AMENDMENT NUMBER 3

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 and 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 III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections*.
2. Modify requirements in *Section V. Scope of Services*.
3. Modify *Section VII. Attachments* as specified herein.

The Parties agree as follows:

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

Specific subsections of the Contract are modified as follows:

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

213. Bulk Care Manager Assignment: A process in which the CFSP will assign the beneficiaries enrolled in the CFSP via the 834 File delivered to the CFSP on October 18, 2025 to a care manager. The Bulk Care Manager Auto Assignment period is October 18, 2025 through October 22, 2025.

214. Bulk PCP Auto Assignment: A process in which the CFSP will auto assign beneficiaries enrolled in the CFSP via the 834 File delivered to the CFSP on October 17, 2025 to an AMH/PCP. The Bulk PCP Auto Assignment period is October 17, 2025 through October 20, 2025.

215. **Cell and Gene Therapy Access Model Candidate Beneficiary:** A Beneficiary who meets all of the following criteria:
    a. Has a documented medical diagnosis of sickle cell disease; and
    b. Has North Carolina Medicaid as the Beneficiary's primary payer for the infused State-Selected Model Drug.
216. **Cell and Gene Therapy Access Model Beneficiary:** A Cell and Gene Therapy Access Model Candidate Beneficiary who meets all of the following criteria:
    a. Has received an infusion of a State-Selected Model Drug;
    b. Has North Carolina Medicaid as the Beneficiary's primary payer for the infused State-Selected Model Drug;
    c. On the date the Beneficiary is infused with the State-Selected Model Drug, a value-based payment supplemental rebate agreement between the Department and the manufacturer of the infused State-Selected Model Drug is in effect; and
    d. If the Beneficiary is enrolled in a Prepaid Health Plan (including a BH I/DD Tailored Plan or CFSP) or NC Medicaid Direct on the date the Beneficiary is infused with the State-Selected Model Drug, such population is included in the terms of the value-based payment supplemental rebate agreement between the manufacturer of the infused State-Selected Model Drug and the Department on such infusion date.
217. **Children and Families Specialty Plan (CFSP):** A statewide capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of Chapter 108D, including the requirements pertaining to the Children and Families (CAF) specialty plan, but excluding the requirements only pertaining to BH I/DD tailored plans.
218. **Closed Network:** Has the same meaning as "closed network" defined in NCGS § 108D-24.
219. **Due Process Clearinghouse**: A single portal web-based solution used to store and retrieve notices of adverse benefit determination and state fair hearing decisions.
220. **Federal Fiscal Year:** The U.S. federal fiscal year is a 12-month period for accounting and budgeting of the federal government that begins on October 1 and ends on September 30 of the following calendar year.
221. **NC Select Drug:** A drug that meets the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, and has been listed on the NC Select Drug List by the Department.
222. **NC Select Drug List:** A list of drugs maintained by the Department and made available on its public-facing website that include but are not limited to Cell and Gene Therapies which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, that are covered under the NC Medicaid Benefit, carved out of the inpatient diagnosis-related group or outpatient ratio of cost to charges and claimed separately to allow the capture of rebates.
223. **Ongoing Care Manager Assignment:** A process in which the CFSP will assign CFSP Members to a care manager after bulk care manager assignment has completed.
224. **Ongoing PCP Auto Assignment:** A process in which the CFSP will auto assign CFSP Members to an AMH/PCP after bulk PCP Auto Assignment has completed.
225. **PCP Assignment Code**: A set of codes used to track the PCP assignment criterion used to assign a PCP to a Member.
226. **PCP Assignment Reason Code**: A set of codes used to track the reasons that triggered the Member's PCP assignment.
227. **PCP Choice Period:** A timeframe during the Crossover Period where a Member is able to choose an AMH/PCP.

228.Score for Neonatal Acute Physiology: A medical scoring system used to predict mortality and morbidity in critically ill newborns.

229.State Selected Drug Model: In the context of the CMS Cell and Gene Therapy (CGT) Access Model, a State-Selected Model Drug refers to a specific cell or gene therapy chosen by a state to be included in the Model. These therapies are typically high-cost treatments aimed at addressing rare or severe diseases. Under the CGT Access Model, states collaborate with the Centers for Medicare and Medicaid Services (CMS) to facilitate access to these transformative treatments. A State-Selected Model Drug is a Model Drug for which the state has chosen to enter into a Value-Based Purchasing (VBP) Supplemental Rebate Agreement (SRA) with the manufacturer, reflecting the key terms for the Model Drug. Providers administering these therapies must participate in CMS-designated patient registries and follow specific guidelines, including patient counseling for CMS-specified studies. NC Medicaid's State-Selected Model Drugs are LYFGENIA (lovotibeglogene autotemcel) and CASGEVY (exagamglogene autotemcel).

b. Section *III. B. Acronyms* is revised to add additional acronyms as follows:

237.AAC: Actual Acquisition Cost
238.ASP: Average Sales Price
239.CGT: Cell and Gene Therapy
240.DRG: Diagnosis-Related Group
241.HHCS: Home Health Care Services
242.RCC: Ratio of Cost to Charges
243.SCD: Sickle Cell Disease

c. Section *III. D. Terms and Conditions, 40. PAYMENT AND REIMBURSEMENT, c., Maternity Event Payments* is revised and restated in its entirety as follows:

c. Maternity Event Payments and NC Select Drug Case Payments:

i. As provided in *Section V.J. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required documentation of an eligible delivery event to the Department. The Contractor must accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.

ii. As provided in *Section V.J. Financial Requirements*, the Contractor will be eligible to receive a separate NC Select Drug Case payment, as applicable. Payment will be made after the Contractor submits required documentation of paid claims in the NC Select Drug Report and the encounter being accepted by the Department. The Contractor must accept the NC Select Drug Case payment rates developed by the Department and its actuary and approved by CMS.

d. *Section III. D. Terms and Conditions, 40. PAYMENT AND REIMBURSEMENT, e., ii., d)* is revised and restated in its entirety as follows:

d) Pilot Service Delivery Payments

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

3. The Department shall distribute monthly prospective Service Delivery payments to the Contractor in a method and total amount to be determined by the Department, as outlined in the Healthy Opportunities Payment Protocol.

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

Specific subsections of the Contract are modified as follows:

a. *V.A. Administration and Management, 1. Program Administration, i. Compliance with Department Policies, i.,* is revised to add the following:

20) Notice of Adverse Benefit Determination Guide

b. *Section V.A. Administration and Management, 1. Program Administration, i. Compliance with Department Policies, i. 12)* is revised and restated as follows:

12) North Carolina Medicaid Transformation Clinical Supplemental Guidance

c. *Section* V.A. Administration and Management is revised to add the following:

10. Clinically Appropriate Placement of Minors

a. The CFSP shall take the following action upon receiving notification that a Member under eighteen (18) years of age remains in the Emergency Department for longer than twenty-four (24) hours and is ready for discharge or transfer to another facility to receive Medicaid State Plan services:
   i. Within one (1) Business Day of receiving notification described in *Section V.A.10.a.* of the Contract:
      1) If the Member is not in DSS custody, the CFSP shall contact the Medicaid help center to open a case for the Member; or
      2) If the Member is in DSS custody, the CFSP shall:
         a) Confirm that the Member has an open case with the Department of Health and Humans Services' Rapid Response Team as defined in ("Rapid Response Team"); and
         b) If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS open a Rapid Response Team case for the Member.
   ii. Within three (3) Business Days of receiving notification described in *Section V.A.10.a.* of the Contract, the CFSP shall demonstrate best efforts to arrange for the Member to receive services in an appropriate placement with the approval of the Member's guardian or legally responsible person (LRP).
   iii. Within seven (7) Business Days of receiving notification described in *Section V.A.10.a*. of the Contract, the CFSP shall develop a rapid response plan for the Member using the Department-developed Rapid Response Plan template and attach the completed Rapid Response Plan to the Member's open Medicaid help center or Rapid Response Team case.
      1) Until the Member is discharged or transferred to a clinically appropriate setting for receipt of medically necessary services, the CFSP shall update the Member's Rapid Response Plan on a weekly basis and shall attach the updated Rapid Response Plan to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last submitted update.
      2) The CFSP shall participate in all Department-led escalation calls to which the CFSP is invited with advanced notice related to arranging placement for the Member.
      3) In the event that a Member is not placed within twenty-four (24) hours following the CFSP's receipt of notification described in *Section V.A.10.a*. of the Contract, the CFSP shall include the Member on the CFSP's next weekly submission of the BCM-073 report.

b. The CFSP shall take the following actions upon receipt of notification from DSS that a Member under eighteen (18) years of age has been taken into physical DSS custody; requires evaluation for or delivery of Medicaid State Plan services, including residential placement in a licensed facility (i.e., residential treatment and/or PRTF service); and is staying overnight in a DSS office, hotel, or similar placement:
   i. Within one (1) Business Day of receiving notification described in *Section V.A.10.f.* of the Contract, the CFSP shall:
      1) Contact the Member's County DSS to confirm that the Member has an open Rapid Response Team case; and
      2) If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS opens a Rapid Response Team case for the Member.
   ii. Within three (3) Business Days of receiving the notification described in *Section V.A.10.b*. of the Contract, the CFSP shall demonstrate best efforts to arrange for the Member to be appropriately placed to receive medically necessary services. Automatic referral to a hospital emergency department for services does not satisfy this requirement.
   iii. Within seven (7) Business Days of receiving the notification described in *Section V.A.10.b.* of the Contract, the CFSP shall develop a rapid response plan using the Department-developed Rapid Response Plan template and attach the completed Rapid Response Plan to the Member's open Rapid Response Team case.
      1) Until the Member is placed in a clinically appropriate setting to receive medically necessary services and is no longer staying overnight in a DSS office or similar placement, the CFSP shall update the Member's Rapid Response Plan on a weekly basis and shall attach the updated Rapid Response Plan to the Member's open Rapid Response Team case within seven (7) Calendar Days of last submitted update.
      2) The CFSP shall participate in all Department-led escalation calls relating to arranging placement for the Member.
   iv. In the event that a Member is not placed in a clinically appropriate setting for receipt of medically necessary services within one (1) Business Day following the CFSP's receipt of notification described in *Section V.A.10.b.* of this Contract, the CFSP shall include the Member on the CFSP's next submission of the BCM-073 report.
   v. The CFSP shall work with the Member's DSS Office to update the crisis/ safety plan for each Member staying overnight in a DSS office, hotel or similar placement while awaiting clinically appropriate placement and shall work with the DSS Office to determine and arrange for the Member to receive medically necessary assessments, services, and supports while staying overnight in a DSS office, hotel, or similar placement pending clinically appropriate placement.

c. A Member's need for services shall be determined through a Comprehensive Clinical Assessment (CCA) or similar evaluation.

d. Nothing in this Section requires the CFSP to arrange for placement outside the recommended level of care determined by the Member's CCA or similar assessment, or outside of services covered under the Member's applicable Medicaid benefit plan.

e. In the event that the parent, legal guardian or legal custodian of a Member under eighteen (18) years of age for whom the CFSP has received notification described in *Sections V.A.10.a.* or *V.A.10.b.* of this Contract rejects or refuses admission to an appropriate placement identified by the CFSP, the CFSP shall, within one (1) Business Day, identify a mutually agreeable placement within the recommended level of care identified by the CCA or similar evaluation by, at minimum, addressing barriers to the Member's parent, legal guardian, or legal custodian accepting the appropriate placement, and shall continue efforts to identify a mutually agreeable placement until placement is achieved.

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

iii. The CFSP shall accept, transfer and utilize Member's claims/encounter history, prior authorizations and transition file content, as described *in Section V.B.3.a. Ongoing Requirements*, between the CFSP, BH I/DD Tailored Plans, Standard Plans, NC Medicaid Direct and other authorized Department Business Associates in accordance with the Department's data transfer protocols and related privacy and security requirements.

e. ***Section V.B. Members, 3. Transitions of Care Across Plans and Delivery Systems, a. Ongoing Requirements, vii., 5)*** **is revised and restated in its entirety as follows:**

5) The CFSP shall provide Trauma-Informed Care for Members and ensure all transition of care services are delivered in a way that supports children subject to Adverse Childhood Experiences (ACEs).

f. ***Section V.B. Members, 3. Transitions of Care Across Plans and Delivery Systems, a. Ongoing Requirements, xi.,*** **is revised to add the following:**

5) For Members meeting the criteria set forth in subsection a) of this Section, the CFSP shall submit a NC Medicaid Long Term Services and Supports (LTSS) Managed Care Disenrollment Form to the Department's LTSS Assessment Vendor within seven (7) business days of the CFSP receiving notification of a Member's disenrollment on the 834 or the CFSP's receipt of a request from the Department's LTSS Assessment Vendor for a form to be submitted for a Member disenrolling from the CFSP to Medicaid Direct..
   a) The CFSP shall send the LTSS Managed Care Disenrollment form if the following criteria apply:
      i) Prior to disenrollment, the Member was receiving any LTSS services in the CFSP; or
      ii) The CFSP receives a request for the LTSS Managed Care Disenrollment Form from the Department's LTSS Assessment Vendor because the Member is disenrolling due to CAP/DA or CAP/C enrollment.
         (1) In the case of anticipated CAP/C or CAP/DA enrollment, the submitted form is required to be submitted by the CFSP, whether the Member previously received other LTSS services or not.
   b) LTSS Managed Care Disenrollment Form should be sent to the Department's LTSS Assessment Vendor via email to the email address appearing on the LTSS Managed Care Disenrollment Form with the subject line, "Disenrollment Form".

g. ***Section V.B. Members, 7. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements*** **is revised to add the following:**

xiii. The CFSP shall develop and maintain a Member Appeal Policy subject to Department review and approval. The CFSP shall submit the Member Appeal Policy to the Department no less than thirty (30) Calendar Days prior to CFSP Launch.

h. ***Section V.B. Members, 7. Member Grievances and Appeals, h. Appeals and Grievances Recordkeeping and Reporting, v., 2)*** **is revised and restated in its entirety as follows:**

2) To support the Department's monitoring efforts, the CFSP shall upload the following to the Due Process Clearinghouse in a manner and frequency specified by the Department:
   a) Each Notice of Adverse Benefit Determination issued by the CFSP;

b) Each Notice of Resolution issued by the CFSP;
c) Clearinghouse uploads should include English and the primary language of the Member (if the Notice is sent in a language other than English); and
d) Include required fields for Clearinghouse ingestion as set forth by the Notice of Adverse Benefit Determination Guide.

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

b. AMH/PCP Choice and Assignment
i. Consistent with 42 C.F.R. § 438.3(l), the CFSP shall ensure that each Member has a choice of AMH/PCP.
ii. The CFSP shall abide by the panel limits set by AMH and PCPs. During the Bulk PCP Auto Assignment period, the CFSP shall auto assign a PCP to Members. The CFSP shall also auto assign a PCP to a Member who enrolls after the Bulk Assignment period.
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.
9) The CFSP shall submit to the Department an operational report that provides information on the CFSP's PCP Assignment Code and Reason Code in accordance with *Section VII. Second Revised and Restated Attachment I: CFSP Reporting Requirements*.
iii. Subject to prior approval by DHHS, the CFSP's methodology may prioritize assignment to practices based on AMH status and/or other additional factors, such as metrics of high performance or patients' patterns of care.
iv. The Department reserves the right to adjust the AMH/PCP methodology for assigning each Member to an AMH/PCP as defined in this Contract and to audit the CFSP's AMH/PCP auto-assignment logic upon request.
v. When applicable, the CFSP shall notify Members when they have been assigned to an AMH/PCP.
vi. Members can change their AMH/PCP without cause twice per year. Members shall be given thirty (30) Calendar Days from receipt of notification of their AMH/PCP assignment each year to change their AMH without cause (1st instance) and shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance). Members who meet the definition of Indian under 42 C.F.R. § 438.14(a) may change their AMH/PCP without cause at any time.
vii. In addition, Members shall be allowed to change their AMH/PCP with cause at any time.
viii. The Department shall consider the following as appropriate "cause" for Member AMH/PCP changes:
1) The provider has failed to furnish accessible and appropriate medical care, services or supplies to which the Member is entitled under the terms of the Contract under which the CFSP has agreed to provide services. This includes, but is not limited to, the failure to:
a) Provide primary care services;

b) Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
c) Arrange for consultation appointments;
d) Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
e) Arrange for services with qualified licensed or certified providers;
f) Coordinate the Member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;

2) The Member disagrees with a treatment plan;
3) The Member and provider are not able to communicate due to a language barrier or other impediment to communication;
4) The provider is not able to reasonably accommodate the Member's special needs;
5) There is a change in the provider's practice, including but not limited to the following:
   a) The provider moves to a location that is not convenient for the Member;
   b) There is a significant change in the hours the provider is available and the Member cannot reasonably make appointments during the new hours;
   c) The provider no longer has hospital access.
6) The Member changes placements or moves to a location where the AMH is no longer reasonably accessible;
7) The Member and the provider agree that a change would be in the best interest of the Member; or
8) The provider leaves the CFSP's Network.

ix. The CFSP shall allow AMH/PCPs to request removal of a Member from their panel and must submit to the Department their process for reviewing and approving such removal requests.

x. The CFSP shall allow Members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such Members direct access to a specialist as appropriate to the Member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).

xi. For Ongoing PCP Auto Assignment, in instances where the Member is enrolled in CFSP for Bulk PCP Auto Assignment and does not select an AMH/PCP during enrollment, the CFSP shall assign the Member to an AMH/PCP immediately to ensure Member receives their CFSP Member Welcome Packet, including ID card with PCP/AMH assignment, prior to CFSP Launch.

xii. For Member choices submitted during the defined PCP Choice Period, the CFSP shall process PCP choices daily, as they are received, and shall process all choices prior to Bulk PCP Auto Assignment. For Member PCP choices submitted outside the defined PCP choice period, the CFSP must process PCP choices daily, as they are received, and assign Members to their selected PCP effective the first Calendar Day of the following month. In instances where a Member submits a PCP choice at the end of the month and the CFSP is unable to complete the assignment process, the CFSP must process the Member's choice within seventy-two (72) hours of receipt and notify the Member of the effective date of their PCP assignment.

j. *Section V.C. Benefits 1. Benefits Package, c. Covered Medicaid Services, v.* is revised and restated in its entirety as follows:

v. The CFSP shall adhere to the Department's North Carolina Medicaid Transformation Clinical Supplemental Guidance, which references requirements for clinical coverage which supplement NC Medicaid clinical coverage policies.

k. *Section V.C. Benefits 1. Benefits Package, c. Covered Medicaid Services, Section V.C.1. Table 2: Behavioral Health, I/DD, and TBI Services Covered in Standard Plans, BH I/DD Tailored Plans, and CFSP[10]* is revised and restated in its entirety as follows:

First Revised and Restated Section V.C.1. Table 2: Behavioral Health, I/DD, and TBI Services Covered in Standard Plans, BH I/DD Tailored Plans, and CFSP[10] (Effective December 1, 2025)		
BH, I/DD, and TBI Services Covered by Standard Plans, BH I/DD Tailored Plans, and the CFSP	**BH, I/DD and TBI Services Covered by BH I/DD Tailored Plans and the CFSP**	**BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)**
Enhanced BH services are *italicized*		
State Plan BH and I/DD Services • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer Support Services • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Opioid Treatment Program* • *Ambulatory Withdrawal Management, without Extended On-Site Monitoring (Ambulatory Detox)* • *Ambulatory Withdrawal Management, with Extended On-Site Monitoring* • Research-based BH treatment for Autism Spectrum Disorder (ASD) • *Diagnostic assessment* • *Medically Monitored Inpatient Withdrawal Management Service (Non-hospital medical detoxification)* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • Diagnostic Assessment • Clinically Managed Residential Withdrawal Management Services (social setting detox)	**State Plan BH and I/DD Services** • *Residential treatment services* • *Child and adolescent day treatment services* • *Intensive CPS In-Home Services* • *Multi-systemic therapy services* • *Psychiatric residential treatment facilities (PRTFs)* • *Assertive community treatment (ACT)* • *Community support team (CST)* [12] • *Psychosocial rehabilitation* • *Clinically Managed Residential Services (Substance abuse non-medical community residential treatment)* • *Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment)* • *Clinically managed low-intensity residential treatment* • *Clinically managed population-specific high intensity residential program* **1915(i) SPA services** • Community Transition	**State Plan BH and I/DD Services** • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **Waiver Services** • Innovations waiver services • TBI waiver services **State-funded Services** [13] **Respite services through TRACK at Murdoch**

[10] Pending legislative change to offer some services in the CFSP that are currently only available in Tailored Plans
[12]CST includes tenancy supports.
[13] Members requiring State-funded Services will need to transfer to a BH I/DD Tailored Plan to access those services.

First Revised and Restated Section V.C.1. Table 2: Behavioral Health, I/DD, and TBI Services Covered in Standard Plans, BH I/DD Tailored Plans, and CFSP[10] (Effective December 1, 2025)		
BH, I/DD, and TBI Services Covered by Standard Plans, BH I/DD Tailored Plans, and the CFSP	**BH, I/DD and TBI Services Covered by BH I/DD Tailored Plans and the CFSP**	**BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)**
Enhanced BH services are *italicized*		
• Early and periodic screening, diagnostic and treatment (EPSDT) services as covered under 1905(a)	• Respite • Supported Employment/Individual Placement Supports • Community Living and Supports • Individual and Transitional Support	

l. *Section V.C. Benefits 1. Benefits Package, c. Covered Medicaid Services, Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services* is revised and restated in its entirety as follows:

First Revised and Restated Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services (Effective December 1, 2025)		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
1	Outpatient Services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.1	Clinically managed low-Intensity residential treatment	Clinically managed low-Intensity residential treatment (*Coverage to be applied on the effective date approved by CMS)
3.3	Clinically managed population-specific high intensity residential program	Clinically managed population-specific high intensity residential program (*Coverage to be applied on the effective date approved by CMS)
3.5	Clinically managed high-intensity residential services	Clinically Managed Residential Services (Substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored community residential treatment)

First Revised and Restated Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services (Effective December 1, 2025)		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
4	Medically managed intensive inpatient services	Inpatient BH services
Reserved.		
Opioid treatment services	Opioid treatment services	Opioid Treatment Program
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory Withdrawal Management without Extended On-Site Monitoring
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory withdrawal management with extended on-site monitoring
3.7-WM	Medically monitored inpatient withdrawal management	Medically Monitored Inpatient Withdrawal Management Services (Non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal management	Inpatient BH services

m. *Section V.C. Benefits, 1. Benefits Package, c. Covered Medicaid Services, x., 3)* is revised and restated in its entirety as follows:

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

n. *Section V.C. Benefits, 1. Benefits Package, e. Utilization Management, xviii., 5), d), ii)* is revised and restated in its entirety as follows:

ii) The CFSP shall not require Members to obtain a referral or prior authorization for sexually transmitted disease (STI) and tuberculosis (TB) services rendered at a Local Health Department (LHD).

o. *Section V.C. Benefits, 1. Benefits Package, g. In Lieu of Services (ILOS)* is revised and restated in its entirety as follows:

g. In Lieu of Services (ILOS)

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

ii. Once each Contract Year, the CFSP shall submit to the Department for review and approval the Department's standardized ILOS Service Request Form for each proposed new ILOS or revision to an existing ILOS offered under the Contract, except that the CFSP may submit the standardized

ILOS Service Request Form to the Department at any time to request termination or reduction of services offered as an ILOS.

1) In no instance shall the CFSP reduce or remove ILOS service without approval by the Department within a Contract Year.
2) Prior to making any changes, reduction, or removal of an ILOS, the CFSP shall submit the Department's standardized ILOS Service Termination Form to the Department for approval. If the request to change, reduce, or remove an ILOS is approved, the CFSP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.
3) The CFSP shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.

iii. If the CFSP receives written notification from the Department that a previously approved ILOS has been determined by the Department or by CMS to no longer be medically appropriate or cost effective or if there are other compliance concerns with the ILOS requirements, including failures to protect Member rights, the CFSP shall submit a transition plan for the ILOS for current Members receiving the terminated ILOS to the Department for review and approval within the timeframe specified by the Department in the written notification. At a minimum, the transition plan shall include the following:
   1) A transition of care plan to phase out the applicable ILOS in no longer than twelve (12) months from receipt of the notice from the Department terminating the ILOS while ensuring access to services required under the Contract with minimal disruption to care for Members.
   2) A process to notify Members of the termination of the applicable ILOS for Members that are currently receiving the ILOS, as expeditiously as required by the Member's health condition.

iv. Upon approval by the Department, the CFSP shall post ILOS policies on its publicly available Member and provider websites no later than thirty (30) Calendar Days prior to the effective date of change.

v. The CFSP shall monitor the cost-effectiveness of each approved ILOS by tracking utilization and expenditures on an annual basis or more frequently upon request of the Department (see *Section VII. Second Revised and Restated Attachment I. Reporting Requirements* for more detailed requirements).

vi. The CFSP may offer the following In Lieu Of Service:
   1) Institute for Mental Disease (IMD): The CFSP may contract and pay for services for members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered setting for no more than fifteen (15) Calendar Days within a calendar month. 42 C.F.R. 438.6(e).
   2) To provide the service, the CFSP must submit an ILOS request form, as defined by the Contract.
   3) If the CFSP does not provide the ILOS request form for review and approval, capitation payments may be adjusted accordingly.
   4) If the CFSP provided the ILOS, the CFSP shall provide the Department with a weekly report on members utilizing IMD services as defined in *Section VII. Attachment I. Reporting Requirements*. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

vii. The CFSP shall ensure that ILOS are provided in a manner that preserves Member rights and protections under State and federal law, including the following rights and protections related to ILOS:
   1) Members shall not be required by the CFSP to utilize an ILOS or be required to replace a Medicaid State Plan service with an ILOS.

2) The availability of an ILOS shall not be used by the CFSP to reduce, discourage, or jeopardize access by the Member to covered Medicaid State Plan services/settings.
3) If a Member chooses not to receive an ILOS, the Member always retains the right to receive the covered Medicaid State Plan service or setting on the same terms as would apply if an ILOS was not available.
4) Medically appropriate Medicaid State Plan services/settings shall not be denied by the CFSP on the basis that a Member was offered an ILOS, is receiving an ILOS, or has previously received an ILOS.
5) The Member shall be able to access the CFSP 's grievance and appeal system described in *Section V.B.7.* Member Grievances and Appeals for any ILOS offered by the CFSP to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

viii. The CFSP shall develop and implement a consistent process to ensure that both the network Providers requesting and the CFSP 's licensed clinical staff recommending an ILOS for a Member use professional judgment to determine and document (e.g., in the Member's care plan or medical record) that the ILOS is medically appropriate for the specific Member based on the ILOS target population descriptions outlined in *Section VII. Third Revised and Restated Attachment L.8. CFSP In Lieu of Services (ILOS)*.

p. *Section V.C. Benefits, 1. Benefits Package, h. Value-Added Services* is revised and restated in its entirety as follows:

h. Value-Added Services

i. The CFSP may offer Value-Added Services as approved by the Department. For each value-added service, the CFSP shall submit to the Department for approval, in the Department developed standardized template, the following information:
1) Definition and description of the Value-Added Service, including if prior authorization is required;
2) Definition of the criteria to be eligible for proposed value-added service;
3) Types of providers eligible to provide the Value-Added Services;
4) Description of how and when providers and Members will be notified about the availability of the proposed Value-Added Services;
5) Duration for which Value-Added Services will be provided; and
6) Description of if, and how, the services will be identified in encounter data.

ii. The CFSP shall submit to the Department for approval any changes to Value-Added Services.
1) In no instance may the CFSP reduce or remove Value-Added Services without approval by the Department during a Contract Year.
2) Prior to change, reduction, or removal of a Value-Added Service, the CFSP shall submit the Department's standardized Value-Added Services Termination Form to the Department for approval. Upon approval of a change, reduction, or removal of a Value-Added Service, the CFSP shall notify Members who are actively receiving the applicable Value-Added Service, as determined by the CFSP, of the change pursuant to the requirements of 42 C.F.R. § 438.10(c)(6) and shall update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change. If a change in a Value-Added Service is made for the betterment of the Value-Added Service, the CFSP shall update their Member website to reflect this change.

iii. Value-Added Services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).

q. *Section V.C. Benefits, 1. Benefits Package, l. Electronic Verification System Requirements i*s revised and restated in its entirety as follows:

l. Electronic Verification System Requirements

i. The CFSP must utilize an Electronic Visit Verification (EVV) system to verify personal care services, and home health care services, including Medicaid State Plan services that provide assistance with ADLs that are provided in the Member's home and are not provided as a per diem service, prior to releasing payment.

ii. The CFSP must utilize an EVV system to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:

1) Type of service performed;
2) Individual receiving the service;
3) Date of the service;
4) Time that the service begins;
5) Location of service delivery;
6) Individual providing the service; and
7) Time that service ends.

iii. If the CFSP utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.

iv. The CFSP shall ensure that utilization of an EVV system for State Plan personal care services and home health care services is in effect by CFSP launch.

v. The CFSP shall deliver the EVV data elements to the Encounter Processing System (EPS) for personal care services, home health care services, or services that provide support with activities of daily living in a Member's home that are not daily rate services.

vi. The CFSP shall permit providers to continue using their existing EVV system provided that the system is compliant with state and federal regulations.

vii. The CFSP shall submit monthly reporting using the EVV Key Metrics Report for the EVV program as described in *Second Revised and Restated Attachment I: Reporting Requirements*.

r. *Section V.C. Benefits, 1. Benefits Package* is revised to add the following:

n. NC Select Drugs Notification and Reporting

i. The CFSP shall notify the Department within fourteen (14) Calendar Days in accordance with the notification process outlined in the *North Carolina Medicaid Transformation Clinical Supplemental Guidance* when any of the following occurs:

1) A provider requests prior approval for an NC Select Drug, which requires prior approval from the CFSP.
   a) The notification by the CFSP shall include the Member identification number, Provider, drug name, and anticipated infusion date (if known).
2) A claim is received by the CFSP for an NC Select Drug.
   a) The notification by the CFSP shall include the Member identification number, provider, drug name, infusion date, and claim received date.
3) A claim is paid by the CFSP for an NC Select Drug.
   a) The notification by the CFSP shall include the Member identification number, Provider, drug name, and claim payment date.

ii. To support Department reporting to CMS related to NC Select Drug usage, the CFSP shall submit the NC Select Drug Report as described in *Second Revised and Restated Attachment I: Reporting Requirements*.

s. Section *V.C. Benefits, 1. Benefits Package i*s revised to add the following:

o. Cell and Gene Therapies (CGTs)

i. CGTs and Department Clinical Coverage Policies

1) The Department has outlined coverage requirements for CGTs approved by the U.S. Food and Drug Administration (FDA) across multiple NC Medicaid Direct Clinical Coverage Policies. To support the CFSP with aligning FDA-approved CGTs to the corresponding NC Medicaid Direct Clinical Coverage Policy, the Department will publish an "Analysis of FDA Approved CGTs for Plan" guidance document for the CFSP.

a) The CFSP can find all FDA-approved CGT products at: https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy-products.

2) The CFSP shall use the "Analysis of FDA Approved CGTs for Plan" guidance document provided by the Department to clarify which NC Medicaid Direct Clinical Coverage Policy covers drugs listed on FDA-approved CGT product lists.

a) At a minimum, the "Analysis of FDA Approved CGTs for Plan" guidance document will include information on the product and trade name, whether the drug is in the Medicaid Drug Rebate Program, product type, applicable NC Medicaid Direct Clinical Coverage Policy, and whether the drug in on the NC Select Drug List.

b) Minimally, on a calendar quarter basis, the Department will publish an updated version of the "Analysis of FDA Approved CGTs for Plan" guidance document and provide the updated version to the CFSP.

ii. CGT Access Model

1) The CGT Access Model is a treatment model wherein CMS facilitates the negotiation, implementation, and evaluation of outcomes-based agreements for cell and gene therapies on behalf of state Medicaid agencies to improve Beneficiary access to innovative treatment and health outcomes and reduce health care expenditures. At this time, CMS has limited the CGT Access Model to gene therapies approved or licensed by the Food and Drug Administration for the treatment of sickle cell disease (SCD) that are covered outpatient drugs under the Medicaid Drug Rebate Program. The Department has elected to participate in CMS' CGT Access Model for the NC Medicaid Direct and Medicaid Managed Care Programs.

2) The Department has selected the following two (2) drugs appearing on the NC Select Drug List as the State-Selected Model Drugs under the CGT Access Model:

a) CASGEVY® (exagamglogene autotemcel); and

b) LYFGENIA™ (lovotibeglogene autotemcel).

3) The CFSP shall participate in the CGT Access Model.

4) The CFSP shall cover the services necessary to determine whether a CGT Access Model Candidate Beneficiary enrolled in the CFSP meets prior authorization criteria for the State-Selected Model Drug(s).

5) The CFSP shall cover the administration of a State-Selected Model Drug to CGT Access Model Beneficiaries enrolled in the CFSP in accordance with the requirements of this Section and as directed by the Department to ensure compliance with CMS requirements of the CGT Access Model.

6) Access Policy for State-Selected Model Drugs

a) The Department's Access policy for State-Selected Model Drugs is comprised of:

i) Clinical Coverage Policy 1S-13: Cell and Gene Therapy; and
ii) Applicable clinical coverage criteria established by the Department for each State-Selected Model Drug found here: https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html

b) The CFSP is required to follow the Department's Access policy, as applicable, for each State-Selected Model Drug.
c) The CFSP shall publish the Access policy for the State-Selected Model Drug(s) publicly in a manner that is accessible by providers and Members.
d) By no later than November 30, 2025, the CFSP shall submit to the Department documentation that the CFSP has published an Access policy for each State-Selected Model Drug that aligns with the Department's Access policy.

7) Reimbursement of State-Selected Model Drugs
a) The CFSP shall reimburse State-Selected Model Drugs in accordance with *Section V.C.3.h.ii.10)e) NC Select Drug List.*
b) The CFSP shall require a provider submitting a claim for reimbursement of a State-Selected Model Drug to follow the billing guidance outlined in *Section 3.12.3.* of the Department's Managed Care Billing Guide. If the CFSP develops any additional billing guidance related to State-Selected Model Drugs for providers, the guidance is required to align with *Section 3.12.3.* of the Department's Managed Care Billing Guide.
i) The CFSP shall publish the billing guidance developed for each State-Selected Model Drug(s) publicly in a manner that is accessible by providers.
ii) By no later than November 30, 2025, the CFSP shall submit to the Department a copy of its billing guidance developed for each State-Selected Model Drug that aligns with the Department's Managed Care Billing Guide.
c) The CFSP is prohibited from reimbursing a provider for administration of a State-Selected Model Drug if:
i) The provider is not a member of the CMS-designated patient registry for the State-Selected Model Drug and a participant in a CMS-specified study; or
ii) The provider otherwise fails to meet State-Selected Model Drug requirements for reimbursement.

8) Continuity of Care for CGT Access Model Beneficiaries
a) For CGT Access Model Beneficiaries transitioning into the CFSP from NC Medicaid Direct or from another PHP (including from a BH I/DD Tailored Plan), the CFSP must honor existing and active prior authorizations for sickle cell disease gene-therapy related care and prescriptions on file with NC Medicaid Direct or approved by the disenrolling CFSP until the end of the authorization period to ensure continuity of care.
b) The CFSP shall allow a CGT Access Model Beneficiary to continue to have access to and shall cover medically necessary services furnished by their same sickle cell disease gene therapy providers for at least one (1) year after receiving their gene therapy infusion.
c) For a period no less than five (5) years following the date of State-Selected Model Drug infusion, the CFSP shall permit a CGT Access Model Beneficiary who has transitioned from another PHP (including from a BH I/DD Tailored Plan) or from NC Medicaid Direct to have access to, and shall cover medically necessary services furnished to the CGT Access Model Beneficiary by, a treatment center qualified to administer State-Selected Model Drugs.

9) Access Model Network Requirements

a) The CFSP shall maintain an adequate network of providers qualified to administer State-Selected Model Drugs for its Members in accordance with this Section.
b) The CFSP shall have at least one (1) in-network treatment center qualified to administer each State-Selected Model Drug or the CFSP shall develop a template single case agreement for sickle cell disease gene therapy.
    i) If the CFSP develops a template single case agreement for administration of a State-selected Model Drug, the template or its accompanying documentation, at a minimum, shall:
        (1) Identify which services are provided in-state and out-of-state (as applicable), taking into account the entire patient care journey including the following services: initial consultation to determine whether the CGT Access Model Candidate Beneficiary is eligible for the State-Selected Model Drug; cell harvesting; chemotherapy, and all other preparation as required per the FDA label; infusion of the State-Selected Model Drug; ancillary care (e.g., behavioral health services); and return visits for long-term follow-up care;
        (2) Contain payment terms consistent with *Section V.C.3.h.ii.10)e). NC Select Drug List*; and
        (3) Include terms that contemplate coverage for the duration of the continuity of care period described in *Section V.C.1.o.ii.8) Continuity of Care for CGT Access Model Beneficiaries*.
    ii) If the CFSP develops a template single case agreement for the administration of a State-Selected Model Drug, the CFSP is required to submit the template to the Department for review and approval.
        (1) The CFSP may utilize proposed single case agreement templates submitted to the Department for review, prior to approval, with notification to the provider that the single case agreement is subject to amendment based upon Department review and approval.
        (2) Upon approval by the Department, the CFSP shall update submitted single case agreement template to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The CFSP shall discontinue use of a previously submitted single case agreement template once an amended version is approved.
    iii) The CFSP shall respond to questions and requests from a provider related to its single case agreement within five (5) Business Days of receipt and shall render decisions on single case agreements within timeframes specified in 42 C.F.R. § 438.210(d) for authorization decisions.
c) The CFSP shall identify a primary and secondary point of contact for providers regarding single case agreements and prior authorization and shall make the contact information available to all treatment centers authorized to administer sickle cell disease gene therapy by posting the information publicly on its website.

10) Access Model Maintenance of Records

a) Notwithstanding *Section III.D.44. RECORD RETENTION*, the CFSP shall retain all books, files, records, documents, and other information related to CGT Access Model participation until May 31, 2045, or from the date of notification by the Department of the completion of any audit, evaluation, inspection, investigation, or rebate dispute related to the CGT Access Model, whichever is later.

b) This term shall survive termination or expiration of the Contract or until such time that the records are transferred to the Department.

t. *Section V.C. Benefits, 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT), i., iii.* is revised and restated in its entirety as follows:

iii. Require that participating primary care providers include all of the following components in each medical screening.
1) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents."
a) Screening for developmental delay at each visit through the fifth (5th) year; and
b) Screening for Autistic Spectrum Disorders per AAP guidelines.
c) Reserved.
2) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
3) Laboratory testing (including blood lead screening appropriate for age and risk factors).
4) Health education and anticipatory guidance for both the child and caregiver.
5) Comprehensive, unclothed physical examination.

u. *Section V.C. Benefits, 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT), s., i.* is revised and restated in its entirety as follows:

i. The CFSP shall not request that providers or Members withdraw or modify a request for EPSDT services to accept a fewer number of hours, or less intensive type of service, or to modify a *Score for Neonatal Acute Physiology* or other clinical assessment.

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

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

w. *Section V.C. Benefits, 3. Pharmacy Benefits, d. Pharmacy Utilization Management, iv., 7)* is revised and restated in its entirety as follows:

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

x. *Section V.C. Benefits, 3. Pharmacy Benefits, f. Pharmacy Benefit Managers, v.* is revised and restated in its entirety as follows:

v. The CFSP shall provide a liaison with whom the Department will communicate with directly. The CFSP liaison shall be available for direct communication with pharmacy providers to resolve issues, and to work with the Department to resolve rebate issues resulting from the CFSP's encounter and drug utilization files.

y. *Section V.C. Benefits, 3. Pharmacy Benefits, h. Pharmacy Reimbursement* is revised and restated in its entirety as follows:

h. Pharmacy Reimbursement

i. Dispensing Fees

1) In accordance with NCGS § 108D-65(5)b, the CFSP shall reimburse pharmacies a dispensing fee at a rate established by the Department.
2) The CFSP shall reimburse a dispensing fee for covered outpatient drugs defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).
3) The Department shall perform a COD study every five (5) years to inform the FFS dispensing rate and notify the CFSP of any changes to the pharmacy dispensing fee.
4) Reserved.
5) Reserved.
6) For 340B Hemophilia and Non-340B Hemophilia drugs, the dispensing fee is paid based on the quantity of units dispensed, utilizing a multiplier at four cents ($0.04) for Hemophilia Treatment Center (HTC) pharmacies and two and a half cents ($0.025) for all other Non-Hemophilia Treatment Center pharmacies.
7) The CFSP shall not reimburse pharmacy professional dispensing fees to drug reimbursement under the all-inclusive rate "AIR" or bundle payment.

ii. Ingredient Costs

1) The CFSP shall reimburse pharmacies' ingredient costs according to the methodology set forth in the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1).
2) The CFSP shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.
3) Beginning in 2026 and subject to Department review and approval, the CFSP may develop its own pharmacy contracting for ingredient reimbursement if the CFSP can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the CFSP must also submit a pharmacy network access monitoring plan.
4) The CFSP shall comply with NCGS § 58-51-37(f) in relation to any rebates or marketing incentives offered by the CFSP.
5) Reimbursement Inquiries. The CFSP shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.
6) Ingredient Costs for Non-340B

a) The CFSP shall reimburse pharmacy ingredient costs using the same reimbursement methodologies as defined in the State Plan and applied to Medicaid Direct programs.
   i) FFS rates are based on the National Average Drug Acquisition Cost (NADAC). If there is no NADAC, the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), or other financial arrangements established by the Department, as defined in the State Plan.
   ii) For traditional ingredient costs, reimbursement is based on the lesser of logic methodology, such that the pharmacy is reimbursed at the lesser of usual and customary (U&C), gross amount due (GAD) or the calculated allowed amount derived from NADAC, plus a professional dispensing fee. If not NADAC, then the lesser of WAC or SMAC (plus a professional dispensing fee), U&C or GAD.
b) Non-340B hemophilia drugs shall be reimbursed by the CFSP based on the Hemophilia reimbursement methodology defined in the State Plan.

i) Under the State Plan non-340B hemophilia drugs are reimbursed at the lesser of the following:
   (1) 340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee. SMAC rates are based on the providers' acquisition cost (purchase price);
   (2) Provider's acquisition cost (purchase price) reported in the usual and customary charge (U&C) field, plus a per unit professional dispensing fee; or
   (3) Provider's Gross Amount Due (GAD).

ii) Under the State Plan, the dispensing fee for hemophilia is paid based on the quantity of units dispensed. The per unit professional dispensing fee is four cents ($0.04) per unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is two and a half cents ($0.025) per unit for all other non-hemophilia treatment center pharmacies.

iii) The CFSP shall require the provider to only bill acquisition costs or purchase price in the U&C field.

7) Ingredient Costs for 340B

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

i) Under the State Plan, reimbursement rates are based on the provider's actual acquisition cost (purchase price) plus a professional dispensing fee. Reimbursement is based on actual acquisition cost when it is the lesser of National Average Drug Acquisition Cost (NADAC) or the gross amount due; if there is no NADAC, the lesser of the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), usual and customary, gross amount due, or other financial arrangements established by the Department.

ii) The CFSP shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B program. The CFSP shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission Clarification field 420-DK at the POS.

b) Hemophilia drugs purchased through the 340B program shall be reimbursed by the CFSP based on the Hemophilia reimbursement methodology as defined in the State Plan.

i) Under the State Plan, 340B hemophilia drugs are reimbursed at the lesser of the following:
   (1) 340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee. SMAC rates are based on the providers' acquisition cost (purchase price);
   (2) Provider's acquisition cost (purchase price) reported in the usual and customary charge (U&C) field, plus a per unit professional dispensing fee; or
   (3) Provider's Gross Amount Due (GAD).

ii) Under the State Plan, the dispensing fee is paid based on the quantity of units dispensed, reimbursement is applicable to pharmacy. The per unit professional dispensing fee is four cents ($0.04) per unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is two and a half cents ($0.025) per unit for all other non-hemophilia treatment center pharmacies.

iii) The CFSP shall require the provider to only bill acquisition costs or purchase price in the U&C field.

8) Reimbursement for Drugs in Indian Health Services
   a) The CFSP shall reimburse the Indian Health Services, or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of Indian Health Care Improvement Act (25 U.S.C § 1603 and authorized by Public Law 93-638 Agreement).
      i) For drugs with calculated allowable amounts of less than one thousand dollars ($1,000) utilizing the Office of Management and Budget (OMB) encounter reimbursement methodology, which will pay a maximum of two (2) prescription drugs per Member, per day, per pharmacy provider under the OMB encounter payments, and for any additional prescription drugs (three (3) and up) same Member, same day, same pharmacy provider, the CFSP shall reimburse at zero.
      ii) For drugs with a calculated allowable amount equal to or greater than one thousand dollars ($1,000), the CFSP shall reimburse the I/T/U utilizing the current FFSs reimbursement methodology as defined by the State Plan. The following is a list of exclusions to the I/T/U OMB encounter/ All Inclusive Rate (AIR):
         (1) Drugs and vaccines procured free of charge;
         (2) Emergency supply dispensation;
         (3) Eyeglasses;
         (4) Prosthetic devices and hearing aids;
         (5) Diabetic testing supplies and continuous glucose monitors;
         (6) Drug counseling or medication therapy management;
         (7) 340B drugs;
         (8) Medicare Part-B drugs;
         (9) Reserved;
         (10) Professional dispensing fees;
         (11) Collection of rebates;
         (12) Drug delivery or mailing; and
         (13) Drugs dispensed to Members assigned to Family Planning Waiver benefit plans.

9) Blood Glucose Diabetes Testing Supplies (BGDTS) and Continuous Glucose Monitors (CGM).
   a) The CFSP shall reimburse BGDTS and CGMs at the lesser of State Maximum Allowable Cost (SMAC) rates or the provider's billable charges reported by the provider in the Usual and Customary Charge field.
   b) The CFSP shall reimburse BGDTS based on the per unit basis (Example: one (1) box contains hundred (100) strips and only forty (40) will be dispensed; provider should bill the CFSP for forty (40) units).
   c) The CFSP shall not pay professional dispensing fees (PDF) for pharmacy BGDTS or CGM.
   d) The CFSP shall only cover BGDTS listed on the PDL at pharmacy point-of-sale (POS).
   e) The CFSP shall only cover therapeutic CGMs listed on the PDL at pharmacy POS.
   f) The CFSP shall only cover BGDTS and CGMs within the quantity limits defined in the NC Medicaid Pharmacy DTS CMG Fee Schedule.
   g) The CFSP shall require PA for a therapeutic CGM dispensed through pharmacy POS.
   h) The CFSP shall cover non-therapeutic CGMs under DME. The CFSP shall ensure the provider submits a non-therapeutic CGM as a medical claim.
   i) The CFSP shall not cover therapeutic CGMs under the DME program.

10) Medical Institutional and Professional Drug Claims
   a) Hospital Outpatient Drug Claims

i) The CFSP shall ensure drugs utilized in the Outpatient Hospital setting are billed to the CFSP at their usual and customary charge, including those drugs used from the 340B inventory (rebates are collected on non 340B drugs in this setting).
ii) The CFSP shall ensure providers bill transactions of outpatient hospital services to the CFSP on a UB-04 or 837i transaction. The drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp RCC).
iii) The requirements in this section apply to physician practices that are part of a hospital-based clinic (e.g., the clinic is a department of a hospital). Drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp) RCC).

b) Hospital Inpatient Drug Claims
i) The CFSP shall reimburse the cost of drugs in the inpatient hospital setting utilizing the inpatient hospital reimbursement methodology, based on diagnosis-related group (DRG) (rebates are not collected for 340B drugs in this setting).

c) Physician Administered Drug Program (PADP)
i) The CFSP shall reimburse procedure coded drugs covered under the PADP and shall require providers to bill the CFSP utilizing the CMS form 1500/837p.
ii) The CFSP shall require claims to be billed by providers utilizing the HCPCS and NDC combination per the NDC: HCPS Crosswalk file.
iii) The CFSP shall ensure drugs used in the PADP program are eligible for rebate (rebates are collected for drugs under this program, except for 340B drugs, radiopharmaceuticals, vaccines, and Crofab).
iv) The CFSP shall ensure 340B Drugs listed under the PADP are billed by the provider to the CFSP at Acquisition Cost.
v) The CFSP shall ensure the provider bills 340B drugs under CMS form 1500/837p with UD Modifiers, at 340B acquisition cost (purchase price) in the usual and customary Charge (U&C) field (rebates are not collected for 340B claims in this setting).

d) Federally Qualified Health Centers/Rural Health Centers
i) The CFSP shall reimburse FQHC/RHC facilities for medical professional drugs at no less than one hundred percent (100%) of the NC Medicaid Federally Qualified Health Center Fee Schedule and NC Medicaid Rural Health Center Fee Schedule.
ii) The CFSP shall require FQHC/RHC facilities to bill 340B drugs at 340B actual acquisition cost.
iii) The CFSP shall reimburse FQHC/RHC facilities for 340B drugs at the 340B acquisition cost plus a professional dispensing fee for point of sale (POS) claims. The CFSP shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B program. The CFSP shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission Clarification field 420-DK at the POS.
iv) The CFSP shall reimburse FQHC/RHC facilities for 340B drugs submitted as professional claims at the 340B acquisition cost. The CFSP shall require the FQHC/RHC to submit professional claims utilizing the UD modifiers.
v) The CFSP shall reimburse FQHC/RHC facilities in compliance with ingredient costs as prescribed in *Section V.C.3.h.ii. Ingredient Costs.*

e) NC Select Drug List

i) Drugs on the NC Select Drug List, including but not limited to Cell and Gene Therapies (CGTs), which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, are covered under the NC Medicaid Benefit.
   (1) The NC Select Drug List maintained by the Department can be found by the CFSP here: https://medicaid.ncdhhs.gov/providers/pharmacy-services.
   (2) The Department may modify the NC Select Drug List for the inclusion or exclusion of additional drugs.
   (3) The CFSP shall reimburse drugs added to the NC Select Drug List according to the reimbursement logic provided in this Section within forty-five (45) Calendar Days of notification from the Department that the NC Select Drug List has been modified.

ii) Drugs administered in an inpatient hospital setting shall be reimbursed by the CFSP based on the ingredient component of the NC Select Drug at the Actual Acquisition Cost (AAC) net of all costs such as rebates and discounts, received by the hospital.

iii) Drugs administered in an outpatient hospital setting shall be reimbursed by the CFSP based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or Average Sales Price (ASP) net of all costs such as rebates or discounts received by the hospital.

iv) Drugs administered in a professional outpatient setting shall be reimbursed by the CFSP based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or the Average Sales Price (ASP) net of all costs such as rebates or discounts received by the provider.

v) If the CFSP enters a single case agreement with a non-participating provider related to NC Select Drugs, the CFSP shall ensure that the NC Select Drugs are reimbursed in accordance with the reimbursement methodology described in this Section.

vi) NC Select Drugs administered in any setting shall be reimbursed directly to the rendering provider or facility eligible to perform the infusion.
   (1) The CFSP shall not reimburse point of sale pharmacies, including specialty pharmacies, directly for NC Select Drugs.

vii) For inpatient and outpatient services related to administration of NC Select Drugs, the CFSP shall require providers to bill NC Select Drugs separate from services reimbursed based on Diagnosis-Related Group (DRG) or Ratio of Cost to Charge (RCC) rate methodologies. The CFSP shall require claims for NC Select Drugs to be billed by providers with both the HCPCS and NDC listed.

viii) The CFSP shall require providers to submit the actual invoice, which reflects the actual acquisition cost paid by the provider or hospital net of any rebates or discounts received by the hospital or provider, to demonstrate the actual drug acquisition cost paid. The CFSP shall ensure that bona fide service fees, meeting the federal definition in 42 C.F.R. § 423.501, are not required to be reported as cost offsets by the provider. Bona fide service fees would be allowable under the federal definition of a service fee.
   (1) For NC Select Drugs administered in an hospital inpatient, hospital outpatient, or professional outpatient setting, the provider's Chief Executive Officer, Chief Financial Officer, or appropriate designee responsible for billing is required to attest that the net invoice cost reflects the actual costs incurred by the provider for the drug, to include all cost offsets such as rebates received by the provider, or discounts. The provider's designee can attest to the validity of the invoice cost by signing the submitted invoice, including their printed name and title.

ix) The CFSP shall not reimburse providers using 340B inventory for drugs on the NC Select Drug List furnished to Members.

x) The reimbursement methodology described in this Section for drugs on the NC Select Drug List is effective for claims reimbursed by the CFSP for dates of services on or after December 1, 2025.

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

ii. Timing of Care Manager Assignment

a) For Bulk Care Manager Assignment, in instances which the Member is enrolled in CFSP within the defined period for Bulk Care Manager Assignment, the CFSP shall assign the Member to a care manager prior to the distribution of CFSP Member Welcome Packets, including ID card and Care Management.

b) For Ongoing Care Manager Assignment, in instances which the member is enrolled in CFSP after the Bulk Care Manager Assignment is completed, the CFSP shall assign the Member to a care manager within twenty-four (24) hours of the Member's enrollment in the CFSP and issue Members their CFSP Member Welcome Packet, including ID card and Care Management, prior to CFSP Launch.

aa. *Section V.D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, i.* is revised to add the following:

6) The CFSP shall submit the DSS CFSP Care Manager Co-Location Report to the Department in accordance with *Second Revised and Restated Attachment I. Reporting Requirements*. The DSS CFSP Care Manager Co-Location Report shall include information on the status of DSS County Offices' agreement to have a CFSP-employed care manager or care management navigator physically co-located in their offices. Additionally, the report shall include information on the number of co-located CFSP care managers at each DSS County Office that agreed to the co-location arrangement, as outlined in S*ection V.D.2.f.i. Co-Location*.

***bb. Section V.D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, ii. Coordination with County Child Welfare Workers, 4)* is revised and restated in its entirety as follows:**

4) During the initial meeting, the care manager shall:

a) Confirm that Members have received or been scheduled to receive the following DSS-required evaluations/assessments coordinated by the County Child Welfare Workers (as relevant and appropriate based on the Member):

i) DSS-required 7-day physical examination (DSS Health Summary Form - Initial Visit (DSS 5206));152

ii) DSS-required 30-day comprehensive medical appointment (Health Summary Form - 30 day Comprehensive Visit (DSS 5208));

iii) A mental health evaluation, with ongoing monitoring and assessment as needed;

iv) A developmental health evaluation if the Member is under the age of six (6);

v) An educational evaluation if the Member is over the age of five (5);

vi) A dental evaluation (if known, this should be based on the date of the child's last dental evaluation);

vii) If such assessments/evaluations have not been scheduled, the care manager shall work with the County Child Welfare Worker to schedule the appropriate appointments;
viii) If the care manager determines that any evaluations/assessments are not required, the care manager must document the reason; and
ix) Child Welfare Trauma Informed Assessment.

b) At a minimum, gather the following information, as applicable:
i) For all Members:
(1) Court-ordered medical services;
(2) Immediate healthcare needs, including BH and Unmet Health-Related Resource Needs;
(3) Member's medication history;
(4) Key updates on Member's family preservation and/or permanency planning process;
(5) Other information necessary for informing the assessment and care planning processes; and
(6) Child Welfare Trauma Informed Assessment.
ii) Additional information for Members in County DSS custody:
(1) DSS Child Health Summary Components, to the extent available;
(2) Placement logs;
(3) Member's family history related to Foster Care placement status, and custody status;
(4) Child Maltreatment Evaluations; and
(5) Identification about whether there are any restrictions to communicating with a Member's Parent(s), Guardian(s) or Custodian(s), including termination of parental rights or a court order restricting communication.

c) Establish ongoing processes and timeframes for the County Child Welfare Worker to share the DSS Child Health Summary Components, to the extent available and applicable, with the care manager.
d) Establish a schedule of regular check-ins between the care manager and the County Child Welfare Worker, as required below.
e) Work with the County Child Welfare Worker to manage any immediate health-related crises, including securing access to crisis services or medically necessary residential treatment services, as needed.
f) Develop a plan for managing future crises for each Member, including crises related to self-harm, suicide attempts, and substance use as appropriate for Members with a documented history of these crises.

cc. *Section V.D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, ii. Coordination with County Child Welfare Workers, 7)* is revised and restated in its entirety as follows:

7) The CFSP shall make "best efforts" to communicate with a Member's County Child Welfare Worker within twenty-four (24) hours of being informed about any of the following occurring in order to determine needed interventions, coordinate those interventions with the County Child Welfare Worker, and update the Member's Care Plan/ISP, as needed (this may be the assigned care manager or another care manager/supervising care manager providing coverage if the assigned care manager is not available). For this requirement, the Department defines "best efforts" as including at least three (3) documented follow-up attempts to contact the Member's County Child Welfare Worker if the first attempt is unsuccessful:

a) Member is admitted to or discharged from an inpatient level of care;
b) Member visits an ED;
c) Member is admitted to an institutional level of care or other congregate setting;
d) Member experiences a BH crisis;
e) Member experiences a disruption in school enrollment or is suspended from school (e.g., Member is expelled or is required to change schools);
f) Member becomes involved with the justice system;
g) Member is boarding in County DSS Office or other location awaiting access to medically necessary behavioral health treatment;
h) Member becomes pregnant;
i) Member experiences and discloses interpersonal violence; or
j) Member becomes unhoused.

dd. ***Section V.D. Care Management, 2. CFSP Care Management, i. Medication Reconciliation and Management, ii.*** **is revised and restated in its entirety as follows:**

ii. The care manager shall conduct Medication Reconciliation by utilizing claims and other data sources and working with the Member, the Member's Parent(s), Guardian(s), or Custodian(s) as applicable, the Member's assigned PCP, other providers serving the Member, and the assigned County Child Welfare Worker, as applicable, to identify the Member's current medications (prescribed and non-prescribed) and medication history. The care manager shall conduct Medication Reconciliation within the following timeframes:

1) For the first ninety (90) Calendar Days after CFSP launch: within thirty (30) Calendar Days of CFSP enrollment for Members identified through the CFSP's risk stratification as high risk and sixty (60) Calendar Days for all other Members.
2) Following the first ninety (90) Calendar Days after CFSP launch: within fourteen (14) Calendar Days of CFSP enrollment for Members identified through the CFSP's risk stratification as high-risk and thirty (30) Calendar Days for all other Members.
3) Upon request by the Member's Parent(s), Guardian(s), or Custodian(s), as applicable
4) For Members who remain enrolled in the CFSP after Aging Out of County DSS Custody or otherwise Exiting County DSS Custody, the CFSP shall make at least three (3) documented attempts to conduct a Medication Reconciliation within ninety (90) Calendar Days of the date on which the Member is Aging Out of County DSS Custody or otherwise Exiting County DSS Custody. For the purposes of this paragraph, best efforts means at least three (3) documented attempts to conduct Medication Reconciliation.

ee. ***Section V.D. Care Management, 2. CFSP Care Management, j. Care Management Comprehensive Assessment, v.*** **is revised and restated in its entirety as follows:**

v. Reserved.
1) Reserved.
2) Reserved.
3) Reserved.
4) Reserved.
5) Reserved.
6) Reserved.

ff. ***Section V.D. Care Management, 2. CFSP Care Management, j. Care Management Comprehensive Assessment, vi.*** **is revised and restated in its entirety as follows:**

vi. Reserved.

gg. ***Section V.D. Care Management, 2. CFSP Care Management, q. Additional Care Management Requirements for Members Obtaining 1915(i) Services*** **is revised and restated in its entirety as follows:**

q. Additional Care Management Requirements for Members Obtaining 1915(i) Services
   i. CFSP Care Management shall incorporate all 1915(i) care coordination activities, namely requirements for an Independent Assessment and development of a person-centered Care Plan/ISP, as required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.
   ii. The CFSP shall notify a Member's care manager when a Member requests or would benefit from 1915(i) Services so that the care manager can commence the Independent Assessment.
      1) The CFSP shall ensure that the Member's assigned CFSP care manager completes and submits to the Department or the Department's specified vendor the Member's 1915(i) independent assessment within fourteen (14) Calendar Days of the CFSP's receipt of a Member's request for or notification that a Member would like to receive 1915(i) services.
      2) Within forty-five (45) Calendar Days of the CFSP's receipt of the Member's 1915(i) eligibility determination, the Member's assigned care manager shall complete the Member's person-centered Care Plan and shall submit the Member's person-centered Care Plan to the CFSP for review and approval. The CFSP shall complete its review and communicate its decision on the Member's person-centered Care Plan within fourteen (14) Calendar Days of receiving the Member's person-centered Care Plan from the Member's assigned care manager.
      3) For 1915(i) services, the Member's person-centered Care Plan will be developed, signed and implemented after the eligibility decision is made.
   iii. The CFSP shall share the results of the Independent Evaluation for 1915(i) Services with the Member's care manager in an electronic format.
      1) The CFSP shall ensure the results of the Independent Assessment are incorporated into the Care Plan/ISP.
      2) The completion of the Independent Assessment does not trigger a full care management comprehensive assessment and may be an addendum or an update to a previous Care Management Comprehensive Assessment.
      3) The CFSP shall ensure that at a Member's annual reassessment, as described in *Section V.D.5. Care Management Policy*, the Independent Assessment for 1915(i) Services is included as part of the broader Care Management Comprehensive Assessment.
      4) For the Member's initial assessment and each annual reassessment, the CFSP shall share the results of the independent evaluation for 1915(i) services with the Member's assigned care manger within ten (10) business days of receiving the Member's 1915(i) eligibility determination.
      5) If the Member is reassigned to a new care manager, the CFSP shall share the results of the Member's most recent independent evaluation for 1915(i) services with the newly assigned care manager within ten (10) business days of the effective date of the Member's reassignment.

hh. ***Section V.D. Care Management, 2. CFSP Care Management, r. Additional Care Coordination Functions for Members Obtaining 1915(i) Services, i.*** **is revised to add the following*:***

3) For Members that have declined to participate in CFSP Care Management, the CFSP shall complete and submit a 1915(i) independent assessment to the Department or the Department's specified vendor within fourteen (14) Calendar Days of the CFSP receiving a Member's request for or notification that a Member is likely to benefit from 1915(i) services.
4) For Members that have declined to participate in CFSP Care Management, the CFSP shall complete the Member's person-centered Care Plan within forty-five (45) Calendar Days of receiving the Member's 1915(i) eligibility determination. A party at the CFSP who was not involved in the Member's 1915(i) assessment and/or development of the Member's 1915(i) person-centered Care Plan shall review and make a determination on approval of the Member's person-centered Care Plan within fourteen (14) Calendar Days of receiving the Member's completed person-centered Care Plan.
    a) For 1915(i) services, Care Plans will be developed, signed and implemented after the eligibility decision is made.

ii. ***Section V.D. Care Management, 2. CFSP Care Management, r. Additional Care Coordination Functions for Members Obtaining 1915(i) Services, iii.*** **is revised and restated in its entirety as follows*:***

iii. Reserved.

jj. ***Section V.D. Care Management, 2. CFSP Care Management, v. Guardrails for Communication and Consent for Members in County DSS Custody*** **is revised and restated in its entirety as follows*:***

v. Guardrails for Communication and Consent for Members in County DSS Custody
    i. The CFSP shall adhere to all applicable federal and state privacy laws for all Members. Nothing in this section will supersede a Member's right to privacy and protection of health information as required by federal and state law.
    ii. For Members in County DSS Custody:
        1) Upon enrollment in the CFSP, the CFSP shall obtain information from the County Child Welfare Worker to identify whether there are any restrictions on communicating with a Member's Parent(s), Guardian(s), or Custodian(s), including termination of parental rights or court order restricting communication.
        2) The CFSP shall provide medical records to the County Child Welfare Worker, as requested and consistent with all federal and state laws (*Section V.D.2.e.xii. Consolidation of Medical Records*):
            a) Reserved.
            b) Reserved.
            c) Reserved.
            d) Reserved.
            e) Reserved.
            f) Reserved.
        3) Reserved.
            a) Reserved.
            b) Reserved.
            c) Reserved.
        4) Reserved.
        5) Reserved.

kk. ***Section V.D. Care Management, 4. Other Care Management Programs, b. Local Health Departments*** **is revised and restated in its entirety as follows*:***

b. Reserved.

ll. ***Section V.D. Care Management, 4. Other Care Management Programs, c. PMP in Coordination with CCMHRP Women*** **is revised and restated in its entirety as follows*:***

c. Reserved.

mm. ***Section V.D. Care Management, 4. Other Care Management Programs, e. High-Fidelity Wraparound, i., 3)*** **is revised and restated in its entirety as follows:**

3) Reserved.

nn. ***Section V.D. Care Management, 4. Other Care Management Programs, e. High-Fidelity Wraparound, iii. High-Fidelity Wraparound Services and Fidelity Monitoring, 1)*** **is revised and restated in its entirety as follows:**

1) Reserved.

oo. ***Section V.D. Care Management, 6. System of Care, b. System of Care Staffing Requirements, ii., 11)*** **is revised and restated in its entirety as follows:**

11) Reserved.

pp. ***Section V.D. Care Management, 6. System of Care, b. System of Care Staffing Requirements, ii., 14)*** **is revised and restated in its entirety as follows:**

14) Reserved.

qq. ***Section V.D. Care Management, 8. Prevention and Population Health Programs, c. Opioid Misuse Prevention and Treatment Program, ii., 1), g)*** **is revised and restated in its entirety as follows:**

g) Plan to meet network adequacy for medication-assisted treatment for opioid use disorders as determined by the Department, including the standards laid out in the *Section VII. Attachment E. CFSP Network Adequacy Standards,* SA Comprehensive Outpatient (adult), SA Intensive Outpatient Program (adults and children), and Opioid treatment (adult);

rr. ***Section V.D. Care Management, 10. Relocation of Members Following Emergency Residential Care Facility Closures, f. Out of State Placements i.*** **is revised and restated in its entirety as follows:**

i. Reserved.

ss. ***Section V.E. Providers, 1. Provider Network, g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207),*** **is revised to add the following:**

vii. Describe the CFSP's plan to ensure provider availability to cover Cell and Gene Therapy services.

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

xxi. Reserved.

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

xxix. Tobacco-Free Policy

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 only applies to settings and/or services that are included within the scope of services of this Contract. 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) Starting January 1, 2027, the following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities, applicable only to the degree that the setting and/or service is within the scope of services of this Contract:
    a) 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.
    b) Outdoor areas of the property under the provider's control as owner or lessee shall:
        i) Ensure access to common outdoor space(s) free from exposure to tobacco use;
        ii) Prohibit staff/employees from using tobacco products anywhere on the property; and
        iii) Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.
3) 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.

vv. *Section V.E. Providers, 2. Provider Network Management, e. Critical Incident Reporting* is revised and restated in its entirety as follows:

e. Critical Incident Reporting
    i. The CFSP shall establish a written process or policy for timely identification, response, reporting, and follow-up to Member incidents and for reviewing, investigating, and analyzing trends in critical incidents, and deaths. The policy or process shall also include preventative action efforts to minimize the occurrence or recurrence of critical incidents. The policy or process shall be

submitted by the CFSP to the Department by June 30, 2026, and annually by June 30th of each calendar year, thereafter.

ii. The CFSP shall require Category A and Category B providers, as those terms are defined in 10A NCAC 27G .0602(8) to report Level II and Level III incidents, as those terms are defined in 10A NCAC 27G .0602(4) and (5) in the NC Incident Response Improvement System.

ii. The CFSP shall monitor and respond to critical incidents in the same manner in which the requirements in 10A NCAC 27G .0608 are applicable to Local Management Entity to ensure the health and safety of Members enrolled in the CFSP.

iv. Reserved.

v. The CFSP shall ensure that Category A and Category B provider contracts are updated to include compliance with incident reporting requirements specified in *Attachment F. Required Standard Provisions for CFSP and Provider Contracts.* If a CFSP determines that a Provider is not complying or there are trends in incident reporting, the CFSP shall utilize processes including but not limited to Provider monitoring and corrective actions to minimize the occurrence of preventable incidents and to ensure health and safety of Members receiving services.

vi. Reserved.

vii. Reserved.

ww.*Section V.E. Providers, 2. Provider Network Management, h. Credentialing and Re-credentialing Process, ii., 1)* is revised and restated in its entirety as follows:

1) The CFSP shall make timely Network contracting decisions using the process outlined in the CFSP's Provider Manual.

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

v. Re-credentialing: Providers are re-credentialed no less than every five (5) years through the Department's centralized credentialing process. The CFSP shall evaluate a contracted Provider's continuing eligibility to participate in the CFSP's Network by confirming the appearance of the Provider each day on the daily Provider Enrollment File (PEF).

1) Reserved.
2) Reserved.

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

i. Unless otherwise written in the contract, the CFSP shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a member and billed to the CFSP by the Provider:
   1) New Medicaid Enrolled Provider (other than hospital(s) or facility Provider(s)): within ten (10) Business Days after contract execution;
   2) New Medicaid Enrolled hospital or facility Provider: within fifteen (15) Business Days after contract execution;
   3) New Medicaid Enrolled Provider attached to an existing contract: within five (5) Business Days after contract execution;

4) Changes for a re-enrolled Medicaid Provider, hospital, or facility attached to an existing contract: within five (5) Business Days from the CFSP's receipt of notification of the change through the Medicaid Enrolled Provider data received from the Department;
5) Change to existing contract terms: within ten (10) Business Days of the effective date after the change; and
6) Changes to a Provider's service location or demographic data or other information related to a Member's access to services: no later than thirty (30) Calendar Days after the CFSP receives updated Provider information as indicated on the PEF file.

zz. ***Section V.E. Providers, 2. Provider Network Management, j. Network Provider Credentialing and Re-credentialing Policy, i.*** **is revised to add the following:**

v. The CFSP shall establish and maintain a process to make network contracting decisions in accordance with the Department's Credentialing and Recredentialing Policy and any other applicable requirements under this Contract.

aaa. ***Section V.E. Providers, 2. Provider Network Management, k. Provider Disenrollment and Termination, iii. 1)*** **is revised and restated in its entirety as follows:**

1) Within one (1) Business Day of receiving notification via the Provider Enrollment File (PEF) from the Department that a Provider has been terminated as a Medicaid provider, the CFSP shall remove the Provider from the CFSP's Provider Network File (PNF) and shall end-date payment to the Provider for services furnished on or after the effective date of the Provider's termination as a Medicaid provider. In addition to end-dating payments to the Provider for services furnished on or after the effective date of the Provider's termination and removing the Provider from the CFSP's PNF, the CFSP shall, within fourteen (14) Calendar Days of receiving notice via the PEF that the Provider is terminated as a Medicaid provider, terminate the Provider's contract and issue a written termination notice without appeal rights to the Provider. The termination notice shall state that the effective date of the termination is the effective date of the Provider's termination as Medicaid provider. This provision applies to all Providers regardless of the Provider's Network status.

bbb. ***Section V.E. Providers, 2. Provider Network Management, k. Provider Disenrollment and Termination, iv. 1)*** **is revised and restated in its entirety as follows:**

1) The CFSP may terminate a Provider from its Network with cause (e.g., due to quality issues not remedied under a corrective action plan or for other breaches of its agreement with the Provider). Any decision to terminate must comply with the requirements of the Contract. Termination is not an adverse determination as that term is defined in NCGS § 108C-2(1). Termination by a CFSP of all or part of a Provider contract is not termination or disenrollment from the Medicaid Program by the Department.

ccc. ***Section V.E. Providers, 3. Provider Relations and Engagement, b. Provider Relations: Service Line; Provider Web Portal; Provider Welcome, iv.*** **is revised and restated in its entirety as follows:**

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

ddd. ***Section V.E. Providers, 3. Provider Relations and Engagement, d. Provider Manual, i., 5)*** **is revised and restated in its entirety as follows:**

5) Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, Credentialing, Re-credentialing, access requirements, no-reject requirements, notification of changes in address, and required availability;

eee. ***Section V.E. Providers, 4. Provider Payments, e. Hospital Payments (Excluding Behavioral Health Claims), v.-viii.*** **is revised and restated in its entirety as follows:**

v. Reserved.
vi. Reserved.
vii. Reserved.
viii. Reserved.

fff. ***Section V.E. Providers, 4. Provider Payments, i. Local Health Department (LHD) Payments, ii.*** **is revised and restated in its entirety as follows:**

ii. Reserved.

ggg. ***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)), x.-xii.*** **is revised and restated in its entirety as follows:**

x. Reserved.
    1) Reserved.
    2) Reserved.
    3) Reserved.
    4) Reserved.
xi. Reserved.
    1) Reserved.
    2) Reserved.
    3) Reserved.
xii. Reserved.
    1) Reserved.
    2) Reserved.
    3) Reserved.

hhh. ***Section V.E. Providers, 4. Provider Payments, m. Nursing Facility Payments, i.*** **is revised and restated as follows:**

i. The CFSP shall reimburse in-network nursing facilities (excluding those owned and operated by the State) according to the Department's fee schedule posted to the Department's Fee Schedules and Covered Codes portal, unless the CFSP and provider have mutually agreed to an alternative reimbursement arrangement.

iii. ***Section V. E. Providers, 4. Provider Payments, p. Payments of Medical Home Fees to AMH, ii.*** **is revised and restated 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 four dollars and eighty-five cents ($4.85) PMPM.

jjj. ***Section V.E. Providers, 4. Provider Payments, aa. EVV System, ii.*** **is revised and restated in its entirety as follows:**

ii. The CFSP shall pay to Providers of Home Health Care Services (HHCS) identified in this Section and who are subject to EVV requirements a reimbursement rate increase in an amount that is no less than ten percent (10%) of the reimbursement rate paid for the applicable HHCS:

1) Physical Therapy;
2) Physical Therapy evaluation;
3) Occupational Therapy;
4) Occupational Therapy evaluation;
5) Speech-language Pathology services;
6) Speech-language Pathology services evaluation;
7) Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or sixty (60) Calendar Day re-assessment);
8) Skilled nursing: Treatment, teaching/training, observation/evaluation;
9) Skilled nursing: venipuncture;
10) Skilled nursing: Pre-filling insulin syringes/Medi-Planners; and
11) Home Health Aide.

kkk. ***Section V.F. Quality and Value, 1. Quality Management and Quality Improvement, m. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)*** **is revised to add the following:**

vi. If the CFSP performs below seventy-five percent (75%) for overall CMS 416 rates, the CFSP shall submit one Performance Improvement Project on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical Performance Improvement Projects annually.

lll. ***Section V.F. Quality and Value, 2. Value-Based Payments/Alternative Payment Models e.*** **is revised and restated in its entirety as follows:**

e. Reserved.

i. Reserved.
ii. Reserved.
iii. Reserved.

mmm. ***Section V.F. Quality and Value, 2. Value-Based Payments/Alternative Payment Models, f., v.*** **is revised and restated in its entirety as follows:**

v. Reserved.

1) Reserved.
2) Reserved.
3) Reserved.
4) Reserved.
5) Reserved.
6) Reserved.
7) Reserved.

nnn. ***Section V.I. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, vi., 2)*** **is revised and restated in its entirety as follows:**

2) Reserved.

ooo. *Section V.I. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i., 4)* is revised and restated in its entirety as follows:

4) The CFSP shall pay medical home fees and care management fees, that includes AMH and Healthy Opportunities Pilot payments, by no later than the last day of each month however, payment for each month shall be based upon Member's enrollment with the CFSP at the beginning of the same month.

ppp. *Section V.I. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., 1) Timeliness, d), i)* is revised and restated in its entirety as follows:

i) Medical: for purposes of determining if the CFSP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters.

qqq. *Section V.I. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., 2) Accuracy, a), i)* is revised and restated in its entirety as follows:

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

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

a. Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of the CFSP. Capitation payments include monthly PMPM payments, maternity event payments, NC Select Drug Case Payments, and payments for additional directed payments to certain providers as required under the Contract.

sss. *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, maternity event and NC Select Drug Case capitation payments.

ttt. *Section V.J. Financial Requirements, 1. Capitation Payments,* is revised to add the following:

i. The Department has established a separate NC Select Drug Case payment for certain drugs on the NC Select Drug List, as indicated on the applicable rate sheet in *Section VIII: CFSP Data Book and Capitation Rate Methodology*. This payment will be made to the Contractor based on NC Select Drugs reported as paid claims in the NC Select Drug Report as defined in *Second Revised and Restated*

Attachment I: Reporting Requirements and the corresponding encounter being accepted by the Department through the Encounter Processing System.

uuu. *Section V.J. Financial Requirements, 2. Medical Loss Ratio* is revised and restated in its entirety as follows:

2. **Medical Loss Ratio**

a. The Medical Loss Ratio (MLR) standards are to ensure the CFSP is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.

b. The CFSP shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:

i. The CFSP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).

1) CMS-defined MLR shall be reported in aggregate, combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

ii. The numerator of the CFSP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the CFSP's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).

iii. The denominator of the CFSP's CMS-defined MLR for a MLR reporting year shall equal the CFSP's adjusted premium revenue. The adjusted premium revenue shall be defined as the CFSP's premium revenue minus the CFSP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).

iv. The CFSP shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.

1) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:

a) The CFSP is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and health equity that align with the Department's Quality Strategy and meet the following conditions:

i) Reflect meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas; and

ii) Are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

b) The CFSP is prohibited from including in the Department-defined MLR numerator any of the following expenditures:

i) Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation payments, NC Select Drug Case Payments and maternity event payments; and

ii) Payments to related providers that violate the Payment Limitations as required in the Contract.

c) The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:

i) Payments from the Department to reimburse for required additional directed or wrap payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

2) For Contract Year 1, the CFSP shall calculate the Department-defined MLR in aggregate for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:

i. The CFSP's classification of activities that improve health care quality, and initiatives that advance public health and health equity, shall be subject to Department review and approval.

ii. The CFSP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:

1) Interest or penalty payments to providers for failure to meet prompt payment standards;

2) Fines and penalties assessed by the Department or other regulatory authorities;

3) Rebates paid to the Department if the CFSP's Department-defined MLR is less than the minimum MLR threshold for a prior year;

4) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of rebates paid to the Department if the CFSP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in Section V.J.2.d. of this Contract;

5) The CFSP shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), PBM fees and spread pricing, marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations; and

6) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of remittances paid to the Department if the CFSP's risk corridor measurement resulted in a payment to the Department for a prior year, as described in *Sections V.J.2.j.xi.9*) of this Contract.

iii. The CFSP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating the CMS-defined MLR and the Department-defined MLR for Contract Year 1.

iv. The CFSP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), if the CFSP has fewer than 380,000 Member months in a MLR reporting year.

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

vi. The CFSP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.

d. If the CFSP's Department-defined MLR is less than the minimum MLR threshold, the CFSP shall do one of the following:

i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;

ii. Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.D.9. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;

iii. Reserved; and

iv. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources and/or Department-approved public health and Health Equity

investments, the remaining portion to a rebate to the Department, with amounts for the CFSP subject to approval by the Department.

e. The minimum MLR threshold for the CFSP shall be eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49.

f. The CFSP must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports, in accordance with 42 C.F.R. § 438.8(n).

g. The CFSP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the CFSP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year or within thirty (30) Calendar Days of being requested by the CFSP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting, in accordance with 42 C.F.R. § 438.8(k)(3).

h. In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the CFSP shall:
   i. Re-calculate the MLR for all MLR reporting years affected by the change; and
   ii. Submit a new MLR report meeting the applicable requirements, in accordance with 42 C.F.R. § 438.8(m).

i. Starting January 1, 2026, CFSP shall require any risk-bearing Subcontractor, as defined by the Department, to calculate and report the CMS-defined MLR experienced in an MLR reporting year as defined in 42 C.F.R. § 438.8. The first MLR reporting year for vendors will be January 1, 2026 – June 30, 2026 and aligned with the CFSP's rating period thereafter.
   i. The CFSP shall require Subcontractors to calculate and report MLR consistent with the Department requirements in 42 C.F.R. § 438.8(c) and 438.8(k) on an aggregate basis combining experience for Medicaid Expansion Eligible Members and non-Medicaid Expansion populations.
   ii. The CFSP's Subcontractor(s) shall apply a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3) using the CMS published credibility factors.
   iii. The CFSP's Subcontractor(s)'s report shall be submitted to the CFSP within one hundred eighty (180) Calendar Days of the end of the MLR reporting year.
   iv. The CFSP may require that all classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity be submitted to the CFSP for review and approval. Any activities approved by the CFSP shall be submitted to the Department for review and approval prior to the Subcontractor's inclusion of the activities in the calculation of its MLR. All activities that the CFSP requests to include in the CFSP's MLR calculations must be submitted to the Department.
   v. The CFSP shall report the outcome of Subcontractor MLR calculations in the MLR templates and associated instructions to be provided by the Department.

j. Risk Corridor

   A risk corridor arrangement between the CFSP and the Department will apply to share in gains and losses of the CFSP populations as defined in this section. The Risk Corridor payments to and recoupments from the CFSP will be based on a comparison of the CFSP's reported Risk Corridor Services Ratio ("Reported Services Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the CFSP Rate Book ("Target Services Ratio").

i. The Risk Corridor Measurement Period is defined as:
   1) For Period 1, December 1, 2025 – June 30, 2026.

ii. For Period 1, the risk corridor shall be calculated in aggregate across Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

iii. The risk corridor payments and recoupments will be based on a comparison of the CFSP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the CFSP Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

iv. The CFSP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the CFSP Rate Book and weighted by the CFSP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based and/or wrap payments).

v. The Reported Services Ratio numerator shall be the CFSP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care program. The numerator shall be defined as the sum of:
   1) Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments or wrap payments.
   2) Advanced Medical Home Fees as defined in *Section V.E.4. Provider Payments* including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department.
   3) Performance Incentive Payments to Advanced Medical Homes as defined in *Section V.E.4. Provider Payments*.
   4) Other quality-related incentive payments to NC Medicaid providers.
   5) Non-claims-based provider stabilization payments to support provider sustainability and beneficiary access.
   6) Contributions to community-based health-related resources and initiatives that advance public health and Health Equity, subject to Department review and approval.

vi. The CFSP is prohibited from including in the Reported Services Ratio numerator the following expenditures:
   1) Payments to providers for delegated Care Management.
   2) Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department.
   3) Interest or penalty payments to providers for failure to meet prompt payment standards.
   4) Payments to related providers that violate the Payment Limitations as required in the Contract.
   5) Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation, NC Select Drug Case Payments and maternity event payments.
   6) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of rebates paid to the Department if the CFSP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in Sections V.J.2.d. of this Contract.
   7) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of remittances paid to the Department if the CFSP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Sections* V.J.2.d. of this Contract.

vii. The Reported Services Ratio denominator represents the Medicaid managed care capitation revenue received by the CFSP for enrollments effective during the Risk Corridor Measurement Period. The denominator shall be equal to the Department-defined MLR denominator.

viii. CFSP shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

ix. The CFSP must provide an attestation of the accuracy of the information provided in its submitted risk corridor calculations, as specified in 42 C.F.R. § 438.606.

x. Terms of the Risk Corridor

1) If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the CFSP shall pay the Department eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus three percent (3%) and the Reported Services Ratio.
2) If the Reported Services Ratio is greater than the Target Services Ratio plus three percent (3%), the Department shall pay the CFSP eight percent (80%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).

xi. Risk Corridor Settlement and Payments

1) The Department will complete a settlement determination for the Risk Corridor Measurement Period.
2) The CFSP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
3) The CFSP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
4) The CFSP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.
5) The Department may choose to review or audit any information submitted by the CFSP.
6) The Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.
7) The Department will provide the CFSP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The Risk Corridor Settlement shall become final if dispute resolution is not requested pursuant to *Section VI. G. Dispute Resolution*.
8) If the final Risk Corridor Settlement requires the CFSP to remit funds to the Department, the CFSP must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.
9) At the sole discretion of the Department, the Department may allow the CFSP to contribute all or a part of the amount otherwise to be remitted to:
    a) Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
    b) Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.
10) To be considered for the in lieu of remittance option, the CFSP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the CFSP's interim Risk Corridor Services Ratio report.

11) If the CFSP has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the CFSP by offsetting a subsequent monthly capitation payment.
12) If the final Risk Corridor Settlement requires the Department to make additional payment to the CFSP, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the CFSP initiates a dispute as described in accordance with *Section VI. G. Dispute Resolution*, the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

vvv. *Section V.K. Compliance, 4. Third Party Liability (TPL), i. Identification of Other Forms of Insurance, i.* is revised and restated in its entirety as follows:

i. The CFSP shall load updates and additions on other forms of insurance into its system within five (5) Business Days of matching and verification and the CFSP is required to review State TPL data prior to denying any claim for TPL or other insurance. The CFSP shall submit to the Department via an upload onto NCTracks the other found insurance results weekly.

www. *Section V.L. Technical Specifications, 9. CFSP Data Management and Health Information Systems, b. North Carolina's Health Information Exchange,* is revised to add the following:

ii. Pursuant to NCGS § 90-414.4(a1)(3), the CFSP may authorize the Department to submit the required data to NC HealthConnex on behalf of the CFSP.

3. Modifications to *Section VI. Contract Performance*:

Specific subsections of the Contact are modified as follows:

***a. Section VI., G. Dispute Resolution, 3. Dispute Resolution Procedures* is revised and restated as follows:**

3. Dispute Resolution Procedures
   a. To initiate a dispute, the CFSP shall submit a written request for dispute resolution within thirty (30) Calendar Days of the date of the written notice imposing the Department's intended action. The Department may extend the CFSP's deadline to request dispute resolution for good cause if the CFSP requests an extension within ten (10) Calendar Days of the date on the written notice.
   b. The CFSP shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
   c. The CFSP waives any dispute not raised within thirty (30) Calendar Days of the date on the written notice imposing any proposed action by the Department (unless the Department grants an extension).
   d. The CFSP also waives any arguments it fails to raise in writing within thirty (30) Calendar Days (unless the Department grants an extension) of the date of the written notice imposing the proposed action, and waives the right to use any materials, data, and information not contained in or accompanying the CFSP's written request for dispute resolution in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
   e. The Department shall review the dispute resolution request and submitted evidence and information and issue a written final decision within sixty-five (65) Calendar Days of the CFSP's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the CFSP of any extension and the reason for such extension.
   f. The final decision issued by the Department following dispute resolution shall not be subject

to further review or Appeal within the Department.

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

   a. *Section VII. Attachment B: Summary of Medicaid Services* is revised and restated in its entirety and renamed *First Revised and Restated Attachment B: Summary of Medicaid Services* and attached to this Amendment.

   b. *Section VII. Attachment D: Required CFSP Quality Metrics* is revised and restated in its entirety and renamed *First Revised and Restated Attachment D: Required CFSP Quality Metrics* and attached to this Amendment.

   c. *Section VII. Attachment E: CFSP Network Adequacy Standards* is revised and restated in its entirety and renamed *First Revised and Restated Attachment E: CFSP Network Adequacy Standards* and attached to this Amendment.

   d. *Section VII. Second Revised and Restated Attachment F: Required Standard Provisions for CFSP and Provider Contracts* is revised and restated in its entirety and renamed *Third Revised and Restated Attachment F: Required Standard Provisions for CFSP and Provider Contracts* and attached to this Amendment.

   e. *Section VII. First Revised and Restated Attachment I. Reporting Requirements* is revised and restated in its entirety and renamed *Second Revised and Restated Attachment I. Reporting Requirements* and attached to this Amendment.

   f. *Section VII. Second Revised and Restated Attachment L. Policies* is revised and restated in its entirety and renamed *Third Revised and Restated Attachment L. Policies* and attached to this Amendment.

   g. *Section VII. Attachment M: Addendum for Division of State Operated Healthcare Facilities* is revised and restated in its entirety and renamed *First Revised and Restated Attachment M: Addendum for Division of State Operated Healthcare Facilities* and attached to this Amendment.

   h. *Section VII. Attachment N: Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* is revised and restated in its entirety and renamed *First Revised and Restated Attachment N: Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* and attached to this Amendment.

   i. *Section IX.J. First Revised Business Associate Agreement* is revised and restated in its entirety and renamed *Section IX.J. Second Revised Business Associate Agreement* and attached to this Amendment.

5. **Effective Date:** This Amendment is effective December 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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Angela Boykin, Chief Executive Officer (CEO)

Date: 11/25/25 | 12:27 PM PST

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

DocuSigned by:
Jay Ludlam
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Date: 11/21/25 | 12:22 PM EST

Jay Ludlam, Deputy Secretary
NC Medicaid

First Revised and Restated Attachment B: Summary of Medicaid Services

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services below documents the set of Medicaid services that will be covered by the CFSP. Full details on the Clinical Coverage Policies are available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
Inpatient Hospital Services	Services that: ▪ Are ordinarily furnished in a hospital for the care and treatment of inpatients; ▪ Are furnished under the direction of a physician or dentist; and ▪ Are furnished in an institution that - ▪ Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; ▪ Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; ▪ Meets the requirements for participation in Medicare as a hospital; and ▪ Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: ▪ Swing Bed Hospitals: a hospital or Critical Access Hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R.§ 482.66. ▪ Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a).	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. § 440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	▪ Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid and NCHC beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three (3) hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well- documented cases, this intensive rehabilitation therapy program might instead consist of at least fifteen (15) hours of intensive rehabilitation therapy within a seven (7) consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. ▪ Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. ▪ Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. ▪ Inpatient hospital services do not include Skilled Nursing Facility and Intermediate	

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	Care Facility services furnished by a hospital with a swing-bed approval. ▪ Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
Outpatient Hospital Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: ▪ Are furnished to outpatients; ▪ Are furnished by or under the direction of a physician or dentist; and ▪ Are furnished by an institution that: (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and ▪ May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. ▪ Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)	Any service that is Medically Necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	federal law at 42U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	NC Clinical Coverage EPSDT Policy Instructions *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* of the Contract
Nursing Facility Services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. § 440.40 42 C.F.R. § 440.140 42 C.F.R. § 440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Home Health Services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	
Physician Services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be Medically Necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life- endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy

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Service	**Description**	**References**
		NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation

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Service	**Description**	**References**
		NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1B, Physician's Drug Program
Rural Health Clinics	The specific health care encounters that constitute a core service include the following face to face encounters:	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411

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	a. Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. Services provided by physician assistants and incident services supplied; c. Nurse practitioners and incident services supplied; d. Nurse midwives and incident services supplied; e. Clinical psychologists and incident services supplied; and f. Clinical social workers and incident services supplied.	42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Federally Qualified Health Center (FQHC) Services	The specific health care encounters that constitute a core service include the following face to face encounters: a. Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. Services provided by physician assistants and incident services supplied; c. Nurse practitioners and incident services supplied; d. Nurse midwives and incident services supplied; e. Clinical psychologists and incident services supplied; and f. Clinical social workers and incident services supplied.	SSA, Title XIX, Section 1905(a)(2)(c) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments

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		NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Telemedicine	The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Communications and Remote Patient Monitoring
Laboratory and X-ray Services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1- A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1S-9, Genetic Testing for Diagnosis and Treatment

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Service	**Description**	**References**
		NC Clinical Coverage Policy 1S-10, Genetic Testing for Carrier and Prenatal NC Clinical Coverage Policy 1S-11, Genetic Testing - Gene Expression NC Clinical Coverage Policy 1S-12, Genetic Testing - Next Generation Sequencing (NGS) NC Clinical Coverage Policy 1S-13, Cell and Gene Therapies NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology
Family Planning Services	Regular Medicaid Family Planning (Medicaid FP) services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Certified Pediatric and Family Nurse Practitioner Services	a. Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section. b. If the State specifies qualifications for pediatric nurse practitioners, the practitioner must: i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a

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	qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. c. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must: i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. d. Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. e. If the State specifies qualifications for family nurse practitioners, the practitioner must: i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. f. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must: i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a family nurse practice	

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	limited to providing primary health care to individuals and families.	
Freestanding Birth Center Services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Non-Emergent Transportation to Medical Care	Medicaid is required to assure transportation to and from medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-D, Page 1-4 Non-Emergency Medical Transportation Managed Care Policy
Ambulance Services	Ambulance services provide Medically Necessary treatment for NC Medicaid Program beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non- emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Clinical Coverage Policy 15
Tobacco Cessation Counseling for Pregnant Women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Prescription Drugs and Medication Management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program

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		NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters *Section V.C.3. Pharmacy Benefits* of the Contract
Clinic Services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: a. Services furnished at the clinic by or under the direction of a physician or dentist. b. Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments

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Service	**Description**	**References**
	operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
Physical Therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Occupational Therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Audiology Therapy	Services to identify children with auditory impairment, using at risk criteria	North Carolina Medicaid State Plan, Att., 3.1-A.1, Page 7c.15

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	and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for the rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use, and evaluation. These services must be provided by an Audiologist. As defined in 42 CFR § 440.110, an Audiologist who has a valid license issued by the NC Board of Examiners for Speech and Language Pathologists and Audiologists.	NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Speech, Hearing, and Language Disorder Services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Inpatient and Outpatient Behavioral Health Services and IDD Services.	Except as noted in the relevant State Plan and clinical coverage policies, there must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17

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	preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35, NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services: • Mobile Crisis Management • Intensive-In-Home Services • Multisystemic Therapy • Child and Adolescent Day Treatment • Partial Hospitalization • Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment) • Clinically Managed Residential Services (substance abuse non-medical community residential treatment) NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-6: Community Support Team (CST) NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification)

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Service	**Description**	**References**
		NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-9: Opioid Treatment Program (OTP) NC Clinical Coverage Policy 8A-10: Clinically Managed Residential Withdrawal Management Services (Social Setting Detox) NC Clinical Coverage Policy 8A-11: Medically Monitored Inpatient Withdrawal Management Services (non-hospital medical detoxification) NC Clinical Coverage Policy 8A-12: Substance Abuse Intensive Outpatient Program NC Clinical Coverage Policy 8A-13: Substance Abuse Comprehensive Outpatient Treatment Program NC Clinical Coverage Policy 8B: Inpatient BH Services • Medically Managed Intensive Inpatient Withdrawal Management Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21

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		North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services North Carolina Clinical Coverage Policy 8D-3: Clinically Managed Low-intensity Residential Treatment Services[£] North Carolina Clinical Coverage Policy 8D-4: Clinically Managed Population-Specific High Intensity Residential Program[£] North Carolina Clinical Coverage Policy 8D-5: Clinically Managed Residential Services (Substance Abuse Non-Medical Community Residential Treatment)[£] North Carolina Clinical Coverage Policy 8D-6: Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Community Residential Treatment)[£] NC Clinical Coverage Policy 8F – Researched Based BH Treatment (RB-BHT) for Autism Spectrum Disorders NC Clinical Coverage Policy 8G – Peer Support Services 8H-1: 1915(i) Supported Employment for IDD and TBI

[£] Policy effective January 1, 2026.

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		8H-2: 1915(i)Individual Placement and Support (IPS) 8H-3: 1915(i) Individual and Transitional Support (ITS) 8H-4: 1915(i) Respite 8H-5: 1915(i) Community Living and Supports (CLS) 8H-6: 1915(i) Community Transition NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH) 8J. Children's Developmental Service Agencies (CDSAs) 8L: Mental Health/Substance Abuse Targeted Case Management
Respiratory Care Services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	SSA, Title XIX, Section 1905(a) (20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services

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Other Diagnostic, Screening, Preventative and Rehabilitative Services	a. Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; b. With respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; c. Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5

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	best possible functional level.	
Podiatry Services	Podiatry, as defined by G.S. § 90-202.2, "is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less."	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Optometry Services	Medicaid shall cover the following optical services when provided by ophthalmologists and optometrists: a. Routine eye exams, including the determination of refractive errors; b. Prescribing corrective lenses; and c. Dispensing approved visual aids. Opticians may dispense approved visual aids.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1- A.1, Page 10a G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Chiropractic Services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services

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Private Duty Nursing Services	Medically Necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. §440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13bNC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age

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	North Carolina Board of Nursing and employed by a licensed home care agency. A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.	
Personal Care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c. In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)

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Service	**Description**	**References**
	workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.	
Hospice Services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.	
Durable Medical Equipment (DME)	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: a. Inexpensive or routinely purchased items b. Capped rental/purchased equipment c. Equipment requiring frequent and substantial servicing d. Oxygen and oxygen equipment e. Related medical supplies f. Service and repair g. Other individually priced items h. Enteral nutrition equipment	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Prosthetics, Orthotics and Supplies	Medically Necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be Medically Necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Home Infusion Therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	care home. Covered services include the following: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy	
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole- body radiation therapy.	North Carolina Medicaid State Plan, Page 27, Att. 3.1- E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
		NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem- Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
		NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multi-visceral Transplants NC Clinical Coverage Policy 11B-9, Thymus Tissue Implantation
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device
Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4;

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. c. The clinical management of the patient unconscious from whatever cause. d. The evaluation and management of acute or chronic pain. e. The management of problems in cardiac and respiratory resuscitation. f. The application of specific methods of respiratory therapy. g. The clinical management of various fluid, electrolyte, and metabolic disturbances.	NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c)NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV Case Management Services	Assists in gaining access to needed medical assistance to facilitate the beneficiary's medical, social, and educational needs. HIV Case Management contains the following core service components: assessment, care planning, referral and linkage, monitoring and follow-up.	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
		NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non- therapeutic Abortions NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Management Program
Ophthalmological Services	General ophthalmologic services include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. c. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter- Products

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
		NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
Vision Services	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; medically necessary contact lenses, and dispensing approved visual aids (medically necessary contact lenses and eyeglasses).	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	Telehealth: Telehealth is the use of two-way real- time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual Patient Communications is the use of technologies other than video to enable	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered Virtual Patient Communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.	
Cell and Gene Therapies	Medicaid covers Cell and Gene Therapies for beneficiaries who meet specific criteria. The therapy must: a. Have U.S. Food and Drug Administration (FDA) approval.	NC Clinical Covery Policy 1S-13, Cell and Gene Therapies

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	b. Meet the definition of a covered outpatient drug as defined in 42 CFR § 447.502. c. Come from a manufacturer enrolled in the Medicaid Drug Rebate Program. d. Be administered in accordance with FDA-approved guidelines, including: 1. Indications and usage. 2. Dosage and administration. 3. Dosage forms and strengths. 4. Warnings and precautions. e. Be provided at a Qualified Treatment Center (QTC) or Authorized Treatment Center (ATC) approved for administering the therapy, as applicable. f. In some cases, the State will publish PA criteria for a specific therapy. In this case, the PA criteria will take precedence over the FDA label. In addition, Medicaid covers Non-Emergency Medical Transportation (NEMT) to assist beneficiaries with transportation to medical appointments. Medicaid does not cover Cell and Gene Therapies under the following circumstances: a. The therapy has not received FDA approval. b. The therapy is administered outside FDA guidelines, including: 1. Indications and usage. 2. Dosage and administration. 3. Dosage forms and strengths. c. The therapy is provided at an unapproved facility. d. The beneficiary is receiving repeat treatment with the same or another Cell or Gene Therapy. e. Psychosocial or non-compliance issues prevent adherence to pre- and post-infusion medical care.	

Section VII. First Revised and Restated Attachment B. Table 1: Summary of Medicaid Services (Effective December 1, 2025)		
Service	**Description**	**References**
	Additional exclusions include: a. Fertility preservation services associated with Cell and Gene Therapy administration. b. NEMT services for fertility preservation appointments. While Medicaid does not cover fertility preservation services, the Centers for Medicare and Medicaid Services (CMS) requires participating manufacturers to fund these services for therapies provided under the CGT Access Model.	

First Revised and Restated Attachment D: Required CFSP Quality Metrics

Section VII. First Revised and Restated Attachment D. Required CFSP Quality Metrics is meant to provide the Department with a complete picture of the CFSP's processes and performance as described in *Section V.F. Quality and Value*. The measures below include a set of Medicaid Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website, as necessary, to align with the annual January update.

The CFSP shall begin to track the updated measures when posted annually in January. The CFSP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with Second Revised and Restated *Section VII. Attachment I. Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the CFSP would report the results in June 2024).

The CFSP will also be required to report the 1915(i) measures listed in *Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with CFSP around these performance measures.

The CFSP shall submit the Final Audit Statement from its third-party NCQA HEDIS Compliance Audit to the Department each year, by no later than August 31st of the subsequent year (e.g., Submit the Final Audit Statement by August 31, 2027 for measurement year 2026).

Section VII. First Revised and Restated Attachment D. Table 1: Survey Measures and General Measures (Effective December 1, 2025)

CBE #	Measure Name	Reporting Responsibility	Steward
Reserved			
Reserved			
Reserved			
32	Cervical Cancer Screening (CCS-E)	CFSP	NCQA
1516	Child and Adolescent Well-Care Visit (WCV)	CFSP	NCQA
38	Childhood Immunization Status (CIS-E) - Combination 10	CFSP	NCQA
33	Chlamydia Screening (CHL)	CFSP	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	CFSP	PQA
3175	Pharmacotherapy for Opioid Use Disorder (POD)	Department calculated	NCQA
18	Controlling High Blood Pressure (CBP)	CFSP	NCQA

Section VII. First Revised and Restated Attachment D. Table 1: Survey Measures and General Measures (Effective December 1, 2025)			
CBE #	**Measure Name**	**Reporting Responsibility**	**Steward**
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	CFSP	NCQA
TBD	EPSDT Screening Ratio	Department-calculated	CMS
3488	Follow-Up After Emergency Department Visit for Substance Use (FUA)	Department-calculated	NCQA
576	Follow-Up After Hospitalization for Mental Illness (FUH)	CFSP	NCQA
108	Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	CFSP	NCQA
0059	Glycemic Status Assessment for Patients with Diabetes (GSD)[4]	CFSP	NCQA
1407	Immunizations for Adolescents (IMA-E) - Combination 2	CFSP	NCQA
NA	Low Birth Weight	Department calculated	NC DHHS
N/A	Tabacco Use Screening and Cessation Intervention (TSC-E)*	Department calculated	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	CFSP	NCQA
1768	Plan All-Cause Readmissions (PCR) [Observed versus Expected Ratio]	Department calculated	NCQA
1517	Prenatal and Postpartum Care (PPC)	CFSP	NCQA
NA	Rate of Screening for Health-Related Resource Needs (HRRN)	Department calculated	DHHS
NA	Rate of Screening for Pregnancy Risk	Department calculated	DHHS
0418/0418e	Screening for Depression and Follow-up Plan (CDF)[5]	CFSP	CMS
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	CFSP	NCQA
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Department-calculated	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Department-calculated	PQA

[4] Pending additional information regarding the collection of clinical data

[5] Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it is inappropriate.

Section VII. First Revised and Restated Attachment D. Table 1: Survey Measures and General Measures (Effective December 1, 2025)			
CBE #	**Measure Name**	**Reporting Responsibility**	**Steward**
1392	Well-Child Visits in the First 30 Months of Life (W30)	CFSP	NCQA

Section VII. First Revised and Restated Attachment D. Table 2: Survey Measures and General Measures: Patient and Provider Satisfaction		
NQF #	**Measure Name**	**Steward**
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new CFSP Members who have an Independent Evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of CFSP Members who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
3.	Number of CFSP Members with SMI/SED who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
4.	Number of CFSP Members with SUD who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
5.	Number of CFSP members with I/DD who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
6.	Number of CFSP members with TBI who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of independent re-evaluations completed at least annually for CFSP members using 1915(i) Services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
8.	Proportion of new Independent Evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Independent Evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to CFSP monitoring schedule	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) Services	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of non-certified 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of Person Centered Plans that are completed in accordance with DHB requirements	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
18.	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
19.	Proportion of Care Plan/ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
20.	Proportion of Care Plans/ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of individuals whose annual Care Plan/ISP was revised or updated	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
22.	Proportion of individuals for whom an annual Care Plan/ISP took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
23.	Number and percentage of CFSP Members using 1915(i) Services whose Care Plans/ISPs were revised, as applicable, by the care manager to address their changing needs	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
24.	Proportion of beneficiaries who are using 1915(i) Services in the type, scope, amount, and frequency as specified in the Care Plan/ISP	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
26.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
27.	Proportion of CFSP Members using 1915(i) Services reporting their care manager helps them to know what 1915(i) services are available	NC DHHS	Annually Fiscal Year	November 1
28.	Proportion of CFSP Members using 1915(i) Services reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
29.	Number and percentage of beneficiary deaths of CFSP members using 1915(i) Services where required CFSP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
30.	Number and percent of actions taken to protect the beneficiary using 1915(i) Services, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
31.	Percentage of CFSP Members using 1915(i) Services who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percentage of medication errors resulting in medical treatment for CFSP Members using 1915(i) Services	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 3 April 1 – June 30	February 1 May 1 August 1 November 1
34.	Percentage of CFSP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
35.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
36.	Number and percentage of level 2 or 3 incidents where required CFSP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
37.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
38.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
39.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. First Revised and Restated Attachment D. Table 3: 1915(i) Service Performance Measures (Effective December 1, 2025)				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
41.	The proportion of claims paid by the CFSP for 1915(i) Services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1
42.	The percentage of continuously enrolled CFSP Members using 1915(i) Services (ages 3 and older) who also received a primary care or preventative health service	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
43.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages twenty (20) and older who received a primary care or preventative health service during the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
46.	Number of CFSP Members on the Innovations waitlist who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1

First Revised and Restated Attachment E: CFSP Network Adequacy Standards

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

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

More background information is available at: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf. The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

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

For purposes of Network Adequacy Standards for physical health providers/services, except as otherwise noted, adult services are those provided to a Member who is 21 years of age or older and pediatric (child/children) services are those provided to a Member who is less than 21 years of age.

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

The CFSP is required to use the definitions of service categories for BH time/distance standards found in *Distance Standards* for BH service types in *Section VII. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards.*

Section VII. First Revised and Restated Attachment E. Table 1: CFSP Time/Distance Standards (Effective December 1, 2025)			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Members
3	Hospitals	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members

Section VII. First Revised and Restated Attachment E. Table 1: CFSP Time/Distance Standards (Effective December 1, 2025)			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
5	Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of Members • *Research-based BH treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of Members • *Research-based BH treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8	Location-Based Services	• P*sychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program :* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members • *Child and Adolescent Day Treatment Services:* Not subject to standard	• *Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program:* ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members • *Child and Adolescent Day Treatment Services:* Not subject to standard
9	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: o 2+ facilities within each SP Region, or o 1 facility within each region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* Not subject to standard	

[1] Measured on Members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. First Revised and Restated Attachment E. Table 1: CFSP Time/Distance Standards (Effective December 1, 2025)			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Medically monitored inpatient withdrawal management services (Non-Hospital Medical Detoxification):* ≥ 2 providers per CFSP Region • *Ambulatory withdrawal management without extended on-site monitoring, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal management services:* ≥ At least 1 provider per CFSP Region	
10	Inpatient BH Services	At least 1 provider per SP Region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of Members
12	Community/ Mobile Services	At least 2 providers per SP Region. Each county must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities and 1915(i) Services)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	
15	Residential Treatment Services	• *Residential Treatment Services*: Contract with 100% of providers statewide for each of the following service levels: ○ Level I /Level II Family Type ○ Level II Program Type ○ Level III ○ Level IV Secure • *Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Residential Treatment)*: At least 1 provider per SP Region (refer to 10A NCAC 27G.3400) • *Clinically Managed Residential Services (Substance Abuse Non-Medical Community Residential Treatment)*: ○ *Adult:* Contract with 100% of providers statewide (refer to licensure requirements to be determined by the Department). *Standard does not apply until ninety (90) Calendar Days following the establishment of licensure requirements as determined by the Department* ○ *Adolescent:* Contract with all designated CASPs statewide ○ *Women & Children:* Contract with all designated CASPs statewide • *Clinically Managed Low-Intensity Residential Treatment Services*:	

Section VII. First Revised and Restated Attachment E. Table 1: CFSP Time/Distance Standards (Effective December 1, 2025)			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		○ *Adult:* At least 1 male program and 1 female program per SP Region (Refer to 10A NCAC 27G.5600E) ○ *Adolescent:* At least 1 provider per SP Region (Refer to 10A NCAC 27G.5600E) • *Psychiatric Residential Treatment Facilities (PRTFs):* Contract with 100% PRTF providers statewide.	
16	Indian Health Care Providers	• Contract with 100% of IHCPs statewide.	
17	1915(i) Services	• Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) Service within each Standard Plan Region. • In-Home Respite: ≥ 2 providers within 45 minutes of the Member's residence. • Community Transition: Not subject to standard	

Section VII. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards (Effective December 1, 2025)		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Opioid Treatment Program (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification) • Medically monitored inpatient withdrawal management services (Non-hospital medical detoxification) (adult)

Section VII. First Revised and Restated Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards (Effective December 1, 2025)		
Reference Number	**Service Type**	**Definition**
		• Ambulatory withdrawal management with extended on-site monitoring
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment services • Psychiatric residential treatment facilities (PRTFs)
7.	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment • Mobile Crisis
8.	1915(i) Services	• Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

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

Section VII. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards (Effective December 1, 2025)			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar Days
1a	Preventive Care Services – child, birth through 20 years of age[2]		Within fourteen (14) Calendar Days for Member less than six (6) months of age Within thirty (30) Calendar Days for Members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar Days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar Days
5a	Initial Appointment – high risk		Within five (5) Calendar Days

[2] Preventive care services appointment wait time standard does not impact the requirement to conduct an initial physical examination within seven (7) days of entering County DSS custody.

Section VII. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards (Effective December 1, 2025)			
Reference Number	**Visit Type**	**Description**	**Standard**
	pregnancy or 3rd Trimester		
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
Behavioral Health Services			
9	Opioid Treatment Program (Adults Only)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Routine: Within forty-eight (48) hours Urgent: Within twenty-four (24) hours
10	Mobile Crisis Management Services	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within two (2) hours
11	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
12	Reserved.		

Section VII. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards (Effective December 1, 2025)			
Reference Number	**Visit Type**	**Description**	**Standard**
13	Residential Treatment Services (Levels I-IV)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five (5) Business Days of the Member's level of care determination, or sooner based on a Member's condition or urgency of treatment need[3] • Admission within seventy-two (72) hours of the Member's level of care determination for Members without a therapeutic placement who are in County DSS custody
14	PRTFs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five (5) Business Days of the Member's level of care determination, or sooner based on a Member's condition or urgency of treatment need[4] • Admission within seventy-two (72) hours of the Member's level of care determination for Members without a therapeutic placement who are in County DSS custody
15	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Psychiatric Beds	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Urgent: Within twenty-four (24) hours • Emergency Services: available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
16	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Substance Use Beds	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Urgent: Within twenty-four (24) hours • Emergency Services: available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
17	Partial Hospitalization	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Available day/night for a minimum of four (4) hours per day, five (5)

[3] SL 2021-132, SB693.
[4] SL 2021-132, SB693.

Section VII. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards (Effective December 1, 2025)			
Reference Number	**Visit Type**	**Description**	**Standard**
			days per week, and twelve (12) months per year
18	Outpatient Mental Health Services	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Routine: Within fourteen (14) Calendar Days • Urgent: Within twenty-four (24) hours
19	Post-Psychiatric Hospital Discharge Visit		• Within seven (7) Calendar Days with Providers listed as meeting numerator criteria in the technical specifications for the Healthcare Effectiveness Data and Information Set (HEDIS)® measure "Follow Up After Hospitalization for Mental Illness" (HEDIS is a registered trademark of NCQA)
20	Comprehensive Clinical Assessment (CCA)		• Within five (5) Business Days of request, or sooner based on a Member's condition or urgency of treatment need [5] • Within twenty-four (24) hours of the request for Members with a Behavioral Health need and without a level of care recommendation who are in County DSS custody or a Member who requires a CCA to begin services necessary to discharge from an emergency room or other emergency/urgent care setting to a community or residential setting
21	Emergency Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
22	Emergency Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

[5] SL 2021-132, SB693.

Section VII. First Revised and Restated Attachment E. Table 3: Appointment Wait Time Standards (Effective December 1, 2025)			
Reference Number	**Visit Type**	**Description**	**Standard**
23	Urgent Care Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
24	Urgent Care Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
25	Routine Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within fourteen (14) Calendar Days
26	Routine Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within forty-eight (48) hours

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

Section VII. First Revised and Restated Attachment E. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery

Section VII. First Revised and Restated Attachment E. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
18.	Pain Management (Board Certified)
19.	Psychiatry (General)
20.	Psychiatry (Child and Adolescent) [6]
21.	Radiology
22.	Rheumatology
23.	Urology

[6] Not subject to separate adult and pediatric provider standards.

Third 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 available capacity. 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. Reserved.

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: For all contracts with Category A and Category B providers, provisions that require compliance 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. Third Revised and Restated Attachment L.2. CFSP Advanced Medical Home Program Policy*

b. Section VII. Third Revised and Restated Attachment L.3. CFSP Pregnancy Management Program Policy

c. Reserved.

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.
2) The Company] shall pay or deny a clean Medical Claim within thirty (30) Calendar Days of receipt of the claim.
3) A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

ii. For Pharmacy Claims:

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

iii. If the requested additional information on a 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.

h. Contract Effective Date

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

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

i. Tobacco-free Policy

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

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

ii. Providers Subject to a Partial Tobacco-Free Policy

Starting January 1, 2027, and applicable only to the degree that the setting and/or service is within the scope of services of this Contract, 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 January 1, 2027, 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 I: Reporting Requirements

The following tables detail the reports that the CFSP must submit to the Department. The Department will provide additional details on report format, fields and frequency. For select reporting requirements, the CFSP is expected to submit a report with metrics for Medicaid as identified in *Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements* and *Section VII. Second Revised and Restated Attachment I. Table 2: CFSP Data Extracts.*

The Department will provide additional details and on report format, fields and frequency.

1. Although the State has indicated the reports that are required, the CFSP may suggest additional reports.
2. As part of Readiness Review, the CFSP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. The Department reserves the right to require additional reports beyond what is included in this document.
4. The CFSP shall submit complete and accurate data required by the Department for tracking information on Members obtaining Medicaid benefits in the CFSP and with providers contracted to provide those services.
    a. This information shall include information on consumer eligibility for services, shadow claims, demographics, adverse events and service outcomes for consumers served by the CFSP.
5. The CFSP shall submit all data on a schedule provided by the Department.
6. The CFSP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to the Department.
7. The CFSP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to the Department.

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
1. Administration and Management		
a. CFSP Operating Report	Annual report of each entity identified under the CFSP Operating Report, providing evidence of CFSP oversight activities and entity performance (i.e. metrics, CAPs, sanctions).	Annually
2. Members		
a. Member Services Quality Assurance Report	Quarterly report of survey results which measures Member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
b. Member Marketing and Educational Activities Report	Quarterly summary of Member Marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.	Quarterly

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
c. Member Appeals and Grievances Report	Quarterly report on the Appeals and Grievances received and processed by the CFSP including the total number of Appeal and Grievance requests filed with the CFSP, the basis for each Appeal or Grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly
d. Children with Complex Needs Report	Monthly report containing the names and Member Medicaid ID numbers of Children with Complex Needs statewide.	Monthly
e. Reserved.		
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
g. CFSP Enrollment Summary Report	Monthly summary report highlighting key Member Enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of Enrollment and disenrollment by Medicaid eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
h. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
i. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
j. Nursing Facility Admission Disenrollment Report	Ad-hoc report including the process for a Member's disenrollment from the CFSP due to a Nursing Facility stay longer than 90 days.	Ad hoc
3. Care Management		
a. Reserved.		
b. Reserved.		
c. Care Needs Screening Report	Quarterly report of Beneficiary screening results including SDOH and Care Needs Screening	Quarterly
d. Reserved.		
e. PCP Operational Monitoring Report	Report to gather data related to PCP assignment, provider panel and demographics, and ongoing assignment activities to facilitate the Department's monitoring efforts.	Bi-Weekly
f. Reserved.		

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
g. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.	Monthly
h. Reserved.		
i. Reserved.		
j. Nursing Facility Transitions Report	Quarterly report listing CFSP Members discharged from a nursing facility and to where they were discharged.	Quarterly
k. High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
l. Reserved.		
m. Reserved.		
n. Reserved.		
o. Reserved.		
p. Reserved.		
q. Reserved.		
r. DSS CFSP Care Manager Co-Location Report	Bi-weekly report to collect opt-in information of co-located care management services and number of co-located CFSP care managers within DSS Office County locations.	Bi-weekly until CFSP Launch, monthly post CFSP Launch
s. PCP Assignment Code and Reason Code Operational Report	Weekly report of PCP assignment codes and reason codes for each PCP assignment and reassignment made.	Weekly
4. Providers		
a. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for Provider Contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
b. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a Member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).	Ad hoc

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
c. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
d. PHP NEMT Provider Contracting Report	Non-emergency provider contracting report at a detailed and summary level from the CFSP's	Twice per month
e. PCP CFSP Panel Capacity Limit Report	PCP CFSP Panel Capacity Limit Report.	Weekly until launch and then monthly
f. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for Behavioral Health within specified timeframes by category.	Annually
g. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for Behavioral Health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
h. Provider Grievances and Appeals Report	Monthly report of all Provider Appeals and Grievances and Provider Grievance and Appeal statistics, including number/type of Appeals, Appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
i. Reserved.		
j. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly
k. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.	Annually
l. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. Submit with Timely Access Physical Health Provider Appointment Wait Times Report.	Annually
m. Provider Preventable Conditions Log	Quarterly report of Provider Preventable Conditions.	Quarterly
n. Reserved.		
o. Reserved.		
p. Reserved.		
q. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for OON services, including status of requests of each request, determination, and basis for determination	Monthly

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
r. Summary UNC_ECU Physician Claims Report	Quarterly report. The CFSP will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
s. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. The CFSP will include records of Members where no payment was received from the State or payment received differed from the amount expected. The CFSP will only include Member records with discrepancies on this report to the State. The CFSP Capitation Reconciliation Report will be submitted on a monthly cadence. The CFSP will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
t. Emergency Department (ED) and DSS Boarding for Children	Weekly report of all Members under age 18 who are boarding in an Emergency Department, DSS Office, hotel or similar temporary setting awaiting Medically Necessary treatment for Behavioral Health, I/DD, or TBI services. For any Member in the ED over thirty (30) consecutive hours or within one (1) Business Day of notification of DSS boarding, document escalation to appropriate parties including but not limited to the CFSP Clinical Director or designee.	Weekly
u. Litigated Provider Appeals Report	Ad hoc report consisting of notification when a provider has sued the CFSP for actions related to Medicaid Managed Care. The report must be provided to the Department within five (5) business days of the CFSP being served.	Ad hoc
5. Quality and Value		
a. Reserved.	[redacted]	
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
c. Reserved.	[redacted]	
d. Reserved.		
e. Reserved.		
f. Reserved.		
g. Quality Measures Report	Annual CFSP performance on quality measures.	Annually
h. Reserved.	[redacted]	
i. Reserved.		
6. Stakeholder Engagement		
a. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by the CFSP to collaborate with county organizations to address issues by county.	Monthly
b. Tribal Engagement Report (as indicated)	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
c. Reserved.		
d. Reserved.		
7. Program Administration		
a. Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
b. Service Line Issue Summary Report	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
c. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
d. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
8. Compliance		
a. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the CFSP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
b. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
c. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
d. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
e. Reserved.		
f. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
g. Reserved.		

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
h. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
i. Reserved.		
j. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	The cost avoidance report is used by the CFSP to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Benefits		
a. Institution for Mental Disease (IMD) Report	Bi-weekly summary of Members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, and revenue code.	Bi-weekly
b. Reserved.		
c. Pharmacy Benefit Determination/Prior Authorization Report	Monthly that lists prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
d. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
e. Top GCNs and GC3s	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
f. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
g. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.	Annually
h. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.	Monthly
i. EPSDT Reports	Quarterly reports of provider/Member outreach and education on EPSDT.	Quarterly
j. Non-Emergency Medical Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
k. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
l. Reserved.		
m. Crossover-Related NEMT Appointments Scheduled	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
n. Ongoing Status Reports on Transitions of Care	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the CFSP on an ongoing basis.	Monthly
o. Reserved.		
p. 1915(i) Performance Measures Report	Report is to demonstrate ongoing compliance with annual/semiannual/quarterly 1915(i) state plan performance measures.	Quarterly
q. 1915 (i) Service Authorization Report	The CFSP will report semi-annually on units authorized vs. units billed for certain 1915(c) waiver, 1915(i), and 1915(b)(3) services.	Semi-Annually
r. EVV Key Metrics	Report on Home Health EVV key data elements; claim data, with and without visit capture, rejected files and denied claims to be used by the Department to evaluate compliance with federal and contract EVV requirements. The report also includes provider level tracking for provider status and compliance with EVV requirements	Monthly
10. In-Reach and Transitions		
a. Rate of Institutionalization	Number and percentage of Members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported overall, by setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) and by age.	Quarterly
b. In-Reach Activity Report	Number and percentage of Members eligible for In-Reach activities who are engaged for In-Reach activities; number and percentage of Members who began transition planning following In-Reach. To be reported overall, by setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV) and by age.	Quarterly
c. IDD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition	Quarterly

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	
d. SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly
e. Reserved.		
f. Transition Activity for PRTF Residents, Members Under Age 18 in a State Psychiatric Facility, and Members Receiving Residential Treatment Levels II/Program Type, III, and IV	• Average length of stay; • Total number of Members in a PRTF, Members under age 18 in a state psychiatric facility, and Members receiving Residential Treatment Levels II/Program Type, III, and IV; and • Percentage of Members under age 18 in a PRTF, Residential Treatment Levels II/Program Type, III, and IV, or state psychiatric facility.	Monthly
11. Healthy Opportunities Pilot		
a. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the CFSP may submit if the Department notifies the CFSP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the CFSP's anticipated spending through the remainder of the Healthy Opportunities Pilot service delivery year.	N/A
b. Healthy Opportunities Pilot Service Delivery Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.	Monthly

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
c. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of CFSP administrative fund spending.	Quarterly
d. Healthy Opportunities Pilot Care Management Assignment Report (if applicable)	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Healthy Opportunities Pilot Enrolled Beneficiaries.	Monthly
e. Reserved.	[redacted]	
f. Reserved.		
12. Financial Requirements		
a. Financial Reporting Template	Monthly financial report providing the Department with details on CFSP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, and expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to Encounter submissions to identify discrepancies.	Monthly
b. Reserved.	[redacted]	
c. Reserved.		
d. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the TP template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
e. Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.	Annually
f. Unaudited Financial Statements	Annual submission of the unaudited financial schedule that includes restated monthly and quarterly financials, as well as a preliminary MLR.	Annually
g. Annual CFSP Medical Loss Ratio (MLR) Report	Annual MLR report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).	Annually

Section VII. Second Revised and Restated Attachment I. Table 1: CFSP Reporting Requirements (Effective December 1, 2025)		
CFSP Report Name	**CFSP Report Description**	**Frequency**
h. Total Cost of Care (TCOC) and Cost Growth Report	As required in Section 5.(6)a. of Session Law 2015-245, annual report to monitor cost growth. Report will also provide a summary of cost drivers and steps the CFSP is taking to address the cost drivers and mitigate future cost growth.	Annually
i. NC Claims Monitoring Report	This report provides a summary of the claims that have been received and processed by the Health Plan during the reporting period based on the Statuses and Claim Types defined within the report template.	Weekly

Section VII. Second Revised and Restated Attachment I. Table 2: CFSP Data Extracts		
CFSP Report Name	**CFSP Report Description**	**Frequency**
1. Providers		
a. Network Data Details Extract	Quarterly report containing demographic information on network providers. *Note: Ad-hoc upon request.*	Monthly Until Children and Families Specialty Plan Launch, then Quarterly and Ad Hoc thereafter
2. Members		
a. CFSP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member Enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including Enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Weekly
b. Monthly CFSP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to 7/1/2021, the extract would include member eligibility as of 7/1/2021. See the "Appx-Members Included" tab for more details.	Monthly
c. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of ABD issued by the CFSP to a Member and each Grievance received by the CFSP from Members.	Daily
3. Benefits and Care Management		
a. Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual Member, service type, determination date, and approval status.	Weekly

Section VII. Second Revised and Restated Attachment I. Table 2: CFSP Data Extracts		
CFSP Report Name	**CFSP Report Description**	**Frequency**
b. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly

Third 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. Third 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. Beneficiaries 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 requests 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.[12]

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).

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

[12] 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.

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;[13,14]
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 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.

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

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. Members will receive annual notice that informs them of their choices for health plan enrollment.

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.[15]
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 the Department and the Enrollment Broker and send notification of the birth within sixty (60) Calendar Days from the date of delivery.

[15] 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.

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.[16]

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:

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.

[16] 42 C.F.R. § 438.56(e).

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.[17]

B. The CFSP shall utilize the Department-developed standardized process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) Calendar Days.

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

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

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[18] or a DMVA-operated Veterans Home[19] 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 regulation, federally approved Medicaid waivers for North Carolina, or a change in the Enrollment processes.

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

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

2. 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. Third 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.

Section VII. Third 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						Y		Y		Y	Y	Y

Section VII. Third 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**
	(applicable to females only)												
4	Diphtheria, Tetanus, Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
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.
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) Reserved.

4. **Reserved.**

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 Manual 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 Provider Manual, 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. Providers are re-credentialed no less than every five (5) years through the Department's centralized credentialing process. The CFSP shall evaluate a

contracted Provider's continuing eligibility for to participate in the CFSP's Network by confirming the appearance of the provider each day on the daily Provider Enrollment File.

A. Reserved.
B. Reserved.
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. Reserved.
13. Reserved.
14. Reserved.
15. Reserved.

b) Reserved.
c) Reserved.
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 disorders 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 individuals 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) suppliers.

   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. Medically Monitored Inpatient Withdrawal Management Services (Non-Hospital Medical Detoxification (adults only)): a crisis service for the purpose of Network Adequacy Standards.

vii. Reserved.

viii. Reserved.

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. Medically Managed Intensive Inpatient Services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4): inpatient BH services for the purpose of Network Adequacy Standards.

xii. Hospitals with Adult Inpatient Substance Use Beds (ASAM Level 4 and ASAM Level 4WM): 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.

8. CFSP In Lieu of Services (ILOS)

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

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

i. The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to the Department by the CFSP demonstrating such cost effectiveness and clinical effectiveness;
ii. The CFSP shall ensure that Members are provided the rights outlined in Section V.C.1.g In Lieu of Services for all approved In Lieu of Services;
iii. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the CFSP; and
iv. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise.

In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process. In accordance with *Section V.C. Benefits*, the following In Lieu of Services have been approved by the Department:

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21, up to 22nd birthday) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently. Transitional Youth	Psychiatric Residential Treatment Facility (PRTF)	Members who are leaving foster care or juvenile justice systems, and have a mental health, and substance use disorder diagnosis or who otherwise find themselves in this life state without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. (Episode of Care) Monthly	H2022 U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	Services Specialists assist and support the member in identifying goals and addressing barriers to independence.				
Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH Diagnosis.	Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH Diagnosis is a short-term residential treatment service focused on treatment of Member with cooccurring conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Inpatient Readmission	Individuals with I/DD and other co-occurring MH diagnosis Aged 5-21. (Episode of Care) Daily per diem- 120 units (120 days)	H0018 HA	12/01/2025
Intercept Program	Intercept is an in-home service that provides intensive diversion and stabilization work with families who have a youth in danger of an out-of-home placement; short-term reunification services for youth who have been recently placed outside the home and are returning directly home; long-term reunification services for youth who have been placed outside the home for an extended period of time; assessments on all youth entering services; and adoption stabilization	Psychiatric Residential Treatment Facility (PRTF)	Children and Adolescents ages 4-20 years old and their families. Children and Adolescents with viable family who are in danger of out of home placement or adoptive placement disruption due to high-risk behaviors, mental health issues/symptoms, serious/chronic behaviors (defiance, runaway, truancy) and/or serious family conflict (including reports of abuse/neglect). (Episode of Care)	H0036 HK U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	for long-term placements.		One (1) month/six (6) units Average of 4-6 months per case for diversion/stabilization and up to 6-9 months per case for reunification.		
In-Home Therapy Services	In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents.	Intensive In-Home	Children and adolescents ages 3-21 in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. (Episode of Care) One (1) unit a week up to twenty-four (24) units per person no more than six (6) months.	H2022 HE U5 H2202 TS U5	12/01/2025
High Fidelity Wrap-Around	Intensive Care Coordination Using High-Fidelity Wraparound, also known as High- Fidelity Wraparound, uses a customized and team-based approach to administer a coordinated and seamless set of services	Psychiatric Residential Treatment Facility (PRTF) Level III Residential Facility Inpatient Readmission	Members ages 3 to 21 with complex behavioral, emotional, or mental health needs. The Member's family is also engaged in these services. Members must meet the criteria documented in the Department's High-Fidelity Wraparound policy.	H0032 U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	and supports for children and youth with complex emotional, behavioral, or mental health needs. We will comply with contractual requirements for offering High-Fidelity Wraparound as outlined in Section V.D.4.e of the Model Contract. As part of that commitment, we will ensure providers offering High-Fidelity Wraparound meet fidelity requirements, as assessed by the Department's fidelity monitoring contracted vendor. We will ensure these providers comply with requirements outlined in the Department's High-Fidelity Wraparound Policy.		(Episode of Care) One (1) per month-targeted length of Service (9-12 months)		
Enhanced Crisis-Rapid Response Teams	Rapid Response Team (RRT) services are directed to children and adult individuals that are experiencing an acute behavioral health crisis that have presented in an Emergency Department and/or for step down from Inpatient. This service includes crisis intervention, stabilization, linkage to supports and treatment needed and next day follow up after discharge. Rapid Response Team are available at all times, 24-hours a day, 7 days a week, 365 days a year. This service provides an	Mobile Crisis Response	Ages 5-64 years of age presenting in crisis, yet do not meet the imminent danger to self or others threshold and can be diverted from the hospital. As a result of crisis situations being unpredictable, the anticipated units of service per person and the team caseload cannot be determined. Units of service will vary based upon the situational crisis. Units shall be billed in fifteen (15) minute increments. The length of service will depend upon the situational crisis and the	H2011 U5 U1 (Weekly Unit)	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	immediate evaluation, triage and access to acute mental health, intellectual developmental disabilities, and substance use services, treatment, and supports to effect symptom reduction, harm reduction, or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports or services needed.		identified needs. The first sixteen (16) units are unmanaged.		
Behavioral Health Urgent Care (BHUC)	Behavioral Health Urgent Care (BHUC) is a designated intervention/treatment location that is an alternative to any community hospital Emergency Department where CFSP members with urgent primary behavioral needs will receive triage and referral. The behavioral health urgent care location must include the ability to initiate the Involuntary Commitment petition via first-level evaluations (Clinician Petition), medical screening, case management and referrals. Services include a nursing assessment, crisis counseling, provider referral, psychiatric services to discuss medication concerns, case management, and discharge planning. Members will be assessed upon presenting at the BH	Emergency Room Observation Inpatient Acute Hospitalization	Mental Health (MH), substance use disorder (SUD), co-occurring MH and Intellectual/Developmental Disorder (I/DD) and experiencing a behavioral health crisis that meets emergent or urgent triage standards.	T2016 U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	Urgent Care, and referrals will be made to appropriate providers for ongoing care, and staff will schedule those appointments in a timely manner to meet member needs.				
Institute for Mental Disease (IMD) for Mental Health Services for Members 21-64	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Beneficiaries age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD. Providers must follow the requirements for inpatient level of care outlined in the Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.	Inpatient Behavioral Health	Members aged 21-64 enrolled in Medicaid with Mental Health (MH) or Substance Use Disorders (SUD) who require inpatient treatment This service is reimbursed at a per diem rate based on occupancy on the inpatient unit during the midnight bed count. Fifteen (15) days or less per calendar month.	RC 0160	12/01/2025
Rapid Response Homes	Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing that provides emergency treatment, structure, stabilization, and	Emergency Department/Facility Based Crisis (FBC) Psychiatric Residential Treatment Facility (PRTF)	Youth that are presenting in crisis, however, do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and	S5145 U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment and prevent or minimize the need for out-of-home placements.		executed. Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and reevaluation/assessment and further development of the crisis plan as needed. (Episode of Care- Per Diem) 7-14 consecutive days with a maximum of twenty-one (21) days; any recurring crisis event would trigger a clinical team review to determine the repeated need for this service. There is no prior authorization (PA) required for the first seven (7) days per episode. An authorization request must be submitted if placement is needed beyond seven (7) days.		
Outpatient Plus	Outpatient Plus (OPT Plus) is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals with complex clinical needs that traditional outpatient cannot adequately address. OPT Plus is a level of care between OPT and IIH/CST.	Intensive In-Home Community Support Team	Members with chronic non-engagement in Outpatient therapy related to symptoms of MH/SUD diagnosis with Multi-system involvement, High Risk/Dual Diagnosis, High risk or recent history (past six months) of criminal/juvenile justice involvement, Significant difficulty meeting basic survival needs, residing in substandard housing,	H2021 U5	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
			homelessness, or imminent risk of homelessness, Traditional office-based therapy is not working, and alternative modalities have been attempted, individual is at risk for higher levels of care, and it is determined this service reduces that risk. A greater level of required collateral contact and involvement DSM diagnosis is required for this service. (Episode of Care) Qualified Professional Encounters billed in fifteen (15) min increments. Licensed Professional Encounters – one (1) per face-to-face therapy session. Anticipated Units of Service per person: 3-6 units		
Family Centered Treatment	Family Centered Treatment is an evidence-based, intensive in-home treatment model specifically designed for children and adolescents who are at risk. This strategy treats the youth and their families with tailored therapeutic interventions. FCT is primarily aimed at maintaining their permanency goals. It serves children and adolescents who might	Intensive In-Home Service Psychiatric Residential Treatment Facility (PRTF) Level II Therapeutic Foster Care	Characteristics of a family that may be an appropriate referral to FCT include but are not limited to the following (for Medical Necessity requirements, please see Utilization Management section below): • Significant family functioning issues • A step down from a higher level of care • There has been DSS involvement in the last year	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	12/01/2025

Section VII. Third Revised and Restated Attachment L.8. Table 1: Approved CFSP In Lieu of Services					
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**	**Effective Date**
	be part of the juvenile justice system, face the risk of out-of-home placements, or be up for reunification. They may have severe emotional and behavioral issues originating from neglect, abuse, trauma from domestic violence, sexual abuse, substance abuse, or serious mental health disorders. FCT works by enhancing the functioning of the youth and their families, providing them with an alternative to out-of-home placements, minimizing their duration if unavoidable and reducing the risk of recurrence.		• There has been Juvenile Justice involvement in the last six (6) months • there has been a behavioral health Emergency Room visit and/or hospitalization in the last six (6) months (Episode of Care) 1 Unit= 30 Days FCT Anticipated length of stay is six (6) months.		

First Revised and Restated Attachment M: Addendum for Division of State Operated Healthcare Facilities

1. **Background**

The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.[20] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The CFSP shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

2. **Scope**

The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, Grievances and Appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the CFSP and DSOHF facilities.

3. **Admissions.**

When admitting a Member to a DSOHF facility, the CFSP must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:

a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):

i. The CFSP or CFSP designated community provider (e.g., BH community provider or hospital/emergency department) shall complete and submit a Regional Referral Form available on the Department's website[21] or initiate referral via the North Carolina behavioral health/psychiatric bed registry and referral system designated by DMH/DD/SUS).

ii. The CFSP must review the admission based on review of the information provided in the Regional Referral Form or behavioral health/psychiatric bed registry and referral system designated by DMH/DD/SUS.

iii. In cases where the Member presents directly to a psychiatric hospital or ADATC for admission, the CFSP shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.

iv. The CFSP shall ensure that a CFSP-employed utilization management staff Member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;

v. *For Members subject to involuntary commitment proceedings, the CFSP must provide information or a representative who can assist the district court in determining if the Member requires continued services. If the CFSP elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the CFSP.*

[20] DSOHF also serves individuals with neuro-medical needs in specialized treatment centers that are carved out of Medicaid Managed Care and therefore not included in the CFSP contract.

[21] The Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC is available at https://www.ncdhhs.gov/regional-referral-form-admissions/open .

vi. Prior to referral or authorization of any Member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the CFSP must verify that the referral is in accordance with the requirements of N.C.G.S. 122C-261 and any other applicable North Carolina law governing the admission of Members with intellectual disabilities to a State psychiatric hospital.

vii. For Members who have multiple disorders and medical fragility or have multiple disorders and deafness, the CFSP shall be designated by the Department to determine whether Members have a high level of disability that alternative care is inappropriate, consistent with N.C.G.S. 122C-261(e)(4).

viii. In determining whether Members are eligible for referral and/or authorization for admission to a State psychiatric hospital, the CFSP must utilize and complete the I/DD Diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.

4. **Authorization**

The CFSP must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid clinical coverage policies as detailed in *Section V.C.1.e. Utilization Management*, as well as the specific requirements listed below.

a. General Requirements for State Psychiatric Hospitals and ADATCs:

i. Emergency Services:

a) The CFSP must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.
b) The CFSP cannot refuse to cover Emergency Services based upon the DSOHF facility failing to notify the CFSP of the individual's screening and treatment following presentation for Emergency Services.
c) For Members who present directly to the psychiatric hospital or ADATC as an emergency commitment or as a self-referral, the DSOHF facility shall submit a completed Electronic Authorization Request (EAR) to the CFSP the next Business Day following an admission to request admission authorization.
d) Upon receipt of the EAR, the CFSP must authorize and cover ongoing emergency medical services in accordance with applicable clinical coverage policies and consistent with the prudent layperson standard, as defined in EMTALA (Section 1867(a) of the Social Security Act).

ii. Inpatient Services:

a) The CFSP must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services, provided that the deadline may be extended for one additional Business Day if: (i) the individual or DSOHF facility requests the extension; and (ii) the CFSP justifies to the DSOHF facility a need for additional information and how the extension is in the Member's interest.
b) The CFSP must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.
c) Following initial admission authorization, the CFSP must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.
d) To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the CFSP prior to the expiration of the prior authorization no later than the last covered day of the existing authorization, or the previous Business Day if the last covered day occurs on a weekend or holiday.

e) The CFSP must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.

b. Requirements for Assessment and Stabilization

i. The CFSP shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of Members who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

ii. The CFSP must identify an appropriate discharge plan for all such Members beginning at admission.

5. **Member Grievances**

a. The DSOHF facility and the Department will manage and resolve all Member clinical concerns, or Grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility Grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with Grievance procedures established by the Department.

b. The CFSP must agree that DSOHF facilities shall refer any unresolved patient Grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and Grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the CFSP Hotline number for reporting any Grievances.)

6. **Event Reporting and Abuse/Neglect/Exploitation.**

a. The CFSP must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to Members receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.

b. The CFSP must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.

c. The DSOHF facility will cooperate with the CFSP's written request for information regarding any individual safety events/allegations involving Members to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the CFSP with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the CFSP's request.

d. The CFSP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The CFSP shall provide the DSOHF a written summary of its finding within thirty (30) days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

First Revised and Restated Attachment N: Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$500 per Calendar Day
2.	Failure to comply with conflict of Interest requirements described in *Section III.D.17. Disclosure of Conflicts of Interests and Section V.A.9.m. Conflicts of Interest.*	$1000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.D.18. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.*	$100 per Calendar Day
4.	Failure to open a Medicaid help center case or to confirm or open a Rapid Response Team case as described in *Sections V.A.10.a.(i)* or *V.A.10.b.(i)* of the Contract within one (1) Business Day of the CFSP receiving a notification described in *Sections V.A.10.a.i.* or *V.A.10.b.i*. of the Contract.	$500 per Member per Calendar Day
5.	Failure to develop a *Rapid Response Plan* and attach the Rapid Response Plan to the Member's Medicaid help center or Rapid Response Team case within seven (7) Business Days of the CFSP receiving notification described in *Sections V.A.10.a.i.* or *V.A.10.b.i.* of the Contract.	$500 per Member per Calendar Day
6.	Failure to update a Member's *Rapid Response Plan* and attach the updated *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last Rapid Response Plan update on a Member for whom the PIHP received notification described in *Sections V.A.10.a.i.* or *V.A.10.b.i.* of the Contract and who is staying in the Emergency Department, DSS Office, hotel, or similar placement while awaiting placement in a clinically appropriate setting for medically necessary services.	$500 per Member per Calendar Day
B. Member		

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
1.	Engaging in prohibited Marketing activities or discriminatory practices or failure to market statewide as prescribed in *Section V.B.5. Marketing*	$5,000 per occurrence
2.	Failure to comply with Member Enrollment and disenrollment processing timeframes as described in *Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.*	$50 per occurrence per Member
3.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section V.B.4.p. Engagement with Consumers.*	$5,000 per required occurrence
4.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.7. Member Grievances and Appeals.*	$50 per occurrence
5.	Failure to comply with all orders and final decisions relating to claim disputes, Grievances, Appeals and/or State Fair Hearing as issued or as directed by the Department.	$500 per occurrence
6.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing Appeal procedures as they become effective as described in *Section V.B.7. Member Grievances and Appeals.*	$50 per Calendar Day for each day the CFSP fails to provide continuation or restoration as required by the Department.
7.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.7. Member Grievances and Appeals.*	$100 for each mediation or hearing that the CFSP fails to attend as required
8.	Failure to comply with Transition of Care requirements as specified *Section V.B.3. Transition of Care Across Plans and Delivery Systems.*	$10 per Calendar Day per Member
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	$500 per occurrence per Member

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.C.1. Benefits Package and V.C.3. Pharmacy Benefits.*	$500 per standard authorization request $750 per expedited authorization request
3.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section V.E.1. Provider Network.*	$100 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Benefits Package.*	$250 per occurrence
5.	Failure to timely update drug ingredient cost reimbursement rates as required by *Section V.C.3. Pharmacy Benefits.*	$250 per Calendar Day per occurrence
6.	Failure to comply with driver requirements as defined in the Department's NEMT Policy.	$150 per occurrence per driver
7.	Failure to comply with the assessment and scheduling requirements as defined in the Department's NEMT Policy.	$25 per occurrence per Member
8.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	$150 per Calendar Day per vehicle
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management Policy as required by *Section V.D.5 Care Management Policy.*	$25 per Calendar Day
2.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with an LHD.	$50 per Calendar Day
3.	Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the CFSP or failure to use CFSP capitation to cover Member's benefits prior to use of Healthy Opportunities Pilot Program funds in at least 98% of Healthy Opportunities Pilot service authorizations, as required in *Section V.D.9. Healthy Opportunities*.	$20 per occurrence AND Refund of the CFSP's Healthy Opportunities Pilot Program budget for total amount spent on Healthy Opportunities Pilot service in each identified instance
E. Quality and Value		

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
1.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.F.1. Quality Management and Quality Improvement.*	$500 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.F.1. Quality Management and Quality Improvement.*	$100 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section V.F.1. Quality Management and Quality Improvement.*	$100 per Calendar Day
4.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.3. National Committee for Quality Assurance (NCQA) Accreditation.*	$10,000 per month for every month beyond the month NCQA accreditation must be obtained until such time as the CFSP is terminated in accordance with *Section V.A.3. National Committee for Quality Assurance (NCQA) Accreditation*.
5.	Failure to timely submit monthly Encounter data set certification.	$100 per Calendar Day
F. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Attachment I: Reporting Requirements.*	$200 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VII. Attachment I: Reporting Requirements.*	$100 per Calendar Day
3.	Failure to timely and accurately submit the MLR Report in accordance with the timeframe described in *Section V.J.2 Medical Loss Ratio* and *Attachment VII. Attachment I. Reporting Requirements.*	$200 per Calendar Day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$100 per Calendar Day

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
G. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.K.3. Fraud, Waste and Abuse Prevention.*	$500 per Calendar Day that the Department determines the CFSP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.K.1. Compliance Program* and *Section VII. Attachment I: Reporting Requirements.*	$100 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.K.4. Third Party Liability* and *Section VII. Attachment I: Reporting Requirements.*	$25 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or Grievance.	$250 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the CFSP's own conduct, a provider, or a Member.	$25 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section V.K.3. Fraud, Waste and Abuse Prevention* and *Section VII. Attachment I: Reporting Requirements.*	$200 per Calendar Day

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
7.	Failure by the CFSP to ensure the privacy, security, and confidentiality of any data and/or electronic or hardcopy documents that contain Member Protected Health Information (PHI), in accordance with the standards of the DHHS privacy and security policies, state regulations, and/or federal regulations including: the Privacy Rule at 45 C.F.R. Parts 160 and 164, the Security Rule at 45 C.F.R. Parts 160, 162 and 164, and the applicable provisions of HIPAA and HITECH that results in a breach of a member PHI.	$50 per Member per occurrence AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the CFSP's failure to comply with the terms of this Contract, the CFSP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.
H. Technical Specifications		
1.	Failure by the CFSP to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$50 per Member per occurrence
2.	Failure by the CFSP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$50 per Member per occurrence
3.	Failure by the CFSP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$50 per Member per occurrence, not to exceed $1,000,000
I. Directives and Deliverables		

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$50 per Calendar Day that the Department determines the CFSP is not in compliance
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$100 per occurrence per committee that the Department determines CFSP is not in compliance
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$50 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain a plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g. prevention and population health management programs, drug utilization review program).	$150 per occurrence per plan/program
5.	Failure to provide a timely corrective action plan or comply with a corrective action plan as required by the Department.	$50 per Calendar Day for each day the corrective action plan is late, or for each day the CFSP fails to comply with an approved corrective action
6.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$50 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
7.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$100 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
8.	Failure to implement and maintain a Member Lock-In Program as described in *Section V.D.8.c. Opioid Misuse Prevention and Treatment Program.*	$50 per calendar day per member that the CFSP is not meeting Lock-In Requirements outlined in *Section V. D.8.c. Opioid Misuse Prevention and Treatment Program* and N.C. Gen. Stat. § 108A-68.2.

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
9.	Failure to remove providers that are not actively enrolled in NC Medicaid within the CFSP Network File within one (1) Business Day as specified in *Section V.E.2. Provider Network Management.*	$10 per provider per Business Day
10.	Engaging in gross customer abuse of Members by CFSP service line agents as prohibited by *Section V.H.1.w. Gross Customer Abuse*.	$100 per occurrence
11.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.H.1.w. Gross Customer Abuse*.	$25 per Business Day the CFSP fails to timely report to the Department
12.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the CFSP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the CFSP in connection with the internal plan appeal within the requirements in *Section V.B.7.f. State Fair Hearing Process*.	$50 per occurrence
13.	Failure to upload Notices of ABD and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$50 per occurrence
14.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.L. Technical Specifications*.	$100 per occurrence
15.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in *Section V.L.10. Healthy Opportunities Pilot*.	$50 per Calendar Day that the Department determines the CFSP is not in compliance
16.	Failure to authorize or deny Healthy Opportunities Pilot services for Members within the Department's required authorization timeframes as specified in *Attachment O. Timeframes for Health Opportunities Pilot Service Authorization*.	$50 per Calendar Day
17.	Failure to pay Healthy Opportunities Pilot invoices to HSOs within the Department's required payment timeframes as specified in *Section V.E.4. Provider Payments*.	$50 per Calendar Day

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
18.	Failure to comply with the following provisions enumerated in *Attachment P. Healthy Opportunities Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that CFSP workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials • Ensure that care managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such care manager initiating a Member contact or an initial Healthy Opportunities Pilot assessment	$50 per occurrence beginning ninety (90) Calendar Days after Interpersonal Violence services become available to Members.
J. Provider		
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section V.E.2. Provider Network Management*.	$100 per instance of inaccurate directory information not updated within the required timeframes
2.	Failure to report notice of Provider termination from participation in the CFSP's Provider Network (includes terminations initiated by the Provider or by the CFSP) to the Department or to the affected Members within the timeframes required by *Section V.E.2. Provider Network Management*.	$10 per Calendar Day per Member for failure to timely notify the affected Member; $10 per Calendar Day that the CFSP is late in reporting a Provider's termination to the Department
3.	Failure to submit a timely initial and/or updated Network Access Plan compliant with the requirements in *Section* V.*E.1. Provider Network*.	$500 per Calendar Day that the Network Access Plan is past due
4.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section V.E.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$250 per month for failure to meet any of the listed standards, either individually or in combination

Section VII. First Revised and Restated Attachment N: Table 1: Liquidated Damages for Compliance Issues (Effective December 1, 2025)		
No.	**PROGRAM ISSUES**	**DAMAGES**
5.	Failure to timely submit a CFSP Network Data File that meets the Department's specifications.	$25 per Calendar Day
6.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.L. Technical Specifications.*	$100 per occurrence
7.	Failure to remove Providers that are not actively enrolled in NC Medicaid from the CFSP Provider Network File within one (1) Business Day as specified in *Section V.E.2. Provider Network Management*.	$10 per Provider per Business Day

Table 2: Performance Metrics, SLAs and Liquidated Damages

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The CFSP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the CFSP to its system to trigger Enrollment and disenrollment processes.	Daily	$100 per 24-hour period Note: Effective one month prior to CFSP launch
B. Member Grievances and Appeals					
1.	Member Appeals Resolution -Standard	The CFSP shall resolve at least ninety-eight percent (98%) of CFSP internal Appeals within the specified timeframes for standard Appeals.	The number of internal Appeals with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Appeal divided by the total number of internal Appeals filed during the measurement period.	Monthly	$1000 per month
2.	Member Appeals Resolution -Expedited	The CFSP shall resolve ninety-nine and one-half percent (99.5%) of internal Appeals within the specified timeframes for expedited Appeals.	The number of internal Appeals with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Appeal divided by the total number of internal Appeals filed during the measurement period.	Monthly	$1000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Member Grievance Resolution	The CFSP shall resolve at least ninety-eight percent (98%) of Member Grievances within the specified timeframes.	The number of Grievances with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Grievance divided by the total number of Grievances filed during the measurement period.	Monthly	$500 per month
4.	Non-Emergency Medical Transportation (NEMT) – Hospital Discharge	The CFSP shall ensure that at least ninety-eight percent (98%) of Medicaid Members discharged from hospitals or emergency departments are picked up within three (3) hours of receipt of the request from the Member, the Member's authorized representative, or hospital staff, or within three (3) hours of the Member's scheduled discharge, whichever is later, as specified in the NC Non-Emergency Medical Transportation Managed Care Policy.	The number of trips per month that Contractor fails to pick up at Medicaid Members being discharged from a hospital or emergency department within the established timeframes after receipt of a request from the Member, the Member's authorized representative, or hospital staff for NEMT	Monthly	$300 per trip for any delay beyond the three (3) hour pick-up requirement where the 98% threshold is not met in the month
C. Pharmacy Benefits					

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Adherence to the Preferred Drug List	The CFSP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$10,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
D. Service Lines					
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$500 per service line per month
2.	Call Response Time/Call Answer Timeliness –Member Service Line	The CFSP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
3.	Call Wait/Hold Times – Member Service Line	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
4.	Call Abandonment Rate – Member Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
5.	Call Wait/Hold Times-Behavioral Health Crisis Line	The CFSP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,500 per month
6.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$1,500 per month
7.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$1,500 per month
8.	Call Response Time/Call Answer Timeliness –Provider Support Service Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$500 per month
9.	Call Wait/Hold Times – Provider Support Service Line	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$500 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
10.	Call Abandonment Rate – Provider Support Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$500 per month
11.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$1,000 per month
12.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
13.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month
14.	Call Response Time/Call Answer Timeliness -Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
15.	Call Wait/Hold Times - Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
16.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$1,000 per month
17.	Call Response Time/Call Answer Timeliness - NEMT	The CFSP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
18.	Call Wait/Hold Times - NEMT	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
19.	Call Abandonment Rate - NEMT	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month
20.	Non-Emergency Medical Transportation (NEMT) – Trip Completion Rate	The CFSP shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the CFSP minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-C operational report, divided by the total number of NEMT trips approved by the CFSP. NEMT trips for hospital discharges will not be included in determining compliance with this SLA.	Monthly	99.25% - 99.49% = $1,500 per month 99.01% - 99.24% = $2,000 per month 99% or less = $2,500 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
21.	Service Line Gross Customer Abuse	There shall be no occurrences of Gross Customer Abuse identified on any of the CFSP's service lines.	Gross Customer Abuse is any time an agent uses profanity, yells or screams at a caller, hangs up on a caller without warning, is condescending to a caller, dismisses a caller's complaint, does not attempt to assist a caller or engages in call avoidance. The Department can identify gross Customer Abuse through Call Listening or external complaints. Call avoidance is defined as disconnecting a call, transferring a call unnecessarily, keeping a caller on the line after the call reason has been resolved, not answering a call during an active period, being unresponsive to a caller to the point the caller disconnects or keeping a caller on hold for an extended period to the point the caller disconnects.	Quarterly	$100 per occurrence of gross customer abuse

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
E. Encounters					
1.	Encounter Data Timeliness/ Completeness – Medical	The CFSP shall submit ninety-eight percent (98%) of Medical Encounters within thirty (30) Calendar Days after payment whether paid or denied. For purposes of this standard, Medical Encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, and Healthy Opportunities payments.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an Encounter.	Monthly	$50 per claim per Calendar Day
2.	Encounter Data Timeliness/ Completeness – Pharmacy	The CFSP shall submit ninety-eight percent (98%) of Pharmacy Encounters within seven (7) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an Encounter.	Weekly	$100 per claim per Calendar Day

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Encounter Data Accuracy – Medical	The CFSP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical Claims. For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, and Healthy Opportunities payments.	A paid claim submitted as an Encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$2,500 per month
4.	Encounter Data Accuracy – Pharmacy	The CFSP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Pharmacy Claims.	A paid claim submitted as an Encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$5,000 per week
5.	Encounter Data Reconciliation—Medical	The Encounters submitted by the CFSP shall reconcile to at least ninety-eight percent (98%) of paid Medical Claims amounts reported on financial reports.	The paid amounts on submitted individual Encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the CFSP.	Monthly	$1,000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
6.	Encounter Data Reconciliation—Pharmacy	The Encounters submitted by the CFSP shall reconcile to at least ninety-eight percent (98%) of paid pharmacy claims amounts reported on financial reports.	The paid amounts on submitted individual Encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the CFSP.	Daily	$100 per day
F. Website Functionality					
1.	Website User Accessibility	The CFSP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.	Any occurrence during which the website is not accessible, except for those occurrences that have been Department approved and pre-announced.	Daily	$250 per occurrence
2.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$250 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Timely response to electronic inquiries	The CFSP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) Business Days of receipt.	Electronic inquires include communications received via email, fax, web or other communications received electronically by the CFSP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence
G. Reserved.					

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
H. Providers					
1.	Provider Welcome Packet Timeliness	The CFSP shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in *Section V.E.3. Provider Relations and Engagement*.	The number of Provider Welcome Packet sent by the CFSP within the required timeframe divided by the total number of new Providers who have executed a contract with the CFSP during the measurement period.	Quarterly	97.99% - 95%: $500 per quarter 94.99% - 80%: $750 per quarter 79.99% or less: $1,000 per quarter
I. Member Welcome Packet Mailings					
1.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet Applies if the CFSP utilizes a single mailing to send all components of the Member Welcome Packet (Welcome letter, Member Handbook, and identification card)	The CFSP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire Member Welcome Packet) mailed within the timeframes specified in *Section V.B.4.l.i*))	The number of Member Welcome Packets (single mailing of entire Member Welcome Packet) mailed by the CFSP within the required timeframe divided by the total number of new Members enrolled in the CFSP during the measurement period.	Monthly	98.99% - 95% $500 per month 94.99% - 80% $750 per month 79.99% or less: $1,000 per month

Section VII. First Revised and Restated Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages (Effective December 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
2.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook Applies if the CFSP utilizes separate mailings to the components of the Member Welcome Packet	The CFSP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member Handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section V.B.4.l.i*	The number of welcome letters and Member Handbooks (mailed separately from identification cards) mailed by the CFSP within the required timeframe divided by the total number of new Members enrolled in the CFSP during the measurement period.	Monthly	98.99% - 95% $500 per month 94.99% - 80% $750 per month 79.99% or less: $1,000 per month
3.	Member Welcome Packet Timeliness – Separate Mailing for Identification Card Applies if the CFSP utilizes separate components of the Member Welcome Packets	The CFSP shall meet or exceed ninety-nine percent (99%) of identification cards (mailed separately from welcome letters and Member Handbooks) mailed within the timeframes specified in *Section V.B.4.l.i*	The number of identification cards (mailed separately from welcome letters and Member Handbooks) mailed by the CFSP within the required timeframe divided by total number of new Members enrolled in the CFSP during the measurement period.	Monthly	98.99% - 95% $500 per month 94.99% - 80% $750 per month 79.99% or less: $1,000 per month