revised and Restated Attachment L. Policies* and attached to this Amendment.

5. Effective Date: This Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, subject to approval by CMS.

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

IN WITNESS WHEREOF, the Parties have executed this Amendment in their official capacities as of the Effective Date.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

DocuSigned by:
Angela Boykin
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Date: 06/25/25 | 10:19 AM PDT

Angela Boykin, Chief Executive Officer (CEO)

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

DocuSigned by:
Jay Ludlam
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Date: 06/24/25 | 6:32 PM EDT

Jay Ludlam, Deputy Secretary
NC Medicaid

Second Revised and Restated Attachment A: CFSP Organization Roles and Positions

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

Section VII. Second Revised and Restated Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Care Management Supervisor	These individuals are responsible for overseeing assigned care managers and ensuring fidelity to the CFSP Care Management model. These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs. These individuals are responsible for ensuring care managers provide Trauma-Informed Care and recognize the impact of ACEs on the CFSP population. These individuals must oversee coordination with a multidisciplinary care team collaborating with primary health care professionals, Behavioral Health care professionals, specialty providers and stakeholders unique to the children, youth and families served by the child welfare system (e.g., Parents with children in Foster Care) and Care Coordination across the child welfare system (e.g., awareness of juvenile justice system).	• Must reside in North Carolina. • Must be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN. • Must have three (3) years of experience providing care management, case management, or care coordination to individuals served by the child welfare system (either in North Carolina or another state). • Supervising care managers overseeing care managers that are conducting in-reach and transition shall also meet the following requirements: o Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
2. Care Managers	These individuals shall be responsible for providing integrated whole-person Care Management under the CFSP Care Management model, including coordinating across physical health, BH, I/DD, LTSS, pharmacy and Unmet Health-Related Resource Needs. These individuals shall be responsible for providing Trauma-Informed Care, recognizing the role of ACEs in the CFSP population and coordinating cross-agency care to meet children's physical, behavioral, social, educational, and legal needs. These individuals shall be responsible for coordinating closely with each Member's	• Must reside in North Carolina. • Must hold a bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as an RN. • Two (2) years of experience working directly with individuals served by the child welfare system is preferred.

Section VII. Second Revised and Restated Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	assigned County Child Welfare Worker and ensuring alignment between the Member's health care needs and permanency planning goals. These individuals shall coordinate with a multidisciplinary care team collaborating with primary health care professionals, Behavioral Health care professionals, specialty providers and stakeholders unique to the children, youth and families served by the child welfare system (e.g., Parents of children in Foster Care) and Care Coordination across the child welfare system (e.g., awareness of juvenile justice system).	
3. Certified Family Peer Specialist	Responsibilities include, but are not limited to, serving as a care manager extender in accordance with *Section V.D.2.s.v. Care Manager Qualifications.*	• Must reside in North Carolina. • Must have National Certification for Family Peer Specialists.
4. System of Care Outreach Coordinators	These individuals support the System of Care Manager with comprehensive planning, implementation, coordination, and training related to the CFSP's core System of Care functions at the local level.	• Must reside in North Carolina. • Must hold bachelor's degree in a human services field. • Must have minimum of two (2) years of professional experience working in and across multiple child-serving systems (e.g., education, child welfare, Behavioral Health, juvenile justice or early childhood systems).
5. System of Care Manager	This individual is responsible for comprehensive planning, implementation, coordination, and training related to the CFSP's core System of Care functions.	• Must reside in North Carolina. • Must hold a master's degree in a human services field. • Must have a minimum of five (5) years of professional experience working in and across child public service systems (e.g., education, child welfare, Behavioral Health, juvenile justice or early childhood systems).
6. Member Appeal Coordinator	This individual manages and adjudicates Member Appeals in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.

Section VII. Second Revised and Restated Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
7. Member Complaint and Grievance Coordinator	This individual manages and adjudicates Member complaints and Grievances in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.
8. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members. All call center employees must receive training related to the CFSP, and the roles and responsibilities of the CFSP and County DSS, and how these agencies will coordinate and collaborate, and ACEs of children, youth, and families served by the child welfare system.	• Must reside in North Carolina.
9. Provider Relations and Service Line Staff	These individuals coordinate communications between the CFSP and providers.	• Must reside in North Carolina.
10. Provider Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates provider. complaints, Grievances and Appeals in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.
11. Pharmacy Director for the Pharmacy Service Line	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract.	• Must reside in North Carolina. • Must be a North Carolina registered pharmacist with a current NC pharmacist license. • Minimum of three (3) years of pharmacy benefits call center experience. • Demonstrated experience in Medication Reconciliation and management for high-risk children, including those who served by the child welfare system.
12. Full-Time Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing. • Pharmacists must be registered, with current NC Pharmacist license.
13. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must reside in North Carolina.
14. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must reside in North Carolina.

Section VII. Second Revised and Restated Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
15. Regional Liaisons to County DSS	These individuals serve as the primary contact for with County DSS, including County Directors of Social Services and County Child Welfare Workers, to triage and escalate issues where County Child Welfare Workers are seeking to coordinate with CFSP care managers and Member specific and/or CFSP-related questions. The CFSP shall establish a minimum of (1) Regional Liaison to County DSS for each DSS Region.[1]	• Must reside in North Carolina. • Must have experience working with North Carolina County DSS staff and knowledge of North Carolina's child welfare system.
16. I/DD and TBI Clinical Director	This individual oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid services to Members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and BH benefits. This individual reports to the CMO.	• Must be licensed in North Carolina. • Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI. • Minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in I/DD care.
17. Full-Time Care Management Housing Specialist(s)	This individual(s) will assist Members who are experiencing homelessness in securing housing.	• Must reside in NC

[1] DSS Regions: https://www.ncdhhs.gov/cws772022a1/download?attachment

Second Revised and Restated Attachment C: Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of CFSP services beginning on December 1, 2025[2]. The Department may make adjustments after Contract Award.

Second Revised and Restated Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
1.	Contract Award	The date the Department will award the CFSP Contract for CFSP	August 15, 2024
2.	Commencement of CFSP Implementation Planning	The date the CFSP Implementation Team must be ready to commence Implementation Planning activities	August 15, 2024
3.	Identification of additional resources for Implementation Team	The date the CFSP must identify any additional resources needed to support the implementation activities	Contract Award + thirty (30) days
4.	Submission of CFSP Operating Plan	The date the CFSP's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
5.	Submission of key technology deliverables	The date the CFSP submits to the Department: • System Security Plan • Encounter Implementation Approach • System Interface Design • SOC 2 Type 2 Report • Vendor Readiness Assessment (VRAR)	Contract Award + thirty (30) days
6.	Submission of Business Continuity Plan	The date the CFSP's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
7.	Submission of key provider materials	The date the CFSP submits to the Department: • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual	Contract Award + thirty (30) days
8.	Value-Added Services	The date the CFSP submits to the Department submit to the Department for approval, in the Department developed standardized template,	Contract Award + thirty (30) days

[2] As defined in SL XYZ, CFSP will launch on December 1, 2024. Upon Contract award and based on the Offeror's responses, the Department will work with NCGA to establish an appropriate launch date.

Second Revised and Restated Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
		required information as described in *Section V.C.1.h.Value-Added Services.*	
9.	ILOS Service Request Form	The date the CFSP submits to the Department the standardized ILOS Service Request Form for approval	Contract Award + thirty (30) days
10.	Draft Implementation Plan	The date the CFSP's Implementation Plan Draft must be submitted to the Department	Contract Award + forty-five (45) days
11.	Submission of Member education efforts	The date the CFSP submits its planned Member education efforts to the Department	Contract Award + sixty (60) days
12.	Acquisition of service line phone numbers	The date the CFSP must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days
13.	Submission of key Member materials	The date the CFSP submits to the Department: • Enrollment and Disenrollment Policy • Member ID Card • Welcome Packet • Mailing Policy • Rights and Responsibilities Policy	Contract Award + sixty (60) days
14.	Submission of Tobacco Cessation Plan	The date the CFSP must submit a Tobacco Cessation Plan to the Department	Contract Award + ninety (90) days
15.	Submission of Fraud Prevention Plan	The date the CFSP must submit a Fraud Prevention Plan to the Department for review and approval	Contract Award + ninety (90) days
16.	Establishment of CFSP Office and Call Center(s) in NC	The date the CFSP must begin implementing call center(s) and staff in North Carolina	Contract Award + ninety (90) days
17.	Submission of Locum Tenens Policy	The date the CFSP submits to the Department the Locum Tenens Policy	Contract Award + ninety (90) days
18.	Tribal Engagement Strategy	The date the CFSP's Tribal Engagement Strategy must be submitted to the Department for review	Contract Award + ninety (90) days
19.	Pharmacy Provider Network Audit Program	The date the CFSP's Pharmacy Provider Network Audit Program must be submitted to the Department	Contract Award + ninety (90) days
20.	Mail Order Program Policy	The date the CFSP's Mail Order Program Policy, including a sample of all Member mail order-related	Contract Award + ninety (90) days

Second Revised and Restated Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
		correspondence, must be submitted to the Department	
21.	Critical Incident Response Policy	The date the CFSP submits to the Critical Incident Response Policy	Contract Award + ninety (90) days
22.	Good Faith Provider Contracting Policy	The date the CFSP shall develop and submit Good Faith Provider Contracting Policy that includes a description of how the CFSP will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions	Contract Award + ninety (90) days
23.	Submission of Third Party Liability Policy	The date the CFSP submits to the Department the Third Party Liability Policy	Contract Award + ninety (90) days
24.	Whistleblower Policy	The date the CFSP shall develop and submit a Whistleblower Policy related to whistleblower protections	Contract Award + ninety (90) days
25.	Opioid Misuse Prevention and Treatment Program Policy	The date the CFSP shall develop and submit an Opioid Misuse Prevention Program Policy	Contract Award + ninety (90) days
26.	Submission of Training Program	The date the CFSP's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
27.	Submission of Transition of Care Policy	The date the CFSP shall submit the Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
28.	Provider Transition of Care Policy	The date the CFSP shall submit the Provider Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
29.	EPSDT Policy	The date the CFSP submits to the Department the EPSDT Policy	Contract Award + ninety (90) days
30.	NEMT Policy	The date the CFSP submits to the Department the NEMT Policy	Contract Award + ninety (90) days
31.	Submission of Local Community Collaboration and Engagement Strategy	The date the CFSP must submit the Local Community Collaboration and Engagement Strategy to the Department for review and approval	Contract Award + ninety (90) days
32.	Provider Hardship Payment Policy	The date the CFSP shall submit the Provider Hardship Payment Policy to the Department for review and approval	Contract Award + ninety (90) days

Second Revised and Restated Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
33.	Conflict of Interest Policy	The date the CFSP shall submit the Conflict of Interest Policy to the Department	Contract Award + ninety (90) days
34.	Prevention and Population Health Management Plan	The date the CFSP shall submit the Prevention and Population Health Management Plan for review and approval	Contract Award + ninety (90) days
35.	Member Engagement and Marketing Plan for Historically Marginalized Populations	The date the CFSP shall submit Member Engagement and Marketing Plan for Historically Marginalized Populations goals and strategies for engaging with Historically Marginalized Populations, specific initiatives to address disparities, and expected outcomes of the plan.	Contract Award + one hundred twenty (120) days
36.	Key Personnel	The date the CFSP must fill all Key Personnel positions listed in *Section V.A.9. Table 1: CFSP Key Personnel Requirements*	May 9, 2025
37.	Member Grievance Policy	The date the CFSP must submit the Member Grievance Policy.	Contract Award + one hundred twenty (120) days
38.	Provider Grievances and Appeals Policies	The date the CFSP shall submit the CFSP Provider Grievances and Appeals Policies	Contract Award + one hundred twenty (120) days
39.	Submission of key clinical and Care Management materials	The date the CFSP must submit to the Department • Care Management Policies • UM Program Policies, including Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy • System of Care Policy • In-Reach and Transition Policy	Contract Award + one hundred twenty (120) days
40.	AMH Performance Incentive Payments Methodology	The date the CFSP must submit its AMH Performance Incentive Payments Methodology for review and approval	Contract Award + one hundred twenty (120) days
41.	Submission of VBP Assessment and VBP Strategy for Medicaid	The date the CFSP's first retrospective VBP Assessment and prospective VBP Strategy must be submitted to the Department	Contract Award + six (6) months
42.	Draft CFSP Marketing Materials	The date the CFSP's Marketing Materials must be submitted to the Department	Eight (8) weeks before use of CFSP Marketing Materials

Second Revised and Restated Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
43.	Commencement of Marketing Activities	The date the CFSP is allowed to begin Marketing activities	Eight (8) weeks before Auto-Enrollment
44.	PHP license	Deadline for CFSP to obtain a PHP license issued by the NCDOI, if applicable under Section V.A.2.b.ii	One hundred eighty (180) days before CFSP launch
45.	Contracting with AMHs/PCPs	The date the Contracts must be finalized with providers to allow for PCP assignment	Ninety (90) days before CFSP launch
46.	Compliance Program report	The date the CFSP shall submit a Compliance Program report describing the workplans for the upcoming year.	Ninety (90) days before CFSP launch
47.	PCP Auto Assignment	The date that PCP auto assignment must be completed for Members enrolling in the CFSP at launch	Sixty (60) days before CFSP launch
48.	CFSP Care Management Member Enrollment Packets	The date the CFSP will send Members the CFSP Care Management Enrollment packet, with information on their Care Management assignment and options for changing their assignment	Thirty (30) days before CFSP launch
49.	CFSP Launch	The date the CFSP must begin delivering health care services to Members	December 1, 2024
50.	Funding of Risk Reserves	The CFSP must meet the capital requirements as outlined in *Section V.J.3.f. Financial Viability*	December 1, 2024
51.	System Test Plan	The date the CFSP shall submit the System Test Plan to the Department	Contract Award + ninety (90) days
52.	Marketing Plan	The date the CFSP shall submit its marketing plan to the Department for review and approval	Contract Award + sixty (60) days

Second Revised and Restated Attachment F: Required Standard Provisions for CFSP and Provider Contracts

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

1. Contracts between the CFSP and providers, must, at a minimum, include provisions addressing the following:
    a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the CFSP utilizes the definition as found in *Section III.A. Definitions* of the CFSP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the CFSP Contract with the State.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. The CFSP shall specifically include a provision permitting the CFSP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the CFSP or the Division.
    e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the CFSP's insolvency the contract must address:
            1) Transition of administrative duties and records; and
            2) Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the CFSP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the CFSP's Network participation requirements as outlined in the CFSP's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the CFSP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain Enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before Contract renewal and in accordance with the following:
            1) During the provider Credentialing transition period, no less frequently than every five (5) years.
            2) During provider Credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

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

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

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

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

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

   i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid Beneficiaries;

   ii. Make services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when Medically Necessary;

   iii. Prior to discharging a Member, make an effort connect the Member to an accepting provider who is best suited to meet their needs. Providers shall notify the CFSP of the Member's discharge within 24 hours of the discharge; and

   iv. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is capacity available. A provider's competency to meet individual referral needs will be negotiated between the CFSP and the provider.

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

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

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

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

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

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

m. Provider Network: The CFSP shall require network providers of services provided under Outpatient Commitment to a Member to notify the CFSP of the Outpatient Commitment order upon receipt.

n. Provider Network: The Contract must include a provider network provision that ensures that lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) Members who obtain covered services are not subject to treatment or bias that does not affirm their identity/orientation.

o. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the CFSP's web-based billing process.

p. Data to the Provider: The contract must address the CFSP's obligations to provide data and information to the provider, such as:

   i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
   ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
   iii. Notification of changes in these requirements shall also be provided by the CFSP, allowing providers time to comply with such changes.

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

r. Quality Management: The Contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.

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

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

u. Assignment: Provisions on assignment of the contract must include that:

   i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the CFSP.
   ii. The CFSP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

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

w. Interpreting and Translation Services: The Contract must have provisions that indicate:

   i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.

   ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

   iii. The provider shall report to the CFSP, in a format and frequency to be determined by the CFSP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

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

y. AMHs: For all Contracts with any provider who is an AMH, a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each Contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.

z. Local Health Departments: For all Contracts with any provider who is a Local Health Department (LHD) carrying out CMHRP, a provision that outlines the Care Management requirements consistent with the Department's CMHRP Policy. Each Contract with a LHD who is carrying out CMHRP shall include a statement that the contracted provider agrees to comply with the Department's CMHRP Policy.

aa. Residential Substance Use Disorder Treatment Providers: For all Contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.

bb. Chapter 58 requirements: As codified in G.S. 108D-65(6)(f), the Contract must include provisions that address the following statutes and subsections:

i. G. S. 58-3-200(c).

ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).

iii. G.S. 58-50-270(1), (2), and (3a).

iv. G.S. 58-50-275 (a) and (b).

v. G.S. 58-50-280 (a) through (d).

vi. G.S. 58-50-285 (a) and (b).

vii. G.S. 58-51-37 (d) and (e).

cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

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

ee. Coordination with County DSS: Contracts should include a provision requiring providers to coordinate and share information with a Member's County Child Welfare Worker, as required by law or as otherwise appropriate.

ff. Clinical Records Requests for Claims Processing: the Contract shall indicate that the CFSP shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.

gg. Amendment of Previous Authorizations for Outpatient Procedures: The Contract must describe that the CFSP shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during

the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) Business Days of concluding the authorized outpatient procedure.

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

ii. For all applicable Contracts with Designated Pilot Care Management Entities, provisions that indicate:

i. The Designated Pilot Care Management Entity shall:

1) Utilize NCCARE360 for functions outlined in CFSP Contract *Section V.d.9.f.viii.* and *Section V.D.9.f.xii.*

2) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *Section V.D.9 Healthy Opportunities*.

3) Manage transitions of care for Healthy Opportunities Pilot-enrolled Members as outlined *Section V.D.2.n. Transitional Care Management* for Members that change health plans.

4) Perform Healthy Opportunities Pilot-related care management responsibilities as outlined in *Section V.D.9.f Healthy Opportunities Pilot to Address Unmet Health-Related Needs*, also known as Healthy Opportunities Pilot.

5) Abide by the Healthy Opportunities Pilot provider complaint process described in *Section V.E.5.k HSO Grievances related to the Healthy Opportunities Pilot.*

6) Adhere to the technology requirements described in *Section V.L. Technology Specifications.*

ii. The CFSP shall:

1) Make Healthy Opportunities Pilot care management payments to Designated Pilot Care Management Entities for Healthy Opportunities Pilot-enrolled members as outlined in *Section V.E.4.cc. Healthy Opportunities Pilot Payments*, as applicable.

2) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, CFSP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.

iii. The CFSP shall include Department-developed standard Contract language included in the AMH Manual in its Contracts with Designated Pilot Care Management Entities.

iv. Healthy Opportunities Network Leads: The CFSP must Contract with any Healthy Opportunities Network Lead operating in the CFSP region, as noted in *Section V.D.9.e.*~~.~~, using a Department-standardized CFSP-Network Lead model Contract, to access the Network Lead's network of Healthy Opportunities Pilot providers, also referred to as Human Service Organizations (HSOs).

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

a. Section VII.L.2. CFSP Advanced Medical Home Program Policy

b. Section VII.L.3. CFSP Pregnancy Management Program Policy

c. Section VII.L.4. CFSP CMHRP Policy

d. Advanced Medical Home Manual

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

a. Compliance with state and federal laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other

court orders that apply to the Contract and the Company's managed care Contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Contract, or any violation of the [Company's] Contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or Federal law.

b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination: Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to provider records

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

i. The United States Department of Health and Human Services or its designee;

ii. The Comptroller General of the United States or its designee;

iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee

iv. The Office of Inspector General

v. North Carolina Department of Justice Medicaid Investigations Division

vi. Any independent verification and validation Contractor, audit firm, or quality assurance Contractor acting on behalf of NC DHHS;

vii. The North Carolina Office of State Auditor, or its designee

viii. A state or federal law enforcement agency.

ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

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

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

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

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

i. For Medical Claims (including BH):

1) The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
   a) The [Company] shall pay or deny a clean Medical Claim within thirty (30) Calendar Days of receipt of the claim.
2) A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

ii. For Pharmacy Claims:

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

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

1) The [Company] shall Reprocess Medical Claims and Pharmacy Claims in a timely and accurate manner as described in this provision (including Interest and penalties if applicable).

iv. If the [Company] fails to pay a Clean Claim in full pursuant to this provision, the [Company] shall pay the [Provider] Interest and penalties. Late Payments will bear Interest at the annual rate of

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

v. Failure to pay a Clean Claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] penalties equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

vi. The [Company] shall pay the Interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to requests the Interest or the liquidated damages.

b. Contract Effective Date

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

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

c. Tobacco-free Policy

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

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

ii. Providers Subject to a Partial Tobacco-Free Policy

Starting April 1, 2024, Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

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

1. Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.

2. Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:

a) Ensure access to common outdoor space(s) free from exposure to tobacco use.

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

iii. Providers subject to Full Tobacco-Free Policy

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

[Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on [Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.

Second Revised and Restated Attachment L: POLICIES

1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy

a. Background

The Department will ensure that Medicaid Beneficiaries and their families and caregivers are supported in the transition to Medicaid Managed Care and the CFSP throughout the Enrollment process, including enrolling in the CFSP and selecting a Primary Care Provider (PCP). The Department will ensure Beneficiaries and their families experience a smooth transition from NC Medicaid Direct and LME/MCOs or from a Standard Plan, BH I/DD Tailored Plan, or Tribal Option to the CFSP and have the tools and resources to access care throughout CFSP implementation.

b. Scope

The North Carolina Medicaid Managed Care and CFSP Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the CFSP in the Enrollment of Beneficiaries into the CFSP. The intent of this Policy is not to replace any existing Enrollment processes related to NC Medicaid Direct.

c. Identification and Enrollment of Beneficiaries in the Auto-Enrolled Groups Eligible for the CFSP

i. Medicaid Beneficiaries meeting one of the following criteria will be eligible for Enrollment in the CFSP and referred to as the "auto-enrolled groups" unless they are otherwise part of a group excluded from managed care Enrollment:

a) Beneficiaries who are in Foster Care;
b) Beneficiaries receiving adoption assistance;
c) Beneficiaries who are enrolled in the Former Foster Youth eligibility group; and
d) Minor children of populations described in *Section VII. First Revised and Restated Attachment L.1.c.i.a - c* as long as their Parent is enrolled.

ii. The Department will employ the processes described below for the auto-enrolled group:

a) In the period between BH I/DD Tailored Plan and CFSP launch:

1. Beneficiaries eligible for the CFSP receiving services in NC Medicaid Direct will have the option to enroll in a Standard Plan, or BH I/DD Tailored Plan, as eligible, upon BH I/DD Tailored Plan launch.
2. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who become eligible for the CFSP will remain in the Standard Plan or BH I/DD Tailored Plan but will have the option of moving to NC Medicaid Direct.
3. Upon CFSP launch, Beneficiaries eligible for the CFSP in NC Medicaid Direct, enrolled in a Standard Plan or a BH I/DD Tailored Plan will be disenrolled (as applicable) and moved to the CFSP.

A. Prior to CFSP launch, the Department will send Beneficiaries who meet the "auto-enrolled groups" CFSP eligibility criteria, except as outlined below, a notice indicating that they will be auto-enrolled in the CFSP and can elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable) at any point during the coverage year.

I. CFSP excluded populations shall include Beneficiaries eligible for the CFSP:

i. Who are enrolled in the Innovations or TBI waivers;
ii. Residing in or receiving respite services at an ICF-IID;

iii. Ages 18 and older who are receiving State-funded BH, I/DD and TBI services that are not otherwise available through Medicaid,
iv. Beneficiaries receiving State-funded residential services, including group living, family living, supported living, and residential supports; and
v. Recipients enrolled in and being served under Transitions to Community Living.

II. CFSP excluded populations will instead be enrolled into BH I/DD Tailored Plans.
III. Beneficiaries enrolled in the Innovations and TBI waiver who wish to enroll in the CFSP will be required to disenroll from their respective waivers prior to submitting a disenrollment request.
IV. Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a) are exempt from Medicaid Managed Care and are auto-enrolled in the Tribal Option or NC Medicaid Direct depending on their county of residence, but will have the choice to enroll in a Standard Plan, the CFSP (as applicable), or a BH I/DD Tailored Plan (as applicable).
V. The Department will transmit CFSP assignment to the CFSP through a standard eligibility file.

4. For a Beneficiary who is eligible for the CFSP and is either auto-enrolled to the CFSP or selects a Standard Plan or BH I/DD Tailored Plan, coverage by the CFSP, Standard Plan or BH I/DD Tailored Plan begins on the first day of CFSP launch.

b) Period after CFSP Launch (ongoing Enrollment)

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the auto-enrolled groups:

A. The Department will send a notice to Standard Plan and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.
B. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria will be auto-enrolled in the CFSP effective the first of the month when CFSP eligibility was determined, unless the Member calls to request to continue Enrollment in the Standard Plan or BH I/DD Tailored Plan.
C. The following BH I/DD Tailored Plan members will remain in the BH I/DD Tailored Plan:

I. Beneficiaries enrolled in the Innovations or TBI waivers;
II. Recipients enrolled in and being served under Transitions to Community Living;
III. Beneficiaries obtaining state-funded BH, I/DD or TBI services not otherwise available through Medicaid;
IV. Beneficiaries living in state-funded residential treatment;
V. Beneficiaries residing in or receiving respite services at an ICF-IID.[3]

D. Beneficiaries who are auto-enrolled in the CFSP will have the option to re-enroll in a Standard Plan or BH I/DD Tailored Plan at any time during the coverage year.
E. If a Medicaid applicant is determined newly eligible for Medicaid, and is eligible for the CFSP, the Department will auto-enroll the applicant to the CFSP through a standard eligibility file (unless they are in a Managed Care Exempt or a CFSP excepted population).

[3] BH I/DD Tailored Plan Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan and transfer to a CFSP.

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined. CFSP Members will have an opportunity to select a Standard Plan or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

d. **Identification and Enrollment of Beneficiaries Eligible for the CFSP on an Opt-in Basis**

i. Pending CMS approval, the following populations who are not otherwise excluded from Medicaid Managed Care as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care* shall be eligible for Enrollment in the CFSP on an opt-in basis at a date that may be later than CSFP launch. They shall have the option of enrolling in the CFSP unless they are otherwise exempt or meet an exception outlined above in *Section VII. First Revised and Restated Attachment L.1.c.ii.b.1.C.:*

a) Parents, Caretaker Relatives, Guardians and Custodians of Beneficiaries in Foster Care working toward family reunification;[4,5]
b) Minor siblings of Beneficiaries in Foster Care working toward family reunification;
c) Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home;
d) Adults identified in an open Eastern Band of Cherokee Indians Department of Public Health and Human Services Family Safety program case and any children living in the same home; and
e) Any other Beneficiary that has been involved with the child welfare system who the Department determines would benefit from Enrollment.

ii. The Department will employ the processes described below for the opt-in groups:

a) In the period prior to CFSP launch:

1. Medicaid Beneficiaries in the opt-in groups will enroll in Standard Plans or BH I/DD Tailored Plans, as eligible.

b) In the period after CFSP launch (ongoing Enrollment which may start at a date later than CFSP launch):

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the opt-in groups:

A. The Department will send a notice to Standard Plan, Tribal Option and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.
B. Beneficiaries enrolled in a Standard Plan, Tribal Option, or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria shall have the option of enrolling in the CFSP at any point during the coverage year effective the first of the month following their election.
C. Beneficiaries who elect to enroll in the CFSP will have the option to re-enroll in a Standard Plan, Tribal Option or BH I/DD Tailored Plan, as eligible at any time during the coverage year.
D. A Medicaid applicant determined newly eligible for Medicaid, and eligible for the CFSP on an opt-in basis will have the option of enrolling in a Standard Plan, Tribal Option (if applicable), BH I/DD Tailored Plan (if applicable) or CFSP.

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined for members who select the CFSP. CFSP Members will

[4] Pending CMS approval.
[5] The CFSP will recognize the Tribal definition of "parents, guardians, and custodians" in determining Tribal member eligibility for the Plan.

have an opportunity to select a Standard Plan, Tribal Option or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

iii. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Available in the CFSP

a) Beneficiaries enrolled in Standard Plans who have a need for a service only available in the CFSP (i.e., a service-related request) and are eligible for Enrollment in the CFSP on an opt-in basis will be able to transfer to the CFSP in an expedited manner through the standard process that the Department will define.

e. Continuing Enrollment in the CFSP

i. CFSP Plan-eligible and enrolled individuals will continue to be eligible for the CFSP if they meet the eligibility criteria described in *Section V.B.1. Eligibility and Enrollment for CFSP*.

ii. Children in Foster Care whose Foster Care eligibility category status changes and who return to the custody of their Parents, Guardians, or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., the date their eligibility category changes).

iii. Minor children in the auto-enrolled groups shall remain eligible for CFSP Enrollment provided their Parent remains eligible for the CFSP.

iv. Parents, Guardians and Custodians of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their child remains eligible for the CFSP and County DSS is working toward family reunification.

v. Minor siblings of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their sibling remains eligible for the CFSP and County DSS is working toward family reunification.

vi. DSS shall notify the Department and the CFSP in cases where they are no longer working toward family reunification.

vii. Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home shall remain eligible for the CFSP if they continue to receive CPS In-Home Services.

a) County DSS shall notify the Department and the CFSP upon the conclusion of CPS In-Home Services Agreement.

viii. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan or BH I/DD Tailored Plan (if applicable) at Redetermination and noticed as part of their Redetermination process.

f. Medicaid Eligibility Redeterminations

i. At a CFSP Member's Medicaid renewal, if a Member is redetermined eligible for Medicaid and continues to be eligible for the CFSP, the Department will auto-enroll the Member into the CFSP, unless the Member chooses to enroll in a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment).

a) The Member will continue to have the opportunity to elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment at any point during the coverage year.

b) Members who enroll in the Innovations or TBI waiver, residing in or receiving respite services at an ICF-IID, ages 18 and older who require State-funded BH, I/DD and TBI services, including residential services, that are not otherwise available through Medicaid, and recipients enrolled in and being served under Transitions to Community Living will be disenrolled and

transferred to the BH I/DD Tailored Plan effective on the first day of the month following the service request.

c) If the Member selects a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment), the Enrollment Broker will transmit the selection to the Department. The Department will in turn transmit the selection to the Standard Plan, BH I/DD Tailored Plan or Tribal Option through a standard eligibility file. Coverage of the Member by the Standard Plan, BH I/DD Tailored Plan, or Tribal Option will begin on the first day of the next month in which the Member selected the Standard Plan, BH I/DD Tailored Plan or Tribal Option.

ii. If a Member is determined to no longer be eligible for Medicaid, the Member will be notified and disenrolled from the CFSP by the Department.

g. **Special Enrollment Cases**

i. Exempt Populations

a) Exempt Population as defined in *Section V.B.1.c.ii.* that are CFSP eligible will be able to enroll in the CFSP on an opt-in basis.

b) The Enrollment Broker will provide Choice Counseling to Exempt Populations and support BH I/DD Tailored Plan (as applicable), Standard Plan, NC Medicaid Direct, CFSP, Tribal Option (as applicable), and PCP selection throughout the Beneficiary's eligibility year.

c) If a Beneficiary in an Exempt Population selects the CFSP, the Enrollment Broker will transmit the CFSP selection to the Department. The Department will transmit CFSP selection to the CFSP through a standard eligibility file.

d) If a Beneficiary in an Exempt Population elects to move from the CFSP to a Standard Plan, BH I/DD Tailored Plan or other delivery system (such as NC Medicaid Direct or Tribal Option) at any point during the Beneficiary's eligibility year, coverage of the Beneficiary by the Standard Plan, BH I/DD Tailored Plan or other delivery system begins on the first day of the next month in which the Beneficiary selected the Standard Plan, BH I/DD Tailored Plan or other delivery system.[6]

e) Beneficiaries who are eligible for the Tribal Option will be permitted to transfer to the Tribal Option from any delivery system at Redetermination and at any point during the year.

ii. Deemed newborns

a) If a Member is known to be pregnant, the CFSP 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 CFSP unless the newborn is the child of an enrollee who meets the definition of Indian under 42 C.F.R. § 438.14(a), and the CFSP will begin providing coverage to the newborn immediately. The CFSP 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 CFSP's roster.

c) If the CFSP receives notification of birth prior to discharge, the CFSP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.

d) The CFSP 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 CFSP has not received confirmation of a deemed newborn's Enrollment in the CFSP through a standard eligibility file following the deemed newborn's birth, the CFSP shall notify

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

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 CFSP 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.

h. **Disenrollment from the CFSP and Medicaid Managed Care**

i. Member disenrollment from the CFSP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from the CFSP to a Standard Plan, BH I/DD Tailored Plan (as applicable) or Tribal Option (as applicable).

ii. Member requested disenrollment

a) A Member, or an Authorized Representative, may submit a verbal or written request for disenrollment from the CFSP to the Enrollment Broker by phone, mail, in-person, or electronically.

b) A Member may request disenrollment from the CFSP and transfer to a Standard Plan, BH I/DD Tailored Plan (if applicable) or the Tribal Option (if applicable) any time during the coverage year.

c) The Member, or the Authorized Representative, must contact the Enrollment Broker in order to initiate a disenrollment request.

d) At the time of the disenrollment request, Choice Counseling for the Member or the Member's Authorized Representative will be available from the Enrollment Broker.

e) The Enrollment Broker will process disenrollment requests in accordance with the following:

1. The Enrollment Broker will evaluate the request and will approve it.
2. The Enrollment Broker will notify the Department of its decision by the next Business Day following receipt of the request.

f) Notice of disenrollment determination

1. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval of the disenrollment request in accordance with G.S. 108D-5.7 and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
2. 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 first day of the following month unless there is an urgent need.[7]

g) Expedited review of Member-initiated requests for disenrollment

1. A Member, or an Authorized Representative, may request an expedited review of the Member's disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued Enrollment in the CFSP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2. The Enrollment Broker will process requests for expedited review in accordance with the following:

[7] 42 C.F.R. § 438.56(e).

A. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
B. The Department will evaluate and decide whether to approve or deny the request.

3. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) Calendar Days of receipt of the request by the Enrollment Broker.

iii. Disenrollment required by the Department

a) The Department shall disenroll Beneficiaries from the CFSP who are no longer eligible for the CFSP who remain Medicaid Managed Care eligible at Redetermination as follows:

1. CFSP Members no longer eligible for the CFSP who remain Medicaid Managed Care mandatory will be notified by the Department that they are no longer eligible for the CFSP, that they will be auto-enrolled into a Standard Plan or BH I/DD Tailored Plan (as applicable) and that they can select a different plan. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.
2. Children in Foster Care who return to the custody of their Parents, Guardians or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., when their eligibility category changes).

b) The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:

1. Loss of eligibility

A. If the Department determines that a Member is no longer eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the CFSP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.
B. If a Member is disenrolled from a CFSP 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 CFSP upon reenrollment in Medicaid. 42 C.F.R. § 438.56(g).

2. Change in Medicaid eligibility category

A. If the Department determines that a Member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care,* the Member will be notified by the Department and the Department will disenroll the Member from the CFSP. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.

3. Nursing facility long-term stays

A. A Member with a nursing facility stay that exceeds ninety (90) continuous Calendar Days will be disenrolled from the CFSP on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[8]
B. The CFSP shall utilize the Department-developed standardized process for monitoring length of stay for Members in nursing facilities to ensure Members

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

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.

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

I. Within thirty (30) days of admission to a nursing facility, the CFSP 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 CFSP 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 CFSP is responsible for tracking the total continuous length of stay for each Member residing in a nursing facility.

III. The Department will send the CFSP 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 CFSP.

IV. The CFSP 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 CFSP will end on the effective date provided by the Department.

c) Neuro-Medical Centers and Veterans Homes

1. A Beneficiary, otherwise eligible for Enrollment in the CFSP, residing in a state-owned Neuro-Medical Center[9] or a DMVA-operated Veterans Home[10] when the Department implements the CFSP is excluded and will receive care in these facilities through NC Medicaid Direct.
2. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of the CFSP will be disenrolled from the CFSP by the Department.

A. 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.

B. The Department will notify the Member and the CFSP of the disenrollment and the disenrollment effective date.

C. Coverage of the Member by the CFSP will end on the effective date provided by the Department.

3. 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.

i. **CFSP and 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

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

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

regulation, federally approved Medicaid waivers for North Carolina, or a change in the Enrollment processes.

2. CFSP Advanced Medical Home Program Policy

a. **Background**

i. The AMH program refers to an initiative under which a Standard Plan, a BH I/DD Tailored Plan, or the CFSP must pay Medical Home Fees to all participating primary care practices that act as PCPs. The CFSP must include the standard terms and conditions below in Contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.E.4.p. Payments of Medical Home Fees to Advanced Medical Homes*

ii. An AMH "practice" will be defined by an NPI and service location.

b. **Standard Terms and Conditions for CFSP Contracts with All AMH Providers**

i. General requirements:

a) Accept Members and be listed as a PCP in the CFSP's Member-facing materials for the purpose of providing care to Members and managing their healthcare needs;
b) Provide primary care and patient Care Coordination services to each Member, in accordance with CFSP policies;
c) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for Emergency Medical Conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;
d) Provide direct patient care a minimum of thirty (30) office hours per week;
e) Provide preventive services, in accordance with *Section VII. Second Revised and Restated Attachment L.2. Table 1: Required Preventive Services*;
f) Maintain a unified patient medical record for each Member following the CFSP's medical record documentation guidelines;
g) Promptly arrange referrals for Medically Necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record;
h) Transfer the Member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or CFSP (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge;
i) Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the CFSP's Network Adequacy Standards;
j) Refer for a second opinion as requested by the Member, based on Department guidelines and CFSP standards;
k) Review and use Member utilization and cost reports provided by the CFSP for the purpose of AMH-level UM and advise the CFSP of errors, omissions or discrepancies if they are discovered; and
l) Review and use the monthly Enrollment report provided by the CFSP for the purpose of participating in CFSP or practice-based population health or Care Management activities.

ii. Requirements specific to Members in Foster Care:

a) Review all available clinical documentation prior to each visit.
b) Coordinate with the Member's assigned care manager and/or County Child Welfare Worker, as appropriate, and make best efforts to ensure the following occur:

1. Initial physical examination within seven (7) days of entering County DSS custody; and
2. Comprehensive physical examination within thirty (30) days of entering County DSS custody.

c) Complete DSS Child Health Summary forms during required physical examinations and return forms to the assigned County DSS.

1. For the initial 7-day physical examination, complete and return Form DSS-5206; and
2. For the comprehensive 30-day physical examination, complete and return Form DSS-5208.

d) Make best efforts to schedule and conduct follow-up well visits in accordance with the AAP Health Care Standards for Members in Foster Care:

1. Members from ages zero (0) to six (6) months: every month;
2. Members from ages six (6) to twenty-four (24) months: every three (3) months; and
3. Members from ages two (2) to twenty-one (21) years: every six (6) months.

e) Conduct required health screenings in accordance with required timeframes (as appropriate based on age and the Member's clinical condition):

1. Screening for evidence of ACEs and trauma: within thirty (30) days of entry into Foster Care and as determined necessary after that;
2. General developmental and behavioral screening (e.g., ASQ-3, PEDS, PEDS DM): within thirty (30) days of entry into Foster Care and at six (6), twelve (12), eighteen (18) and twenty-four (24) months, and three (3), four (4), and five (5) years of age;
3. Psychosocial assessment (e.g., ASQ-SE, PSC, PSC-Y, SDQ, PSQ-A, Beck's, CRAFFT, Vanderbilt, Conners, Bright Futures Adolescent Questionnaire, GAPS, HEADSSS): within thirty (30) days of entry into Foster Care and every well visit thereafter as Medically Necessary;
4. Autism Spectrum Disorder screening (e.g., MCHAT R/F, STAT): at eighteen (18) and twenty-four (24) months; and
5. Oral health screening and risk assessment (e.g., NC Priority Oral Risk and Referral Tool, Bright Futures Oral Health Risk Tool): within thirty (30) days of entry into Foster Care all subsequent well visits up to age three-and-a-half (3 ½).

f) As appropriate, coordinate with care manager to refer Member to a dental home.

g) As appropriate, utilize best practices described in "Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System" from the American Academy of Child and Adolescent Psychiatry (AACAP) when treating Members served by the child welfare system.

Second Revised and Restated Attachment L.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus, Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					

Second Revised and Restated Attachment L.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
5	Haemophilus Influenza Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

3. CFSP Pregnancy Management Program Policy

a. Background

i. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among Participating Providers. Refer to the Contract for additional detail regarding the Pregnancy Management Program.

b. Scope

i. The scope of this Policy covers the requirements that must be in agreements between the CFSP and providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program outlined below and in *Section V.D.4.c. Pregnancy Management Program in Coordination with Care Management for High-Risk Pregnant Women.*

c. Pregnancy Management Program Requirements

i. The CFSP shall incorporate the following requirements into their Contracts with all providers of prenatal, perinatal and postpartum care, including the following requirements for providers of the Pregnancy Management Program:

a) Complete the standardized risk-screening tool at each initial visit.
b) Allow the CFSP or the CFSP's designated Vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
c) Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
d) Commit to decreasing the cesarean section rate among nulliparous women.
e) Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
f) Complete a high-risk screening on each pregnant CFSP Member in the program and integrate the plan of care with CFSP Care Management and/or CMHRP.
g) Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty percent (20%)).
h) Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
i) Require that CFSP network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for Members in CMHRP to the CFSP or LHD that is responsible for the provision Care Management services for high-risk pregnancy.

4. CFSP Care Management for High-Risk Pregnancy Policy

a. **Background**

i. "Care Management for High-Risk Pregnancy" refers to Care Management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs). Refer to the Contract for additional detail regarding CMHRP in *Section V.D.4.b. Local Health Departments*.

ii. For Contract Year 1, LHDs shall have "right of first refusal" as contracted providers of CMHRP Women. Women participating in CMHRP with an LHD are also eligible for CFSP Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.

iii. After Contract Year 1, CMHRP shall be fully subsumed into the CFSP Care Management model.

b. **Scope**

i. The scope of this Policy covers the agreement between the CFSP and LHD providers offering CMHRP, as outlined below and in the Contract.

c. **General Contracting Requirement**

i. LHD shall accept referrals from the CFSP for CMHRP services.

d. **Care Management for High-Risk Pregnancy: Outreach**

i. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in Care Management.

e. **Care Management for High-Risk Pregnancy: Population Identification and Engagement**

i. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated Care Management documentation system within five (5) Calendar Days of receipt of risk screening forms.

ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

iii. LHD shall accept pregnancy Care Management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Division of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

iv. LHD shall review available CFSP data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and CMHRP teams to facilitate cross-county partnerships to ensure coordination of care and appropriate Care Management assessment and services for all patients in the target population.

f. **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**

i. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for Care Management for level of need for Care Management support.

ii. LHD shall utilize assessment findings, including those conducted by the CFSP, to determine level of need for Care Management support.

iii. LHD shall document assessment findings in the Care Management documentation system.

iv. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.

v. LHD shall assign case status based on level of patient need.

g. **Care Management for High-Risk Pregnancy: Interventions**

i. LHD shall provide Care Management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes in-person Encounters (practice visits, home visits, hospital visits, community Encounters), telephone outreach, professional Encounters and/or other interventions needed to achieve Care Plan goals.

ii. LHD shall provide Care Management services based upon level of patient need as determined through ongoing assessment.

iii. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.

iv. LHD shall utilize NCCARE360 to identify and connect Members with additional community resources.

v. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the Member's CFSP Network.

vi. LHD shall document all Care Management activity in the Care Management documentation system.

h. **Care Management for High-Risk Pregnancy: Integration with the CFSP and Health Care Providers**

i. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.

ii. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.

iii. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.

iv. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.

v. LHD shall ensure awareness of CFSP Members' "in network" status with providers when organizing referrals.

vi. LHD shall ensure understanding of the CFSP's prior authorization processes relevant to referrals.

i. **Care Management for High-Risk Pregnancy: Collaboration with CFSP**

i. LHD shall work with the CFSP to ensure program goals are met.

ii. LHD shall review and monitor CFSP reports created for the Pregnancy Management Program and CMHRP services to identify individuals at greatest risk.

iii. LHD shall communicate with the CFSP regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

iv. LHD shall participate in pregnancy Care Management and other relevant meetings hosted by the CFSP.

j. **Care Management for High-Risk Pregnancy: Training**

i. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy Care Management training offered by the CFSP and/or the Department, including webinars, new hire orientation or other programmatic training.

ii. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the CFSP and/or the Department.

iii. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based Care Management of pregnancy and postpartum women at risk for poor birth outcomes.

iv. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and Trauma-Informed Care techniques on an ongoing basis.

k. **Care Management for High-Risk Pregnancy: Staffing**

i. LHD shall employ care managers meeting pregnancy Care Management competencies, defined as having at least one of the following qualifications:

a) Registered nurses
b) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
c) Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

ii. LHD shall ensure that Community Health workers for CMHRP services work under the supervision and direction of a trained care manager.

iii. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.

iv. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

v. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.

vi. LHD shall ensure that pregnancy care managers demonstrate:

a) A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
b) Proficiency with the technologies required to perform Care Management functions
c) Motivational interviewing skills and knowledge of adult teaching and learning principles
d) Ability to effectively communicate with families and providers
e) Critical thinking skills, clinical judgment and problem-solving abilities

vii. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

a) Provision of program updates to care managers
b) Daily availability for case consultation and caseload oversight
c) Regular meetings with direct service Care Management staff
d) Utilization of reports to actively assess individual care manager performance
e) Compliance with all supervisory expectations delineated in the CMHRP Program Manual

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following CFSP/Department guidance about communication with the CFSP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

ix. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the CFSP.

5. CFSP Uniform Credentialing and Re-credentialing Policy

a. **Background**

This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a CFSP in determining whether to allow a provider to be included in the CFSP's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider.

b. **Scope**

This Policy applies to the CFSP and covers Credentialing and Re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to acute, primary, Behavioral Health, Substance Use Disorders, and Long-Term Services and Support (LTSS) [42 C.F.R. § 438.214(b)(1)].

c. **Policy Statement**

The CFSP shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Re-credentialing Policy.

i. **Centralized Provider Enrollment and Credentialing**

a) The Department, or Department designated Vendor, will implement a CCRP with the following features:

1. The Department, or Department designated Vendor, shall collect information and verify credentials, through a centralized Credentialing process for all providers currently enrolled or seeking to enroll in the North Carolina's Medicaid program.

A. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.

B. The Department may, at its option, Contract with a Vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

2. The Department shall apply the Credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for the Medicaid services, including all providers that must be credentialed under Credentialing standards established by a nationally recognized accrediting body. 42 C.F.R. § 438.602(b).
3. The process and information requirements shall meet the most current data and processing standards for a Credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.

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

4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid enrolled provider, with the application

serving for enrollment as a Medicaid Fee-for-Service provider as well as a Medicaid Managed Care Provider.

A. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

5. Providers will be reverified and recredentialed as permitted by the Department in the Contract.
6. The CFSP shall use its Provider Credentialing and Re-credentialing Policy to decide whether to Contract with a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
7. The Department, or its designated Vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled Providers.

A. The CFSP shall use the Provider Enrollment File to identify active Medicaid Enrolled Providers who are eligible for contracting.

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

a) The CFSP shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:

1. Meet the requirements specified in 42 C.F.R. § 438.214;
2. Meet the requirements specified in this Contract;
3. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;
4. Establish that the CFSP shall accept provider Credentialing and verified information from the Department and shall not request any additional Credentialing information without the Department's approval.
5. Establish a documented process for determining if a provider is an active Medicaid Enrolled Provider and therefore eligible for contracting;
6. Prohibit the CFSP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
8. Prohibit the CFSP to employ or Contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E;
10. If the CFSP requires a provider to submit additional information as part of its contracting process, the CFSP's Provider Manual shall include a description of all such information.

A. The CFSP shall make network contracting decisions based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates.

B. Reserved.

11. CFSP shall re-credential providers as follows:

A. The CFSP shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.

B. After the Provider Credentialing Transition Period, no less frequently than every five (5) years.

C. CFSP shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.

D. CFSP shall have discretion to make network contracting decisions consistent with the Policy.

12. Include all previous versions, be published on the CFSP's website and include the Policy effective dates.
13. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of CFSP services. At a minimum, these standards shall assess a provider's ability to deliver care.
14. Describe the information that providers will be requested to submit as part of the contracting process.
15. Describe the process by which the CFSP will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.214.

b) CFSP shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state network providers.

c) CFSP shall have discretion to make contracting determinations consistent with this Policy.

d) Reserved.

6. CFSP Management of Inborn Errors of Metabolism Policy

a. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.

b. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.

c. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that CFSP cover the full cost of evidence-based therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized Care Plan.

d. Once a client is established with a specialized treatment facility a nutrition Care Plan is developed and products prescribed. The current system of product coverage is four pronged:

    i. Clients with Health Insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers.

    ii. Clients with Medicaid coverage are served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product. Medicaid is billed for the cost of the product by IHC. The IHC will no longer serve Medicaid Beneficiaries once they transition into managed care.

    iii. Clients participating in WIC are served through the Nutrition Services Branch (NSB). Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. WIC funds are used to pay the metabolic product invoices.

    iv. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC

agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

e. The CFSP will need to establish working relationships with the NSB, Specialty Treatment Centers, and metabolic formulas suppliers/manufacturers.

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

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

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

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

7. CFSP Behavioral Health Service Definition Policy

a. Background

The CFSP Behavioral Health Service Definitions Policy provides the CFSP with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

b. Behavioral Health Services Definitions

i. 1915(i) Services: The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members covered by this Contract.

ii. Opioid Treatment Program (adults only): a location-based service for the purpose of Network Adequacy Standards.

iii. Adult Facility-Based Crisis Services: a crisis service for the purpose of Network Adequacy Standards.

iv. Facility-based Crisis Services for Children and Adolescents: a crisis service for the purpose of Network Adequacy Standards.

v. Professional treatment services in facility-based crisis: a crisis service for the purpose of Network Adequacy Standards.

vi. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of Network Adequacy Standards.

vii. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

viii. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

ix. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

x. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xi. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xii. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiii. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiv. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xv. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvi. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvii. Acute Care Hospitals with Child Inpatient Psychiatric Beds as inpatient BH services for the purpose of Network Adequacy Standards.

xviii. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xix. Partial Hospitalization: partial hospitalization for children and adults for the purposes of the Network Adequacy Standards.

xx. 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 in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxi. 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.

xxii. Urgent care for SUD:
   a) 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.
   b) 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.

xxiii. 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.

xxiv. 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 for the purpose of BH appointment wait-time standards.

xxv. Urgent Care for Mental Health:
   a) 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.

b) 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.

xxvi. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the 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.

xxvii. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

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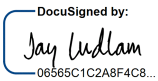
Jay Ludlam jay.ludlam@dhhs.nc.gov Deputy Secretary, NC Medicaid DHHS Security Level: Email, Account Authentication (None)	DocuSigned by:  06565C1C2A8F4C8... Signature Adoption: Pre-selected Style Using IP Address: 2600:387:f:6819::a Signed using mobile	Sent: 6/24/2025 4:22:47 PM Viewed: 6/24/2025 6:32:11 PM Signed: 6/24/2025 6:32:29 PM
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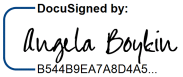
Angela Boykin Angela.Boykin@bcbsnc.com Security Level: Email, Account Authentication (None)	DocuSigned by:  B544B9EA7A8D4A5... Signature Adoption: Pre-selected Style Using IP Address: 170.69.109.14	Sent: 6/24/2025 6:32:32 PM Viewed: 6/25/2025 1:06:35 PM Signed: 6/25/2025 1:19:16 PM
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Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)

Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	• Allow per session cookies • Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

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