Children and Families Specialty Plan RFP
V. Scope of Services

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V. Scope of Services

A. Administration and Management

1. Program Administration

a. 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. DHB is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) program. DSS is designated with the administration and determination of eligibility for the program. In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.

b. The Department has the authority as outlined in Section 9E.22 of Session Law 2023-134, as codified by NCGS §108D-62, to administer the program in the way outlined herein under the terms of the State's waiver under Section 1115 of the Social Security Act, as amended and various Medicaid State Plan Amendments.

c. During the term of the Contract, and in future years, the Department will modify its Medicaid Program, including Medicaid Managed Care and the supporting technical and operational infrastructure, to conform with Federal and State requirements or Department policies and goals. Modifications may be communicated through administrative memos and bulletins issued by the Department. The CFSP is obligated to review such memos and bulletins to stay informed of program changes.

d. The Department will remain responsible for all aspects of the North Carolina Medicaid program and will delegate the direct management of certain health services, including physical health, BH, Intellectual and Developmental Disability (I/DD), long-term services and supports (LTSS), pharmacy services and financial risks to the CFSP as defined in the Contract. The CFSP will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the CFSP has an adequate provider network, delivers high quality care, and operates a successful Medicaid Managed Care program.

e. The CFSP shall work cooperatively with the Department to be good stewards of Department funds and Department personnel time and to ensure effective administration of Medicaid Managed Care.

f. In partnership with the Department, the CFSP shall develop processes and procedures to ensure the CFSP is soliciting stakeholder input, including input from Members and providers, to drive continual improvement in the overall program.

g. The CFSP shall provide certification concurrently with the submission of all data, documentation, or information required under federal and state law and under this Contract to the Department in accordance with 42 C.F.R. § 438.606.

h. The CFSP shall cooperate with the Department in the administration of North Carolina's Section 1115 Demonstration Waiver, including providing reporting and data, engaging with the Department's External Evaluators, and supporting waiver-required stakeholder engagement.

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

1) North Carolina Medicaid Managed Care and CFSP Enrollment Policy;
2) Department Clinical Coverage Policies;
3) Transition of Care Policy;
4) Care Management Policy;
5) NC Non-Emergency Medical Transportation Managed Care Policy;
6) AMH Provider Manual;
7) AMH Program Policy;
8) PMP Policy;
9) Care Management for High-Risk Pregnancy Policy;
10) Uniform Credentialing and Recredentialing Policy;
11) Management of Inborn Errors of Metabolism Policy;
12) Managed Care Clinical Supplemental Guidance;
13) PHP Member Advisory Committee Guidance;
14) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions;
15) Medicaid Managed Care Billing Guide;
16) BH Service Definition Policy;
17) Healthy Opportunities Pilot Care Management Protocol: CFSP;
18) Healthy Opportunities Pilot Payment Protocol: CFSP; and
19) Healthy Opportunities Pilot Transitions of Care Protocol: CFSP.

ii. The Department may amend policies and shall provide updated versions to the CFSP at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The CFSP shall have the opportunity to review and provide feedback prior to finalization.

2. Entity Requirements

a. Operational Authority

i. At the time of Offer and through the duration of the Contract, the entity operating the CFSP Contract through the Department for the provision of Medicaid Managed Care services must be an entity that meets the definition of PHP as defined under NCGS § 58-93-5 or NCGS § 108D-62 or a consortium established under 122C-116.

ii. An Offeror may submit only one proposal for consideration to become the entity operating the CFSP Contract as defined below.

1) An entity participating in an Offeror consortium established under 122C-116 may not serve as a lead entity on another proposal and may not participate in any other Offeror consortium.

2) An entity that owns five percent (5%) or greater in any Offeror may not serve as an Offeror entity on any other proposal.

iii. An Offeror is permitted to partner or otherwise collaborate to meet the requirements of the CFSP.

b. Licensure, Governance and Operations Requirements

i. An Offeror that also holds a Behavioral Health I/DD Tailored Plan contract must:

1) Comply with all licensure, governance and operations requirements outlined in the Behavioral Health I/DD Tailored Plan contract.

2) Submit a plan to address reconciliation of the statewide objectives for the CFSP and its regional governance structure and authority.

ii. An Offeror that does not hold a Behavioral Health I/DD Tailored Plan contract shall hold a valid and current PHP license issued by the NCDOI.

1) A PHP license is not required as a condition of award.

2) The CFSP that does not hold a Behavioral Health I/DD Tailored Plan Contract shall have a PHP license no later than one hundred eighty (180) Calendar Days prior to CFSP launch. At the discretion of the Department, failure to obtain a license may result in termination of the Contract between the CFSP and the Department.
3) Upon request by the Department, the CFSP shall share with the Department any information related to its Medicaid business that was provided to DOI.
4) If the Offeror also operates a Standard Plan licensed by NCDOI, the CFSP must have an approved significant modification of operations filing approved by NCDOI no later than ninety (90) Calendar Days after Contract Award. At the discretion of the Department, failure to obtain such approval may result in termination of the Contract between the Offeror and the Department.

iii. Provider Led Entity (PLE) Governance and Operations Requirements

1) The majority of voting members on the governing body of each PLE shall be licensed in North Carolina as physicians, physician assistants, nurse practitioners or psychologists, and have treated beneficiaries of North Carolina Medicaid.
2) A minimum of twenty-five percent (25%) of voting members on each PLE governing body shall be providers who have received reimbursement for the treatment of at least one (1) Medicaid Managed Care eligible beneficiary in the previous twenty-four (24) months (e.g., a provider joining a PLE's governing body on January 1, 2024, must have received reimbursement in the twenty-four (24) months leading up to January 1, 2024, which would be December 31, 2021 through December 31, 2023).
3) Voting providers shall play a meaningful role in strategic decisions and day-to-day operations of PLEs to ensure the PLE advances high-value care, improving population health, and engaging and supporting providers.
4) The PLE shall make available and submit for review to the Department, upon request:
   a) The bylaws of their governing body;
   b) Information to explain the operations and authority of the governing body, (e.g., the types of decisions that will and will not be subject to a board vote);
   c) PLE Governance Plan outlining the role of physicians and other health team members in the day-to-day operations of the PLE including, but not limited to:
      i) List of clinical staff positions and roles;
      ii) List of individuals in executive or other leadership positions with clinical experience, and a description of roles and responsibilities;
      iii) List and description of all provider advisory and consultative committees (e.g., quality committee, AMH advisory committee);
      iv) List and description of provider relations or provider partnership initiatives;
      v) Descriptions of how providers will be held accountable for clinical and financial program outcomes; and
      vi) Description of any other ways that physicians and other health team members will be involved in the day-to-day business operations of the PLE.
5) The CFSP shall submit the PLE Governance Plan to the Department for review and approval:
   a) Within thirty (30) Calendar Days after award;
   b) Annually, no later than forty-five (45) Calendar Days after the end of the Contract Year; and
   c) Within three (3) Business Days after request from the Department
6) The CFSP must provide written notice to the Department within ten (10) Business Days of any material changes to the PLE Governance Plan.

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

iv. Consortium Governance and Operations Requirements

1) A consortium established under NCGS § 122C-116 may serve as the Offeror.
2) A consortium shall make available and submit to the Department for review, upon request:
   a) A copy of the interlocal agreement;
   b) Its Consortium Governance Plan which includes the following:
      i) Structure and participants of the governing body, including any deviations from the requirements of NCGS § 122C-118.1 that have been approved by the Secretary;
      ii) Role of each participating area authority in the day-to-day operations of the consortium;
      iii) Description of how the consortium will structure its finances, including how funds will be allocated by each consortium participant to meet the capital reserve and other financial requirements outlined in *Section V.J. Financial Requirements*; how financial risk will be managed across consortium members; and identification of where the funds will be held;
      iv) Description of how the consortium operates as a single accountable entity to meet the requirements of the Contract; and
      v) Explanation of how the consortium will be governed, including how decisions are made, who has voting rights with regard to what decisions, and descriptions of the process for addressing disputes and process for terminating the agreement.
3) The CFSP shall submit its Consortium Governance Plan to the Department for review and approval:
   a) Within thirty (30) Calendar Days after award;
   b) Annually, no later than forty-five (45) Calendar Days after the end of the Contract Year; and
   c) Within three (3) Business Days after request from the Department.
4) The CFSP must provide written notice to the Department within ten (10) Business Days of any material changes to the Consortium Governance Plan.

c. Ownership and Control and CFSP Operating Plan

i. The Department seeks the most qualified Contractor to serve within the North Carolina Medicaid Managed Care program and with whom the Department may entrust the care of individuals eligible for the CFSP (see *Section V.B.1. Eligibility and Enrollment for the CFSP*).

ii. As required by 42 C.F.R. § 455.101, the CFSP shall provide information, including corporate or other legal entity name, address, telephone number, and nature of relationship, regarding all entities, including parent entities, subsidiaries and business partners who:

1) Meet the definition of an ownership or controlling interest in the CFSP; terms are defined in 42 C.F.R. § 455.101, including the area director, where applicable, and Members of the entity's governing board; and
2) Do not meet the definition of ownership or controlling interest.

iii. The CFSP shall develop and maintain an up-to-date CFSP Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care services.
   1) Core Medicaid operations shall include but are not limited to:
      a) Managing Medicaid Managed Care Beneficiary lives (including Member services and the administration of clinical benefits and services);
      b) Provider network management;
      c) Performing Care Management functions;
      d) Performing quality management and data reporting;
      e) Processing and paying claims; and
      f) Assuming risk through a capitated contract.
   2) Entities included in the Operating Plan shall include Subcontractors, partners, subsidiaries, and any other entities involved in core Medicaid operations.
   3) The CFSP Operating Plan shall:
      a) Identify each entity by corporate or other legal entity name, address, and telephone number;
      b) Describe general roles, responsibilities and functions that the entity performs;
      c) Describe the CFSP's legal or contractual relationship with each entity;
      d) Describe how the CFSP trains Subcontractor staff; and
      e) Describe how the CFSP manages each entity and ensures compliance with the standards described in the Contract.
   4) After the first year and annually thereafter, the CFSP must provide a report for each entity providing evidence of the CFSP's oversight activities and describing entity performance including key metrics, corrective actions taken, and sanctions.

iv. The CFSP shall promptly respond to any additional requests for information pursuant to this subsection as directed by the Department.

v. The CFSP shall submit the CFSP Operating Plan to the Department for review and approval:
   1) Within thirty (30) Calendar Days after award;
   2) Annually, no later than forty-five (45) Calendar Days after the end of the Contract Year; and
   3) Within three (3) Business Days after request from the Department.

vi. The CFSP must provide written notice to the Department within ten (10) Business Days of any material changes to the CFSP Operating Plan.
   1) Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
   2) At the Department's discretion, the CFSP will be subject to a reevaluation and readiness review prior to approval of the amended CFSP Operating Plan.
   3) The CFSP may be responsible for any cost to the Department of such review.

d. Third Party (Subcontractor) Contractual Relationships

i. The following requirements apply if an Offeror contracts with another entity, including Subcontractors, partners, and subsidiaries, and any other entities involved in core Medicaid operations.

ii. The CFSP must demonstrate its ability to manage Subcontractors and ensure integrated approaches to plan operations and member's care on a statewide basis.

iii. The CFSP must comply with the following operational requirements:
   1) The CFSP must ensure that care managers delivering the CFSP Care Management model coordinate across a Member's whole-person needs, including physical health, BH, I/DD,

LTSS, pharmacy, and unmet-health related resource needs. See *Section V.D.2. CFSP Care Management* for more information on the CFSP Care Management model;

2) The CFSP must provide a single phone line for Member-facing services, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement. See applicable requirements throughout *Section V. Scope of Services* for more information on requirements for operational services;
3) The CFSP must provide a single phone line for provider-facing services, including utilization management, claims payments, provider relations, and provider-facing plan operations, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement;
4) The CFSP shall implement streamlined provider-facing administration and operational solutions, including provider contracting, service authorization, claims submission and claims payment processes to align processes across service types and reduce the administrative burden on providers. Such solutions may include, but are not limited to, provider contracting, integration with provider electronic health records, and unified electronic claims submission and payment processes. See applicable requirements in *Section V.E. Providers, Section V.I. Claims and Encounter Management*, and elsewhere throughout *Section V. Scope of Services* for more information on other operational services;
5) The utilization management process must support an integrated, holistic look at a Member's physical health, BH, I/DD, LTSS, pharmacy, and Unmet Health-Related Resource Needs, noting that standard utilization protocols or guidelines may not be appropriate in light of a Member's complete clinical and other support needs. See *Section V.C.1.e. Utilization Management* for more information;
6) The Medicaid Member appeals processes must follow Department policy and must be centralized, regardless of service type. See *Section V.B.7. Member Grievances and Appeals* for more information;
7) The CFSP must operate a single statewide care management platform;
8) The CFSP must have a single Medicaid Provider Network directory, encompassing all providers regardless of service type, available in both electronic and paper versions. See *Section V.E.2. Provider Network Management* and *Section V.E.2.m. Provider Directory* for more information.
9) The CFSP must ensure close coordination and collaboration with County DSS, including consistency and standardization across engagement with all County DSS and maintaining a single point of accountability to coordinate with County DSS. *See Section V.D.2.f. Collaboration with County DSS* for more information.

iv. The CFSP shall comply with the following financial requirements for all third-party subcontracting contracts:
    1) The CFSP and Subcontractor may not split physical and BH risk or savings in a way that is inconsistent with integrated care.
        a) The CFSP and Subcontractor may not segregate risk based on type of service or percent of premium allocated to service type. For example, a CFSP may not enter a contract with a PHP that sub-capitates all physical health services and holds the PHP accountable for the risk associated with those services.
        b) Limited scope sub-capitation arrangements (e.g., for primary care services or bundled payments) are permitted.

2) The CFSP and Subcontractor may enter a contract under which the two entities share savings from reduced medical expenditures, however:
   a) Any savings must be shared across the total cost of care of both physical and BH (including I/DD and TBI services); and
   b) Physical and BH cannot be divided into separate budgets.

3. National Committee for Quality Assurance (NCQA) Accreditation

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

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

c. In accordance with, 42 C.F.R. § 438.322(b)(1)-(3), the CFSP shall submit accreditation information to the Department, including:
   i. Accreditation status;
   ii. Accreditation level;
   iii. Accreditation survey type, if applicable;
   iv. Accreditation results (corrective action plans, summaries of findings), if applicable; and
   v. Accreditation expiration date.

d. The CFSP shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO.

4. CFSP Managed by Provider-Led Entities

a. The payment strategy of the CFSP to its owned or related providers has the potential to introduce behaviors that may be considered anti-competitive or self-dealing and, therefore, detrimental to both North Carolina's health care delivery system, generally, and Medicaid Managed Care, specifically.

b. The CFSP shall not pay for similar services rendered by any provider or Subcontractor that is "related to" the CFSP in an amount or frequency that is greater than the CFSP pays to Providers and Subcontractors that are not "related to" the CFSP.
   i. In this context, "related to" is defined as providers or Subcontractors:
      1) With a direct or indirect ownership interest or ownership or control interest in the CFSP;
      2) An affiliate of the CFSP; or
      3) The CFSP's management company with a direct or indirect ownership interest or ownership or control interest in a provider or Subcontractor.

c. Any payments made by the CFSP to owned or related providers that exceed the limitations set forth in this Contract shall be considered non-allowable expenses for covered services and will be excluded from medical expenses reported in the Medical Loss Ratio (MLR) report and future capitation rate calculations.

5. Implementation

a. The Department requires the CFSP to have the resources, expertise, and technology to support the Department's Medicaid Managed Care implementation schedule and the ongoing operations and clinical objectives.

b. The CFSP shall have a fully assembled implementation team ready to begin work immediately following Contract Award. The team shall include an implementation manager and separate implementation resources for, at a minimum, the following workstreams:

i. Finance;
ii. Compliance;
iii. Member;
iv. Providers;
v. Analytics;
vi. Plan Administration;
vii. Benefits;
viii. Care Management;
ix. Value-Based Payment;
x. Healthy Opportunities Pilots;
xi. Quality;
xii. Strategy & Payment Innovation;
xiii. Technology;
xiv. Collaboration with County DSS; and
xv. Communication and Engagement.

c. Additional resources to support the implementation of all workstreams identified as part of the services and requirements of the RFP must be added to the implementation team no later than thirty (30) Calendar Days after the Contract Award.

d. The CFSP shall be responsible for developing business requirements documents, Implementation Plans and test plans for each workstream. Documents must be approved by Department. The Medicaid Director, Deputy Medicaid Director or designee is authorized to approve these documents for the Department.

e. The CFSP shall provide to the Department an updated, draft Implementation Plan forty-five (45) Calendar Days after Contract Award that defines, at minimum, following tasks and milestones:
i. CFSP licensure and other DOI requirements, as applicable;
ii. Provider network development, including provider education, training and contracting;
iii. Member engagement program, including educational materials, welcome and enrollment materials, and community outreach;
iv. Service Line operations;
v. Utilization management development and implementation;
vi. Care and case management program development and implementation, including PCP assignment;
vii. Transition of Care data exchange;
viii. Quality management infrastructure;
ix. Member and provider enrollment systems;
x. Claims and encounter systems;
xi. Required system interfaces;
xii. Design, development, and testing activities;
xiii. Coordination with County DSS; and
xiv. Other administrative supports.

f. To support Medicaid Managed Care implementation and operations, the CFSP shall perform the following testing and technology operations:
i. Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable.

ii. End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting.
iii. Production defect resolution and testing of production incidents.

g. The Department maintains the discretion to require the CFSP to establish additional implementation teams, plans and testing requirements, including distinct environments to support testing and implementation, on an ongoing basis as new program requirements are implemented or prior to the CFSP effectuating, for example, a material program, operational or technical change.

6. Readiness Requirements

a. The Department is committed to ensuring the CFSP is prepared and able to serve as a good administrator of Medicaid Managed Care. The Department will engage in a thorough Readiness Review of the following functions immediately after Contract Award through the first six (6) months, or a different period as determined by the Department, and shall include all areas identified in 42 C.F.R. 438.66 and others to be identified by the Department.

b. The Department and its partners will conduct a Readiness Review to verify the CFSP, its staff, providers, Subcontractors and other individuals and organizations are prepared to provide Medicaid Managed Care services statewide on behalf of the Department prior to opening new lines of business, accepting new eligibility populations or at the Department's discretion.

c. The CFSP shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a Readiness Review.
   i. The CFSP shall participate in Readiness Review(s) conducted by the Department to review the CFSP's readiness to begin and sustain operations statewide throughout the term of the Contract.
      1) The requirements covered within the Readiness Review shall be determined by the Department and communicated to the CFSP at least fifteen (15) Calendar Days prior to the Readiness Review.
      2) The Department may determine, at its discretion, the frequency and intensity of the Readiness Review requirements and may tailor the particular Readiness Review to a specific issue.
      3) The CFSP must meet these Readiness Review requirements and Contract requirements in the time frame specified by the Department.
   ii. Readiness Reviews must include, but are not limited to, onsite reviews, desktop reviews, policy reviews, financial reviews, system demonstrations, staff interviews and self-audit evaluations.

d. The Department maintains the discretion to conduct Readiness Reviews on an ongoing basis as new program requirements are implemented or prior to the CFSP effectuating, for example, a material program, operational or technical change.

e. Readiness Reviews are different and distinct from program integrity, program audits, quality reviews, routine oversight or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.

f. Based upon results of the Readiness Review(s), the Department reserves the right to:
   i. Offer acceptance to allow the CFSP to commence full operations;
   ii. Offer conditional acceptance to allow the CFSP to commence operations if the CFSP is found not to meet certain requirements of the Readiness Review(s), so long as the CFSP develops

and executes a Department-approved corrective action plan describing how it will meet Readiness Review criteria within the timeframe specified by the Department;

iii. Offer limited acceptance to limit the CFSP's level of participation in Medicaid Managed Care based on the results of the Readiness Review and any resulting corrective action plans;

iv. Determine a remedy consistent with the terms of this RFP, including corrective action, liquidated damages or sanctions up to and including removal of key personnel; or

v. Terminate this Contract in accordance with the termination provisions of the Contract.

g. Prior to allowing a CFSP to be assigned Members under this Contract, the CFSP shall demonstrate compliance with the Department's solvency requirements specified in *Section V.J.3.f. Financial Viability*. If the CFSP uses the services of a Third-Party Administrator (TPA), the TPA shall be licensed by DOI no later than ninety (90) Calendar Days after Contract Award.

h. The CFSP shall submit to the Department all policies and procedures that require review and/or approval or as requested by the Department and defined in the Contract.

7. Non-discrimination

a. The CFSP shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:

i. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;

ii. Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity and national origin;

iii. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;

iv. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;

v. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;

vi. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;

vii. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;

viii. Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;

ix. The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;

x. The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;

xi. The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and

xii. Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017, by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex,

pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression.

b. The CFSP shall not discriminate against Members, providers, or employees in the provision of services or administration of the program.

c. The CFSP shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3).

d. The CFSP shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.
   i. At a minimum, the Non-Discrimination Policy shall include:
      1) The definition of discrimination under federal law and regulation, as amended;
      2) How the CFSP will collaborate with all of the Department's thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (example: Division of Services for the Deaf and Hard of Hearing);
      3) How the CFSP's policy will apply to clinical, marketing, and Care Management programs offered to Members;
      4) The CFSP's internal complaint process for Members and employees including penalties;
      5) The legal recourse, investigative, and complaint process available for Members through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and
      6) Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.

e. The CFSP shall make the Non-discrimination Policy available for Department review, upon request.

f. The CFSP shall make updates to its Non-discrimination Policy as necessary, and, at a minimum, the CFSP shall review its Non-discrimination Policy for updates annually.

g. The CFSP shall make the Non-discrimination Policy available to Members and employees of the CFSP.

8. Advance Directives

a. The CFSP shall comply with all state and federal laws and regulations related to Advance Directives, including advance instructions for mental health treatment established by Article 3, Part 2 of Chapter 122C of the General Statutes, Article 23 of Chapter 90 of the General Statutes and Article 3 of Chapter 32A.

b. The CFSP shall reflect changes in state law in its written Advance Directives information as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change. 42 C.F.R. § 438.3(j)(4).

c. The CFSP shall maintain written policies and procedures on Advance Directives for all adult Members receiving medical care by or through the CFSP. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a), Article 3, Part 2 of Chapter 122C of the General Statutes and Article 3 of Chapter 32A, as applicable.

d. The CFSP is prohibited from conditioning the provision of care or otherwise discriminating against a Member based on whether or not the Member has executed an Advance Directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).

e. The CFSP shall educate staff concerning their policies and procedures on Advance Directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).

f. The CFSP shall provide adult Members with written information on Advance Directive (including advance instructions for mental health treatment) and include a description of applicable state law. 42 C.F.R. 438.3(j)(3). Written information shall include the following:
   i. Member's rights under State law;
   ii. CFSP policies with respect to the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives;
   iii. Information on the Advance Directive policies of the CFSP;
   iv. Each Member's right to file a Grievance with the State Certification and Survey Agency for fully licensed services and the CFSP for unlicensed services concerning any alleged noncompliance with the Advance Directive law;
   v. Each Member has the right to file a Grievance with other applicable agencies such as advocacy agencies, licensing boards, etc.; and
   vi. Option to register his or her Advance Directive with the North Carolina Secretary of State's Office so the Advance Directive can be retrievable by medical professionals.

9. Staffing and Facilities

a. The CFSP shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The CFSP shall provide qualified persons in numbers appropriate to the CFSP's size of enrollment and consistent with the requirements to successfully operate the CFSP.

b. Unless otherwise specified, the CFSP may combine or split the listed responsibilities among the CFSP's key personnel if the CFSP demonstrates that the responsibilities are being met and that someone is accountable. Similarly, the CFSP may contract with a third party (Subcontractor) to perform one or more of these responsibilities.

c. The CFSP shall be responsible for screening all employees and Subcontractors to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
   i. The CFSP shall not employ, contract, or affiliate with an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610 (a) and (b)].

d. Key CFSP Personnel
   i. The CFSP shall hire key personnel (defined in *Section V.A.9.: Table 1. CFSP Key Personnel Requirements*) to be assigned, unless otherwise indicated, exclusively to the North Carolina Medicaid market for the duration of this Contract. Key personnel shall be identified and mapped to the staffing roles provided in *Section V.A.9.d. Key CFSP Personnel.* The CFSP shall include the name of the proposed individual to perform each role as part of the Offeror's Proposal.
   ii. The Director of Population Health and Care Management must be dedicated to the CFSP, unless otherwise approved by the Department. The remaining key personnel are not required to be dedicated solely to the CFSP and shall be permitted to perform functions for a Standard Plan or BH I/DD Tailored Plan, as long as key personnel comply with the required minimum certifications and credentials as described in *Section V.A.9.: Table 1. CFSP Key Personnel Requirements*.

iii. For key personnel positions that require the employee to reside in North Carolina, the Department shall consider the requirement met if the individual resides within forty (40) miles of the North Carolina border.

iv. Key personnel include the following as identified in *Section V.A.9.: Table 1. CFSP Key Personnel Requirements*:

Section V.A.9.: Table 1. CFSP Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	• Must reside in North Carolina.
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program	Individual responsible for accounting and finance operations, including all audit activities	• Must reside in North Carolina.
3.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program	Individual who oversees and is responsible for the delivery of physical health, BH, I/DD, and LTSS provided to children, youth, and families served by the child welfare system including but not limited to the proper provision of covered services to Members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and Care Management, and quality management. Individual responsible for ensuring an integrated approach to the physical health, BH, I/DD, LTSS needs of Members.	• Must reside in North Carolina. • Must be a licensed pediatrician or family practice physician with a minimum of seven (7) years working with children in a clinical setting. • Minimum of two (2) years' experience in managed care. • Minimum of one (1) year of experience working with children, youth, and families served by the child welfare system and/or demonstrated familiarity with the State agencies that are involved with their care (e.g., DSS, Department of Public Instruction, Division of Juvenile Justice and Delinquency Prevention, Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS)).
4.	Chief Compliance Officer (CCO) of North Carolina Medicaid Managed Care Program	Individual to oversee and manage all fraud, waste, and abuse and compliance activities.	• Must reside in North Carolina.
5.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North	Individual responsible for establishing and maintaining the security processes to ensure	• Must reside in North Carolina. • Must hold a bachelor's degree in information security or computer Science.

Section V.A.9.: Table 1. CFSP Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	Carolina Medicaid Managed Care Program	information assets and technologies are protected.	• Must have CISSP and one of the following certifications: CISM, CISA or GSEC.
6.	Quality Director of North Carolina Medicaid Managed Care Program	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances.	• Must reside in North Carolina. • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries. • Must be a North Carolina fully licensed clinician (e.g., LCSW, RN, MD, DO). • Certified Professional in Healthcare Quality (CPHQ) is preferred.
7.	Provider Network Director of North Carolina Medicaid Managed Care Program	Individual responsible for providers services and provider relations, including all network development and management issues	• Must reside in North Carolina. • Minimum of five (5) years of combined network operations, provider relations, and management experience.
8.	Behavioral Health Director of North Carolina Medicaid Managed Care Program	Individuals responsible for providing oversight and leadership of integrated behavioral health benefit, including UM program, network development and care management.	• Must reside in North Carolina. • NC-licensed psychiatrist or • Psychologist. • Minimum experience of five (5) years in a BH clinical setting and two (2) years in managed care.
9.	Deputy Chief Medical Officer of North Carolina Medicaid Managed Care Program	Individual who oversees and is responsible for the delivery of medical services provided to children, youth and families served by the child welfare system as assigned by the Chief Medical Officer including but not limited to the proper provision of covered services to Members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy,	• Must reside in North Carolina. • Must be a Child/ Adolescent Psychiatrist fully licensed to practice in NC and in good standing. • Minimum of five (5) years clinical experience and two (2) years' experience in managed care. • Minimum of one (1) year of experience working with children, youth and families served by the child welfare system and/or demonstrated familiarity with the

Section V.A.9.: Table 1. CFSP Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		population health and Care Management, and quality management. Individual responsible for supporting the Chief Medical Officer in ensuring an integrated approach to the physical health, Behavioral Health I/DD and TBI needs of Members. Individual reports to the Chief Medical Officer.	State agencies that are involved with their care (e.g., DSS, Department of Public Instruction, Division of Juvenile Justice and Delinquency Prevention, DMH/DD/SUS).
10.	Director of Population Health and Care Management of North Carolina Medicaid Managed Care Program	Individual responsible for providing oversight and leadership of all prevention/population health, Care Management and Care Coordination programs, including oversight of the statewide CFSP Care Management model and required coordination and co-location with County DSS. Individual responsible for providing oversight of LHDs delegated Care Management entities, if applicable.	• Must reside in North Carolina. • Must be a fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT). • Minimum of five (5) years of demonstrated Care. Management/population health experience in a healthcare organization serving Medicaid beneficiaries. • Minimum of two (2) years of experience working with children, youth and families served by the child welfare system and/or familiarity with the State agencies that are involved with their care (e.g., DSS, Department of Public Instruction, Division of Juvenile Justice and Delinquency Prevention, DMH/DD/SUS).
11.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the CFSP pharmacy benefits and services. The Pharmacy Director shall lead the Plan's efforts implementing the Medication Reconciliation and management requirements in accordance with the contract.	• Must reside in North Carolina. • Must be a North Carolina-registered pharmacist with a current NC pharmacist license. • Minimum of three (3) working years of Medicaid pharmacy benefits management experience. • Minimum of two (2) years of experience in Medication Reconciliation and management for high-risk children, including children

Section V.A.9.: Table 1. CFSP Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
			who are served by the child welfare system.
12.	Healthy Opportunities Pilot Program Director of North Carolina Medicaid Managed Care Program	Individual who is responsible for: a. Serving as the CFSP's liaison with the Department and other Healthy Opportunities Pilot entities (including Network Leads, HSOs, NCCARE360 vendor, and "Care Management Team" on Healthy Opportunities Pilot-related issues-topics) on the CFSP's Healthy Opportunities Pilot-related roles and responsibilities; b. Overseeing the Healthy Opportunities Pilots on behalf of the CFSP and coordinating within the organization to ensure all CFSP Healthy Opportunities Pilot responsibilities are met; c. Tracking CFSP's compliance and performance against Healthy Opportunities Pilot-related deadlines and milestones; d. Submitting Healthy Opportunities Pilot-related reports to the Department by required deadlines; e. Supporting HSOs to ensure their capacity to receive payment for Healthy Opportunities Pilot services delivered (e.g., via direct deposit); f. Ensuring the CFSP and its "Care Management Team" (as appropriate) are onboarded onto and using NCCARE360 for	• Must reside in North Carolina. • Minimum of two (2) years of experience serving or working on behalf of Medicaid beneficiaries. • Minimum of two (2) years of experience project managing large and complex engagements. • Minimum of two (2) years of experience coordinating across different types of stakeholders. • Minimum of two (2) years of experience in an organization or field that demonstrates an understanding of the impact of social needs on individuals' health and well-being.

Section V.A.9.: Table 1. CFSP Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		its Healthy Opportunities Pilot-related functionalities; and g. Ensuring CFSP staff who use NCCARE360 have proper access to the platform.	
13.	Liaison to the DSS	Individual who serves as the primary liaison with the DSS coordinating outreach, distribution of materials, and understanding the scope of services/programs coordinated through County DSS Offices.	• Must reside in North Carolina. • Must have experience working with North Carolina DSS staff and knowledge of North Carolina's child welfare system.

e. The CFSP shall:
   i. Ensure that key personnel hold no more than one (1) position that is required by the Contract, with time limited exceptions for vacancies as approved by the Department.
   ii. Ensure all key personnel meet the key personnel role and minimum certification and/or credentialing requirements.
   iii. Ensure all key personnel positions are filled within one hundred twenty (120) Calendar Days of Contract Award.

f. Key personnel shall be available to meet during normal business hours at the Department's requested location within twenty-four (24) hours' notice from the Department unless they are able to provide good cause exceptions.

g. The Department may, at its sole discretion, reject a potential candidate or require the removal of any key personnel providing services under this Contract.

h. The CFSP shall not substitute key personnel preforming under the Contract without prior written approval by the Department. The CFSP shall inform the Department in writing within seven (7) Calendar Days of staffing changes in key personnel positions, including vacancies. The CFSP shall fill key personnel roles with permanent qualified replacements within ninety (90) Calendar Days of the departure of the former staff Member. At no time, however, shall a key personnel role be vacant. It is the CFSP's responsibility to keep the role filled until the Department approves a substitution.

i. Upon filling a key personnel vacancy, the CFSP shall demonstrate that CFSP staff proposed as key personnel have the proper credentials and experience to perform all duties and responsibilities of that role. The CFSP shall provide the following to the Department for each position:
   i. Name;
   ii. Role;
   iii. Experience relevant to the services to be provided under this Contract;
   iv. Resume;

v. Proof of North Carolina Residency (as applicable); and
vi. Any certifications, licenses or credentials for the role where requested by the Department.

j. If the CFSP is unable to find a candidate for a key personnel position that meets the full requirements of the Contract, the CFSP may submit an exception request for the Department's approval. The exception request shall include the proposed candidate and mitigation and reporting strategy to fulfill the full requirements of the Contract. The Department reserves the right to provide input on the mitigation and reporting strategy, specify conditions for approval, and request documentation and provide feedback on performance of the candidate.

k. Organization Roles and Positions
   i. The CFSP shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Section VII. Attachment A. CFSP Organization Roles and Positions*.
   ii. Member Services Staffing
      1) The CFSP shall adequately staff and operate its Member Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related to North Carolina Medicaid Managed Care for the populations covered by the CFSP.
      2) The CFSP shall ensure that unlicensed Member services staff are prohibited from providing health-related advice to Members requesting clinical information and instead shall triage/refer such requests to fully licensed staff with appropriate clinical expertise in treating the Member's condition or disease.
      3) Annually, all unlicensed Member services staff and Member services management will submit an attestation that the staff and management understand and adhere to the requirements of the prohibition.
   iii. Fraud, Waste and Abuse Staffing
      1) The CFSP shall establish a single point of contact to serve as a liaison with the Department and North Carolina Department of Justice Medicaid Investigations Division (MID) and to facilitate timely response to Department requests for information, including claims data.
      2) The CFSP shall establish a custodian of records to authenticate the business records of the CFSP, provide the business records of the CFSP to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:
         a) Made at or near the time of the events by a person with knowledge;
         b) Kept in the normal course of regularly conducted business activity; and
         c) Made in the regular practice of the CFSP's business activity.
   iv. The CFSP shall submit resumes for any employee or subcontracted employee upon request by the Department.
   v. The CFSP shall provide, upon request, an updated business continuity plan with detailed staffing contingency plan in the event of public health emergencies, natural disasters, sudden and unexpected increases in enrollment, with a description on how the plan shall be implemented and coordinated with the Department.
   vi. The FC Plan shall provide staffing levels, hiring, layoff activity, and plans upon request by the Department.

l. Physical Presence in North Carolina
   i. The CFSP shall have a physical presence in North Carolina by having one or more offices located in the State.

ii. The CFSP shall establish call center(s) and staff in North Carolina within ninety (90) Calendar Days after Contract Award.
iii. The Department requires the CFSP establish an office that serves to support Care Management functions and Member, provider and stakeholder engagement requirements of the Contract by CFSP launch within one hundred twenty (120) Calendar Days of Contract Award.
iv. Additionally, the following personnel and roles, at a minimum, shall be located in and operate from within the State of North Carolina unless otherwise noted (as found in *Section VII. Attachment A. CFSP Organization Roles and Positions*):
    1) Care Managers and Supervisors;
    2) Certified Family Peer Specialist(s);
    3) System of Care Outreach Coordinator(s);
    4) System of Care Manager;
    5) Member Appeal Coordinator;
    6) Member Complaint and Grievance Coordinator;
    7) Full-Time Member Services and Service Line Staff;
    8) Provider Relations and Service Line Staff;
    9) Provider Complaint, Grievance, and Appeal Coordinator;
    10) Pharmacy Director and Pharmacy Service Line Staff;
    11) Full-Time Utilization Management Staff;
    12) Tribal Provider Contracting Specialist;
    13) Liaison between the Department and the North Carolina Attorney General's MID;
    14) Regional Liaisons to County DSS; and
    15) I/DD and TBI Clinical Director
v. For the CFSP key personnel and roles outlined above that require the employee to reside in North Carolina, as described in *Section VII. Attachment A. CFSP Organization Roles and Positions,* the Department shall consider the requirement met if the individual resides within forty (40) miles of the North Carolina border.

m. Conflict of Interest
i. The CFSP shall verify that its employees, directors, and Contractors comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and NCGS § 108A-65 and NCGS § 143B-139.6C.
ii. The CFSP shall undertake reasonable actions to verify that employees or Contractors who have been officers or employees of the State and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the Medicaid Managed Care or NC Medicaid Direct programs, abide by all applicable federal conflict of interest requirements and with NCGS § 108A-65.
iii. The CFSP and its employees and directors shall:
    1) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee if such Department employee participated personally and substantially in the procurement of the CFSP's contract or the oversight of such contract as a Department employee.
    2) Not promise or give a gift to any Department employee or any family member of a Department employee.
    3) Fully and completely disclose to the Department any situation that may present a conflict of interest.
    4) Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.

5) Not solicit or obtain from the Department any non-public information relating to the Department's criteria or processes for evaluating bids to enter into or renew CFSP contract.

iv. The CFSP shall ensure that financial considerations do not influence decisions to provide medically appropriate care.

v. The CFSP shall validate that all its employees, directors, Subcontractors or owners who are fully licensed providers abide by their professional obligations to their Members and shall not take any actions which conflict with such obligations.

vi. The CFSP entity shall not serve as a legal Guardian for any of its Members.

vii. No official or employee of the CFSP shall acquire any personal interest, direct or indirect, in any provider or vendor contracted with State or Federal funds that would be considered a conflict of interest under this Contract.

viii. The CFSP Board of Directors, advisory committees, employees, volunteers, agents, and Contractors shall not participate in clinical or administrative activities or decision in which there is or may be a conflict of interest.

ix. As required by NCGS § 143B-139.6C, the CFSP shall not use a former Department employee, director, or Contractor in the administration of its CFSP contract for six (6) months after such person's employment or contract with the Department is terminated, if such person personally participated in the following activities:

1) The award of the Contract to the CFSP;
2) An audit, decision, investigation, or other action affecting the CFSP; or
3) Regulatory or licensing decisions that applied to the CFSP.

x. The CFSP shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices.

xi. The CFSP shall submit its written Conflict of Interest Policy for its employees to the Department for review ninety (90) Calendar Days after Contract Award.

n. In support of the Department's health equity goals, the CFSP shall establish and maintain a Health Equity Council that reports to the CEO no less than quarterly. The council members shall be reflective of the diverse populations served by the CFSP and at a minimum:

i. Identify and analyze health disparities through review of utilization and quality data;

ii. Address stakeholder representation and engagement improvements;

iii. Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid Members;

iv. Develop new initiatives that would address health disparities; and

v. Examine existing policies that can be amended to improve health equity and reduce health disparities.

B. Members

1. Eligibility and Enrollment for the CFSP

a. Department Roles and Responsibilities

i. Pursuant to Session Law 2015-245, as amended, the Department was directed to transition certain North Carolina Medicaid populations from a NC Medicaid Direct to a Medicaid Managed Care structure. The Department shall maintain authority in determining North Carolina Medicaid eligibility and defining populations to be transitioned into Medicaid Managed Care consistent with Chapter 108D-40 of the North Carolina General Statute. Pending legislative change, the Department will transition populations eligible for the CFSP to the CFSP as detailed in *Section V.B.1. Eligibility and Enrollment for the CFSP.*

ii. The Department shall maintain sole authority for performing, managing, and maintaining all eligibility and cost sharing determinations.
iii. The CFSP shall be responsible for adhering to Medicaid eligibility and cost sharing determinations made by the Department.
iv. The Department shall be responsible for determining if a Beneficiary is Medicaid Managed Care excluded, exempt or mandatory at any point in time.
v. The Department shall be responsible for determining if a Beneficiary is CFSP eligible.
vi. The Department shall be responsible for transmitting to CFSP all information related to North Carolina Medicaid eligibility and cost sharing via the standard eligibility file format.
vii. Consistent with 42 C.F.R. § 438.810, the Department shall contract with an Enrollment Broker (EB) to:
    1) Educate beneficiaries on Medicaid Managed Care;
    2) Provide Choice Counseling and enrollment assistance to beneficiaries and/or to their Authorized Representatives who want to select a Standard Plan, CFSP, BH I/DD Tailored Plan, Tribal Option or a PCP; and
    3) Transmit enrollment selections and approved disenrollment requests to the Standard Plan, CFSP or BH I/DD Tailored Plan to effectuate.

b. CFSP Eligible Populations
    i. 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 and will be automatically enrolled unless they are otherwise exempt or meet an exception outlined below:
        1) Beneficiaries who are in Foster Care;
        2) Beneficiaries receiving adoption assistance;
        3) Beneficiaries who are enrolled in the Former Foster Youth eligibility group; and
        4) The minor children of populations described in *Section V.B.1.b.i.a.-c.* while the Parent remains enrolled.
    ii. ~~In Contract Year 2~~ No sooner than June 30, 2026, 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 and shall have the option of enrolling in the CFSP unless they otherwise meet an exception as outlined below:
        1) Parents, Caretaker Relatives, Guardians, and Custodians of children in Foster Care;[1]
        2) Minor siblings of Beneficiaries in Foster Care;
        3) Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home;[2]
        4) Adults identified in an open Eastern Band of Cherokee Indians (EBCI) Department of Public Health and Human Services Family Safety program case and any children living in the same home; and
        5) Any other Beneficiary that has been involved with the child welfare system that the Department determines would benefit from Enrollment.

[1] Pending CMS approval.
[2] Temporary safety provider caregivers are excluded from enrollment.

iii. The following populations shall be excluded from CFSP enrollment and shall enroll in a BH I/DD Tailored Plan at BH I/DD Tailored Plan launch[3,4]:
   1) Beneficiaries who are enrolled in the Innovations or TBI waivers;[5]
   2) Beneficiaries residing in or receiving respite services at an ICF-IID;
   3) Beneficiaries ages 18 and older who are receiving State-funded BH, I/DD and TBI services that are not otherwise available through Medicaid;
   4) Beneficiaries living in State-funded residential treatment; and
   5) Recipients enrolled in and being served under Transitions to Community Living.

c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care
   i. In accordance with Chapter 108D-40 of the North Carolina General Statutes, the following populations shall be excluded from Medicaid Managed Care, including the CFSP:
      1) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
      2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
      3) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611
      4) Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations or TBI waivers;
      5) Presumptively eligible beneficiaries, during the period of presumptive eligibility;
      6) Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations or TBI waivers;
      7) Beneficiaries enrolled under the Medicaid Family Planning program;
      8) Beneficiaries who are inmates of prisons or jails;
      9) Beneficiaries being served through CAP/C;
      10) Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice Counseling); and
      11) Beneficiaries with services provided through the PACE.[6]
   ii. In accordance with Chapter 108D-40 of the North Carolina General Statute, the following population shall be exempt from Medicaid Managed Care, including the CFSP:
      1) Eligible recipients who meet the definition of Indian under 42 C.F.R. § 438.14(a).
   iii. In accordance with Chapter 108D-40 of the North Carolina General Statute, the following populations are temporarily excluded, for a period not to exceed five (5) years from the date capitated CFSP contracts begin, and shall be treated as excluded until the Department includes them in Medicaid Managed Care:
      1) Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) Calendar Days or longer and (ii) are not being served through CAP/DA. If an individual enrolled in the CFSP resides in a nursing facility for ninety (90) Calendar Days or more, such an individual shall be disenrolled from the CFSP on the first

[3] More information about BH I/DD Tailored Plan eligibility and State-funded Services is available at https://medicaid.ncdhhs.gov/transformation.

[4] Innovations and TBI waiver services, ICF/IID services, receiving respite services through Murdoch Developmental Center's TRACKS program, TCL covered services, and State-funded BH, I/DD and TBI services will only be available to beneficiaries enrolled in the BH I/DD Tailored Plan. Beneficiaries receiving these services may opt-in to the CFSP when they no longer require those services.

[5] 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.

[6] Codified at NCGS § 108D-35(3).

day of the month following the ninetieth (90th) Calendar Day of the stay and enrolled in NC Medicaid Direct.

a) The Department considers beneficiaries residing in or determined eligible for and transferred to a state-owned Neuro-Medical Center operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) or a Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) at Medicaid Managed Care Implementation and (ii) beneficiaries determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation to be temporarily excluded until the Beneficiary is discharged and determined eligible for Medicaid Managed Care.

b) For Members of the CFSP determined eligible for and transferred for treatment to a DSOHF Neuro-Medical Center or Veterans Home after CFSP implementation, the Department shall disenroll the Member from the CFSP into NC Medicaid Direct in accordance with the CFSP Managed Care Enrollment policy and the Contract.

2) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding beneficiaries served through CAP/DA and Innovations and TBI waiver participants.

iv. At any time during the Contract Term, the Department reserves the right to amend the Contract based on an increase or decrease in covered populations included in the Medicaid Managed Care program based on federal or state law or regulatory changes, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes or CFSP.

2. Medicaid Managed Care Enrollment and Disenrollment

a. The Department has sole authority to direct enrollment and disenrollment of beneficiaries into and out of Medicaid Managed Care. In partnership with an EB, the Department will educate beneficiaries on Medicaid Managed Care, support their selection of the CFSP, and transmit enrollment selections and approved disenrollment requests to the CFSP to effectuate.

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

c. CFSP Roles and Responsibilities

i. The CFSP shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1).

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

iii. The CFSP shall notify the Department in a format defined by the Department within five (5) Business Days when it identifies information in a Member's circumstances that may affect the Member's Medicaid eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. 42 C.F.R. §438.608(a)(3).

iv. The CFSP shall ensure automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid eligibility for period of two (2) months or less. 42 C.F.R. § 438.56(g). From September 27, 2022 through seventeen (17) months after the end of the COVID-19 Public Health Emergency, the CFSP shall ensure automatic reenrollment of

a Member who is disenrolled solely because he or she loses North Carolina Medicaid eligibility for a period of ninety (90) Calendar Days as allowed in under the Department's CMS approved waiver of Automatic Reenrollment into Medicaid Managed Care Plans as defined in section 1902(e)(14)(A) of the Social Security Act.

v. The CFSP shall only process enrollment for beneficiaries who are eligible for CFSP coverage.

vi. The CFSP shall notify the Department in a format defined by the Department of the receipt of enrollment information for any Beneficiary who is ineligible for the CFSP within five (5) Business Days.

vii. The CFSP shall adhere to the Department's Medicaid Managed Care enrollment approach, including but not limited to CFSP enrollment format and processes, as defined in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy* and consistent with federal regulations.

viii. The CFSP shall direct the Member to the online Beneficiary Portal or perform a Warm Transfer to the County DSS if a Beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, income etc.); this requirement does not apply to the choice of Standard Plan, CFSP or BH I/DD Tailored Plan, PCP or, if applicable, prescriber.

ix. The CFSP shall, if a Member contacts the CFSP to change to a Standard Plan, BH I/DD Tailored Plan, the Tribal Option or NC Medicaid Direct (if eligible), perform a Warm Transfer to the EB.

1) The CFSP shall ensure as outlined in *Section V.H. Program Operations* that its telephone system will have the functionality to transfer beneficiaries and Authorized Representatives from the call center to each County DSS without disconnecting the call.

2) If a Member's demographic information is not updated during the next Member reconciliation cycle with the CFSP and the Department, the CFSP shall follow up with Members to provide them with information on how to change their demographic information and assist in making a connection to the County DSS or online Beneficiary Portal.

3) The CSFP shall, if a Member contacts the CSFP to change their PHP, perform a warm transfer to the EB.

d. Beneficiary Disenrollment

i. The CFSP shall adhere to the Department's Medicaid Managed Care disenrollment approach as defined in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy* and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:

1) Member disenrollment requests;

2) CSFP disenrollment processes (including special populations transitions out of Medicaid Managed Care); and

3) Department disenrollment requests.

ii. The CFSP shall accept and process all CFSP enrollments and disenrollments within twenty-four (24) hours of receipt of the standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file. In limited instances and consistent with North Carolina Medicaid Managed Care and CFSP Enrollment Policy and federal requirements under 42 C.F.R § 438.56(b)(2), the CFSP, with approval from the Department, shall be allowed to request Member disenrollment from the CFSP in limited instances. The CFSP will be accountable to use all information available to the CFSP, including beneficiary self-referral, when making waiver program referrals.

iii. The CFSP shall comply with the Department's membership reconciliation process as defined in *Section V.L. Technical Specifications*.

iv. The CFSP shall develop and maintain a North Carolina Medicaid Managed Care and CFSP Enrollment Policy and submit to the Department for review and approval sixty (60) Calendar Days after the Contract Award. The CFSP shall submit to the Department for review any material updates to the policy at least ninety (90) Calendar Days prior to implementation.

3. Transitions of Care Across Plans and Delivery Systems

a. Ongoing Requirements

i. The CFSP shall develop policies, processes and procedures to support Members transitioning to the CFSP from BH I/DD Tailored Plans, Standard Plans, Tribal Option, between delivery systems (e.g., from NC Medicaid Direct to the CFSP), or from the CFSP to a Standard Plan, BH I/DD Tailored Plan, Tribal Option or NC Medicaid Direct.

ii. Within sixty (60) Calendar Days after Contract Award, the CFSP shall provide the Department with a contact person who will coordinate Transitions of Care for newly enrolling Members on behalf of the CFSP, including for the initial transition to the CFSP.

iii. The CFSP shall accept and transfer 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.

iv. The CFSP shall adhere to the Department's Transition of Care Policy for newly enrolling Members and Members transitioning out of the CFSP.[7] The CFSP shall at a minimum:

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

2) Provide for the transfer and receipt of relevant Member information, including a summary page narrative of member-specific circumstances that are time-sensitive or potentially impact continuity of care, a summary listing of the Member's providers, treatment records that would encompass both physical and BH, a copy of DSS Health Summary Form - Initial Visit (DSS 5206) and Health Summary Form - 30 day Comprehensive Visit (DSS 5208) as applicable, Care Management records, open service authorizations, prescheduled appointments (including NEMT), historic claims and encounter data, and other pertinent materials, to the transitioning Member's Receiving Entity upon notification of the transition such that the transition of care shall be with minimal disruption to the Member's established relationships with providers and existing care treatment plans. Transferred information described here is collectively referred to as the transition file content.

a) The CFSP shall assist with clinical record transfer among practitioners, as needed.

b) The CFSP shall transfer all relevant information to the BH I/DD Tailored Plan to facilitate the transition of diversion, in-reach and transition activities for recipients enrolled in and being served under Transitions to Community Living as described in *Section V.D.2.p. Diversion from Institutional and other Congregate Settings* and

[7] The Department's draft Transition of Care Policy is available here: https://medicaid.ncdhhs.gov/ncdhhs-transition-care-policy-0/download?attachment.

Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings.

c) The CFSP shall adhere to the Department's Transition of Care Policy regarding managing open appeals at the time of the Member's transition to a Standard Plan, BH I/DD Tailored Plan, Tribal Option or NC Medicaid Direct as referenced in *Section V.B.7.b. Member Grievances and Appeals General Requirements.*

d) The CFSP shall facilitate the transfer of a Member's claims/encounter history and Prior Authorization data between authorized Transition Entities and Department business associates following requirements established and published by the Department.

e) If the CFSP is contacted by a Receiving Entity (such as a Standard Plan, other plan established by the Department, or designated entity within NC Medicaid Direct), requesting relevant member information, the CFSP shall provide such data to the entity within five (5) Business Days of receiving the request, unless otherwise governed by established technical requirements, as well as contact the County Child Welfare Worker and a Member's Parent(s), Guardian(s) and Custodian(s) for Members in County DSS custody as appropriate.

f) The CFSP shall engage in pre-transition planning discussions and knowledge transfer with other Transition Entities as required in the NC DHHS Transition of Care Policy or as requested by another Transition Entity.

g) If the CFSP receives notice of an enrollment and has not received the applicable TOC data file or Enrollee's Transition File within five (5) Business Days of the Transition Notice Date, the CFSP will contact the applicable Transition Entity on the following Business Day to request transition information, as needed.

h) Within five (5) Business Days of the CFSP receiving notice that a Member will disenroll, the CFSP shall ensure the Member's transition data files and Member's transition file are transferred utilizing process and schedule established in applicable technical requirements.

v. The CFSP shall ensure that any Member enrolling into the CFSP is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.

vi. The CFSP shall allow a Member to complete an existing service authorization period for a Medicaid-covered service established by their previous Standard Plan, BH I/DD Tailored Plan, Tribal Option or NC Medicaid Direct.

1) If applicable, the CFSP shall assist the Member in transitioning to an in-network provider at the end of the service authorization period established by their previous Standard Plan, BH I/DD Tailored Plan, Tribal Option or NC Medicaid Direct.

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

1) The CFSP shall make a good-faith effort to contract with a non-participating provider who is treating a Member.

2) The CFSP shall facilitate the transition to establish a new participating provider and plan a safe and medically appropriate transition for the Member if the non-participating provider does not contract with the CFSP.
3) The CFSP shall allow Members to obtain medications on an as needed basis for the 180-day transitional period.
4) The CFSP shall work closely with County DSS to identify any other medically necessary services or medications that will be necessary to ensure a smooth transition and support a Member's permanency goals as relevant.
5) The CFSP shall take all reasonable measures to 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).

viii. The CFSP shall allow pregnant Members to continue to receive services from their BH treatment provider or obstetrician, without any form of prior authorization, until the birth of the child, the end of pregnancy, or loss of Medicaid eligibility during the pregnancy, whichever is later.

ix. The CFSP shall bear the financial responsibility for the diagnosis-related group (DRG) based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the CFSP (or prior in the case of a Member who is inpatient on their first day of enrollment in the CFSP if there is no prior Medicaid Managed Care or NC Medicaid Direct coverage for inpatient services). The CFSP shall send DRG codes on encounter data. Post discharge care may be coordinated prior to discharge.

x. For facilities paid a per diem rate, the CFSP shall only be responsible for the days the Member resides in the facility and is also enrolled with the CFSP.
1) The CFSP's financial responsibility shall not extend beyond the date of disenrollment.
2) Post-discharge care shall be coordinated prior to discharge in accordance with *Section V.D. Care Management*.

xi. The CFSP shall establish a written CFSP Transition of Care Policy.
1) The CFSP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and include processes and procedures for coordinating care for:
a) Members who have an Ongoing Special Condition;
b) Members transitioning to the CFSP from a BH I/DD Tailored Plan, Standard Plan, Tribal Option, or NC Medicaid Direct;
c) Members transitioning from the CFSP into a BH I/DD Tailored Plan, Standard Plan, Tribal Option, or NC Medicaid Direct;
d) Recipients enrolled in and being served under Transitions to Community Living;
e) Members poised to lose Medicaid eligibility, including Former Foster Youth upon reaching 21 or 26, as applicable, and other adult Members, who are transitioning out of the CFSP, as described in *Section V.D.2.o. Care Management Requirements for Members Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody and Members Who Lose Medicaid Eligibility;*
f) Members being served by County DSS;
g) Members covered by the Management of Inborn Errors of Metabolism (IEM) Program, as defined in *Section V.D.8. Prevention and Population Health Programs*;
h) Members who have had two (2) or more visits to the emergency department for a psychiatric problem or two (2) or more episodes using BH crisis services within the prior eighteen (18) months as defined in NCGS § 108D-40;
i) Services delivered through other delivery systems including NC Medicaid Direct;

j) Coordination of Members enrolled in the Healthy Opportunities Pilot transitioning toa BH I/DD Tailored Plan, Standard Plan, Tribal Option or NC Medicaid Direct; and

k) Other requirements as defined in this section and the Department's Transition of Care Policy as revised.

2) The CFSP Transition of Care Policy shall integrate processes and procedures for managing the transition of Members transitioning between health plans and delivery systems, including Members transitioning from juvenile justice, jail, prison or other detention facilities.

3) Processes and procedures shall be consistent with the Department's Transition of Care Policy and ensure:

a) Timely Warm Handoffs as defined in *Section III.A. Definitions* with the other Transition Entity;

b) Proactive, communication with the other Transition Entity (e.g., Standard Plan, BH I/DD Tailored Plan, NC Medicaid Direct) throughout the transition process;

c) Proactive communication, including pre-enrollment planning and post disenrollment follow up, including with the County Child Welfare Worker and the Parent(s), Guardian(s), or Custodian(s) of a Member in County DSS custody, as appropriate;

d) Population and service-specific coordination with other entities to ensure the Member's continuity of care; and

e) Member and provider education on anticipated changes to current services resulting from the Member's disenrollment from the CFSP.

4) The CFSP shall submit the CFSP Transition of Care Policy to the Department for review and approval ninety (90) Calendar Days after Contract Award.

xii. Transition Between Providers due to Provider Termination or Disenrollment

1) The CFSP shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated, otherwise leaves the CFSP's network or discharges the Member.

a) Provider Termination, Expiration or Nonrenewal of the Contract. In instances in which a provider leaves the CFSP's network for expiration or nonrenewal of the contract and the Member is in an Ongoing Course of Treatment or has an Ongoing Special Condition, the CFSP shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with NCGS § 58-67-88(d), (e), (f), and (g).

b) Provider Termination for Reasons Related to Quality of Care or PI. In instances in which a provider is terminated or leaves the CFSP's network for reasons related to quality of care or PI, the CFSP shall notify the Member in accordance with this section and shall assist the Member in transitioning to an appropriate in-network provider that can meet the Member's needs.

c) Provider Discharge of Member. In instances in which a provider discharges the Member, the CFSP shall assist the Member in transitioning to an appropriate provider that can meet the Member's needs.

2) Member Notification of Provider Termination or Member Discharge

a) The CFSP shall provide written notice of termination of a network provider to all Members who have received services from the terminated provider within the six (6) month period immediately preceding the date of notice of termination. 42 C.F.R. § 438.10(f)(1).

b) The CFSP shall provide the written notice of termination of a network provider to Members by the later of thirty (30) Calendar Days prior to the effective date of the termination or fifteen (15) Calendar Days after the receipt or issuance of a provider termination notice, except if a terminated provider is a PCP for a Member. 42 C.F.R. § 438.10(f)(1).

c) If a terminated provider or provider discharging the Member is a PCP for a Member, the CFSP shall notify the Member within seven (7) Calendar Days of the following:
   i) Procedures for selecting an alternative PCP.
   ii) That the Member will be assigned to a PCP if they do not actively select one within thirty (30) Calendar Days.

d) If a terminated provider is a PCP for a Member, the CFSP shall validate that the Member selects or is assigned to a new PCP within thirty (30) Calendar Days of the date of notice to the Member and notifies the Member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.

e) The CFSP shall use a Member notice consistent with the Department-developed model Member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).

3) The CFSP shall hold the Member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.

4) The CFSP shall establish a Provider Transition of Care Policy.
   a) The Provider Transition of Care Policy shall include processes and procedures for coordinating care for Members who:
      i) Have an Ongoing Special Condition as defined in NCGS § 58-67-88(a)(1);
      ii) Are discharged from a residential or institutional setting;
      iii) Have a service or permanency plan with the County DSS that needs to be adhered to;
      iv) Are obtaining services from a provider that leaves the CFSP's network;
      v) Must select a new PCP after a provider termination; and
      vi) Other requirements as identified by the Department.
   b) The CFSP shall submit the Provider Transition of Care Policy to the Department for review and approval ninety (90) Calendar Days after the Contract Award.

b. Cross-over Population
   i. In addition to the requirements listed above in *Section V.B.3.a. Ongoing Requirements,* the CFSP shall adhere to time-limited requirements to support Members transitioning during the Crossover Period.
   ii. The CFSP shall implement strategies to minimize the disruption of benefits at CFSP implementation by adhering to additional prior authorization requirements, including resetting the number of visits that do not require prior authorization, continuing to honor current authorizations for ongoing benefits and complying with Department-defined protocols for streamlining prior authorization requests.
   iii. The CFSP shall instruct its NEMT Member and Provider Service Lines to accept reservations for appointments following CFSP launch beginning forty-five (45) Calendar Days prior to CFSP launch.
   iv. The CFSP shall have the capacity to accept, ingest and utilize claims, encounter, prior authorization data files and Care Plans from other authorized Department Business Associates related to Crossover Period activities.

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

vi. The CFSP shall make direct contact with each Member transitioning during the Crossover Period to ensure service continuity on a timeline specified by the Department.

vii. The CFSP must honor existing and active medical prior authorizations on file with NC Medicaid Direct (including LME/MCOs), BH I/DD Tailored Plans, or Standard Plans whether transferred as part of Cross-over Population data file transfer or submitted directly by the provider at no less than the first one hundred twenty (120) Calendar Days after CFSP implementation or until the end of the authorization period, whichever occurs first after CFSP implementation to ensure continuity of care for Members. For the first ninety (90) Calendar Days after CFSP launch, CFSP shall pay claims and authorize services for Medicaid-enrolled nonparticipating/out-of-network providers equal to that of in network providers. To ensure that providers fully understand the CFSP's prior authorization requirements during the transition, the CFSP will still process and pay for services rendered during the Crossover Period if:

1) A provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service; or
2) A provider submits for retroactive prior authorizations.

viii. This exception does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period. If a transitioning Beneficiary is under an Ongoing Course of Treatment covered under NCGS § 58-67-88, the CFSP will pay claims and authorize services to the Beneficiary's out-of-network providers on par with in-network providers for the duration of the applicable transitional period defined in statute.

c. Transition of Care for Members enrolled in the Healthy Opportunities Pilot

i. The CFSP shall handle Healthy Opportunities Pilot-related transitions of care as detailed in the forthcoming Healthy Opportunities Pilot Transitions of Care Protocol: CFSP.

4. Member Engagement

a. Members, their families, and caregivers may need support in the initial transition to Medicaid Managed Care and as Members in the Medicaid Managed Care program. The CFSP will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting Members and their families with understanding Medicaid Managed Care, navigating the health care system, improving overall Member health through various avenues, including maintaining a Member Services department, conducting Member and community outreach, and providing education during and after Medicaid Managed Care implementation. The Department strongly encourages the CFSP to develop innovative approaches, including the use of electronic mechanisms for Member education and outreach.

b. The CFSP shall be responsible for engaging with Members and their Authorized Representatives to provide assistance with understanding Medicaid Managed Care and their rights and responsibilities and accessing available benefits and services in-person, by telephone, by mail, and online/electronically. 42 § C.F.R. 438.10(c)(7).

c. The CFSP shall utilize various engagement strategies and communication mediums to engage, educate, and assist Members, including the operation of a dedicated Member Services Department.

d. The CFSP shall use standard managed care terminology in all communications with Members and Potential Members as defined in *Section VII. Attachment K. Managed Care Terminology Provided to the CFSP for Use with Members Pursuant to 42 C.F.R. § 438.10.*

e. Unless otherwise stated, all written communications, call center scripts, websites or other communications directed to Members or Potential Members must adhere to the requirements in this Contract and receive prior approval from the Department before the material is communicated. All communication must be tailored to meet the unique needs of Members enrolled in the CFSP and be sensitive to Members in need of Trauma-Informed Care. The Department may require changes to previously approved communications, at its sole discretion.

f. Member Services Department
   i. The Member Services Department shall:
      1) Maintain a Member call center and a Member services website;
      2) Engage with the Department engagement and customer service offices, as well as local community and county organizations;
      3) Provide written and oral educational materials, activities and programs;
      4) Coordinate with County DSS to help support communications and informed decision-making; and
      5) Collaborate with other entities operating within the Medicaid Managed Care delivery system and NC Medicaid Direct.
   ii. The CFSP shall have and implement Member services policies and procedures that are consistent with the North Carolina System of Care framework as described in *Section V.D.6. System of Care* and address the needs of Potential Members, Members, those individuals who support and care for Members and address all Member services activities.
   iii. The CFSP shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to Members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
   iv. The Member services staff shall be responsible, at a minimum, for the following functions:
      1) Explaining operation of the CFSP, including the role of the PCP and what to do in an emergency, disaster or urgent medical situation;
      2) Assisting with arranging NEMT for Members;
      3) Assisting Members in selecting or changing PCP or care manager;
      4) Educating and assisting Members with obtaining services under Medicaid Managed Care, including out-of-network services and carved out services;
      5) Explaining transition of care requirements and Care Management services offered by the CFSP, including service continuity protections and how to seek assistance in the event concerns or questions related to service continuity;
      6) Explaining the System of Care approach as described in *Section V.D.6. System of Care.*
      7) Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
      8) Fielding and responding to Members' questions and complaints;
      9) Clarifying information in the Member Handbook;
      10) Advising Members of and assisting Members with the Appeals, Grievance, and State Fair Hearing processes;
      11) Referring Members to the Department's EB if an individual requests information regarding how to enroll in or select the CFSP (for Potential Members), BH I/DD Tailored Plan, Standard Plan, or NC Medicaid Direct;

12) Referring Members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues; and
13) Educating and assisting Members with obtaining Healthy Opportunities Pilot services including how to access services and instructions for submitting a Healthy Opportunities Pilot-related grievance.

v. The CFSP shall operate and maintain the following four (4) Member facing Service Lines:
1) Member Service Line (see *Section V.H.1. Service Lines*);
2) Behavioral Health Crisis Line (see *Section V.H.1. Service Lines*);
3) NEMT Member Service Line (see *Section V.H.1. Service Lines*); and
4) Nurse Line.

vi. The CFSP shall conduct ongoing quality assurance of its Member Services Department via Member surveys and internal audits of departments to ensure Member satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
1) Member surveys shall be made available after each web, call center (with exception of Behavioral Health Crisis Line) or in-person interaction.
2) Surveys and internal audits are intended to measure Member's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
3) Reports, including the results of member surveys and the CFSP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.

g. Member Services Website
i. The Department encourages the CFSP to utilize processes, procedures and technology to improve the Member experience and effectively reduce or ease administrative burdens on the Member.
ii. The CFSP shall develop and maintain a dedicated, interactive North Carolina Medicaid Member services website that, at a minimum, has the functionality to allow the Member to search for in-network providers and search the drug formulary.
iii. Within two (2) "clicks" from the homepage, the CFSP shall also include on its website at a minimum:
1) An up-to-date copy of the Member Handbook;
2) Information on hours of operation;
3) How to contact the Member services staff and care managers;
4) How to access CFSP services;
5) Appeals, Grievances, and State Fair Hearing policies and processes;
6) Information regarding the Ombudsman program;
7) Health promotion and educational materials;
8) Any specific prevention, population health, or Care Management programs offered by the CFSP;
9) Information relevant to any disasters or states of emergency affecting the CFSP;
10) Information on System of Care Community Collaboratives and how Members can participate;
11) Information on Healthy Opportunities Pilot services available, including how to access services and instructions for submitting a Healthy Opportunities Pilot-related grievance; and
12) Other information the CFSP believes would support the Member and their families.

iv. The CFSP shall meet the same literacy standards identified for written materials in any materials made available electronically.
v. The CFSP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
vi. The CFSP website shall be accessible via mobile devices.
vii. The CFSP website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's Systems that impact the ability for the website to operate correctly.
    1) The CFSP shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
    2) The CFSP shall notify the Department and Members of unscheduled downtime within one (1) hour and include a notice on its website with an estimated time until the website is functioning and alternative methods of how the Department and Members can communicate with the CFSP during the downtime.

h. Communications with Members and Potential Members
    i. The CFSP shall ensure all contacts with Members or Authorized Representatives are Culturally and Linguistically Competent and provide effective communication to the Member, with deference to the method requested by the Member, including sign language interpreters, and occur in a timely manner that protects the privacy and independence of the individual with a disability.
    ii. The CFSP shall ensure that Members and Potential Members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and NCGS § 58-3-191(b)(5) in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
    iii. The CFSP shall address the following in the development of Member materials:
        1) The population size and geographic/regional needs and differences throughout the State;
        2) Language proficiencies;
        3) Types of disabilities;
        4) Literacy levels;
        5) Cultural needs of the Member population;
        6) Age and age-specific or other targeted learning skills or capabilities;
        7) Sensitivity in language and tone of communication to individuals who experienced trauma and ACEs; and
        8) Ability to access and use technology.
    iv. The CFSP shall be permitted to provide information required to be communicated to Members and Potential Members in the following manner:
        1) Mailing a printed copy of the information to the Member's mailing address is the default absent an explicit preference stated by a Member or their Authorized Representative;
        2) Emailing the information, after receiving the Member's or Potential Member's express consent to receive information via email and obtaining a valid, up to date email address;
        3) Posting the information on the CFSP's website and advising the Member or Potential Member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a Member may request communication accommodations; and

4) Providing the information by any other method that can reasonably be expected to result in the Member receiving the information. 42 C.F.R. § 438.10(g)(3).

v. The CFSP shall not construe any requirement herein to limit or alleviate the CFSP's obligation to communicate directly with the Member, a Member's Authorized Representative, or Potential Member as required under the Contract or under federal or state law or regulation.

vi. The CFSP shall provide information in the Member's preferred format upon request at no cost (e.g., a Member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).

vii. The CFSP shall consult with and comply with practices of the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.

i. Written and Verbal Member Materials

i. The CFSP shall provide Member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which address information requirements related to written and verbal information provided to Members.

ii. The CFSP shall provide all written materials to Members and Potential Members consistent with the following:

1) Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).

2) Use a san serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.

3) Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members or Potential Members with disabilities or limited English proficiency.

4) Include a tagline that is sufficiently conspicuous and visible (san serif font type and font size no smaller than 12 points) for Members or Potential Members to see and read the information on how to request auxiliary aids and services, including materials in alternative formats. The font type and size shall be appropriate to the audience. 42 C.F.R. § 438.10(d).

a) Taglines are required on materials that are critical for Potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d).

5) Written in accordance with Associated Press Style and Department-specific style guide.

6) Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).

7) Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the CFSP's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:

a) Spanish;
b) Chinese (Mandarin Simplified);
c) Vietnamese;
d) Korean;
e) French;
f) Arabic;

g) Hmong;
h) Russian;
i) Tagalog;
j) Gujarati;
k) Mon-Khmer (Cambodia);
l) German;
m) Hindi;
n) Laotian; and
o) Japanese.

iii. The CFSP shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to Members in their original format.

iv. The CFSP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.

v. The CFSP shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on various platforms, such as website and mobile devices.

j. Mailing Materials to Members

i. The CFSP shall verify addresses against a United States Postal Service approved product or service on all Members enrolled in the CFSP prior to mailing materials, at no additional cost to the Department or the Member.

1) The CFSP shall make all reasonable attempts to identify the correct mailing address, including through coordination and communication with County DSS Offices, and mail information to the Member within applicable timeframes, as required under the Contract.

2) The CFSP shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.

3) The CFSP shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.

ii. If the CFSP identifies a new, updated address, the CFSP shall resend only Member specific information at no additional cost to the Department or the Member.

iii. All materials mailed to Potential Members, Members, and, when applicable, Authorized Representatives, shall be sent via first class mail.

iv. The CFSP shall consider cost-effective methods for controlling postage costs when producing Member materials for mailing.

v. The CFSP shall develop a Member Mailing Policy, subject to Department review and approval. The CFSP shall submit the Member Mailing Policy to the Department sixty (60) Calendar Days after Contract Award.

k. Translation and Interpretation Services

i. The CFSP shall make interpretation services available to all Potential Members, Members and Authorized Representatives. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).

ii. The CFSP shall notify its Members or Authorized Representatives of the availability of interpretation services and inform them of how to access such services, including providing the following information:
    1) That verbal information is available for any language and written translation is available in prevalent languages free of charge to each Member. 42 C.F.R. § 438.10(d)(4); and
    2) That auxiliary aids and services are available upon request and at no cost for Members with disabilities. 42 C.F.R. § 438.10(d)(5).
iii. The CFSP shall offer qualified interpreter services available for verbal contacts with Members and Authorized Representatives whose primary language is not English.
iv. The CFSP shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member or Authorized Representative.
v. The CFSP shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with Member audiences.
vi. The CFSP shall make interpretation services available free of charge to each Member or Authorized Representative. 42 C.F.R. § 438.10(d)(4).
vii. The CFSP shall staff Member facing service lines with enough fluent Spanish speakers to converse with Members or Authorized Representatives who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the Member or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department.
viii. Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:
    1) Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
    2) Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
ix. The CFSP shall notify the Department in writing within five (5) Business Days for each time the CFSP or its Subcontractor charges a Member, Potential Member, Authorized Representative or Guardian for interpreter or translation services.
x. The CFSP shall notify the Department of any change in the language preference for Members or Authorized Representatives in an electronic format and frequency as defined by the Department.

l. Member Welcome Packet
    i. The CFSP shall send a Welcome Packet to the Member within six (6) Calendar Days following receipt, from the Department, of the standard enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment.
    ii. The CFSP shall include the following in the initial Member Welcome Packet and upon Redetermination:
        1) A welcome letter that notifies the Member of their enrollment in the CFSP and provides:
            a) The effective date from which the CFSP shall assume health coverage for the Member;
            b) Information on how to access the online Provider directory and how to request a hardcopy of the provider directory;
            c) Information on how to change to a Standard Plan, BH I/DD Tailored Plan, Tribal Option, or NC Medicaid Direct;

d) The toll-free service line numbers which a Member may call for the Member Service Line, Behavioral Health Crisis Line, NEMT Member Service Line, ~~and~~ Nurse Line and Pharmacy Service Line;
e) Information on how to inquire about accessing Care Management services, including background on CFSP Care Management and how to change a care manager;
f) The role of a PCP in Medicaid Managed Care;
i) How to select or change a PCP;
ii) Why a Member might be auto-assigned a PCP;
g) How to arrange for NEMT;
h) An offer of assistance in arranging initial visit to his or her PCP;
i) Contact information for the Ombudsman Program; and
j) The CFSP website address.
2) Member identification (ID) card;
3) A current Member Handbook; and
4) The CFSP may opt to send the ID card or handbooks separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.

iii. The CFSP shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within sixty (60) Calendar Days of Contract Award, and then annually thereafter. The Department may require changes to the Member Welcome Packet and other communications, at its sole discretion.

iv. All materials mailed to Potential Members, and when applicable, Authorized Representatives, shall be sent via first class mail, unless otherwise approved by the Department or permitted by the Member Mailing Policy.

m. Member Identification Cards

i. The CFSP is required to generate an identification card for each Member enrolled in the CFSP with the following printed information:
1) The Member's North Carolina Medicaid identification number;
a) The Member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and
b) The Member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the CFSP.
2) The CFSP's name, mailing address and Member Portal;
3) The Member's PCP name, physical address and phone number;
4) The toll-free help line numbers for the Member Service Line, ~~NEMT Member Service Line,~~ Behavioral Health Crisis Line, Nurse Line, Provider Support Service Line, and ~~Prescriber Service Line~~ Pharmacy Service Line;
5) Indicator if Member is NC Medicaid; and
6) The North Carolina Department of Justice Medicaid Investigations Division (MID), fraud, waste and abuse hotline with the following language:
a) If you suspect a doctor, clinic, hospital, home health service or any other kind of health provider is committing Medicaid fraud, report it. Call (919) 881-2320.

ii. A replacement identification card shall be provided at least once every twelve (12) months, upon request by the Member or the Member's Authorized Representative or upon PCP change, at no charge to the Member.

iii. The CFSP may send a certificate of coverage in lieu of a Member identification card for Members who have a coverage termination date prior to notification of enrollment to the CFSP via the standard enrollment file layout, if approved by the Department.

iv. The CFSP shall submit the Member identification card to the Department for review and approval sixty (60) Calendar Days after Contract Award, at the direction of the Department, or when changes are made to the card layout or content.
    1) As part of the CFSP's submission of its Member identification card sixty (60) Calendar Days after Contract Award, the CFSP must include the Plan's logo as a separate image file from the Member identification card.

n. Member Handbook
    i. The CFSP shall use the Department's model CFSP Member Handbook as guidance in the development of the Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii).
    ii. The CFSP shall ensure that each Member receives a Member Handbook, which serves as a summary of benefits and coverage, within six (6) Calendar Days after the CFSP receives notice of the Member's enrollment in the CFSP. 42 C.F.R. § 438.10(g)(1).
    iii. The CFSP shall ensure that all Member Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
    iv. In accordance with 42 C.F.R. § 438.10(g) and NCGS § 58-3-190(f), NCGS § 58-51-38(b), and NCGS § 58-67-88(j), the CFSP shall ensure that the Member Handbook includes sufficient information that enables the Member to understand how to effectively use Medicaid Managed Care. This information shall include at a minimum:
        1) Covered benefits provided by the CFSP;
        2) Member Enrollment and Disenrollment Policy, including Information on the Member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract;
        3) Care Management, including how to change care managers;
        4) In selected Healthy Opportunities Pilot regions - Information on the Healthy Opportunities Pilot Program and how to access its services, including through CFSP Care Management and instructions for submitting a Healthy Opportunities Pilot-related grievance;
        5) How and where to access any benefits provided by the Department, including carved out services and how NEMT is provided;
        6) List of counseling or referral services that the CFSP does not cover because of moral or religious objection, instructions for how the Member can obtain information from the Department about how to access those services, and notification that the CFSP's failure to cover a service based on moral or religious objection is a "with cause" reason for Member disenrollment;
        7) The amount, duration, and scope of benefits available under the CFSP in sufficient detail to ensure that Members understand the benefits to which they are entitled;
        8) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's PCP;
        9) Information on the EPSDT benefits for Medicaid Managed Care Members under the age of twenty-one (21), including:
            a) The benefits of preventive health care;
            b) Populations eligible for EPSDT;
            c) Services available under the EPSDT program and where and how to obtain those services;
            d) That EPSDT services are not subject to cost sharing; and

e) That CFSP will provide scheduling and transportation assistance for EPSDT services upon request by the Member.

10) The extent to which, and how, after-hours and emergency coverage are provided, including:
    a) What constitutes an Emergency Medical Condition and emergency services;
    b) The fact that prior authorization is not required for emergency services; and
    c) The fact that, subject to 42 C.F.R. § 438.10, the Member has a right to use any hospital or other setting for emergency care.
11) Any restrictions on the Member's freedom of choice among in-network providers and out-of-network providers;
12) The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the CFSP cannot and shall not require a Member to obtain a referral before choosing a family planning provider;
13) Cost sharing, if any, imposed on North Carolina Medicaid beneficiaries;
14) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract;
15) The process of selecting and changing the Member's PCP, including, but not limited to:
    a) The number and frequency limitations of PCP changes;
    b) Information on the two (2) annual without cause PCP changes; and
    c) The with cause reasons for switches beyond the two (2) without cause changes.
16) Grievance, Appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
    a) The right to file Grievances and Appeals;
    b) The requirements and timeframes for filing a Grievance or Appeal or State Fair Hearing;
    c) The availability of assistance in the filing process;
    d) The right to request a State Fair Hearing after the CFSP makes a decision on the Member's Appeal which is adverse to the Member; and
    e) The fact that, when requested by the Member, benefits that the CFSP seeks to reduce or terminate will continue if the Member files a request within the timeframes specified for filing and that the Member may be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Member.
17) How to exercise an Advance Directive, as set forth in 42 C.F.R. § 438.3(j);
18) An overview of its continuation of benefits policy and define when, why and how a Member or a Member's Authorized Representative may file for a continuation of benefits;
19) How to access auxiliary aids and services, including additional information in alternative formats or languages;
20) The toll-free help line numbers for the Member Service Line, NEMT Member and Provider Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Support Service Line, and Pharmacy Service Line;
21) Information on how to report suspected fraud, waste or abuse;
22) Information about Opioid Misuse Prevention and Treatment Program and the Tobacco Cessation Program;
23) Information on the CFSP Transition of Care Policy;
24) Information about the CFSP's prevention and population health programs;

25) Information about the System of Care approach, including Community Collaboratives, as described in detail in *Section V.D.6. System of Care;* and
26) Contact information for Beneficiary support systems, including the Ombudsman Program and the EB.

v. The CFSP shall make the Member Handbook available for review by the Department, upon request.
vi. The CFSP shall provide the Department for review any changes to the Member Handbook, forty-five (45) Calendar Days prior to the intended effective date of the change.
vii. The CFSP shall notify each Member, using Department-developed templates, of any significant change to the Member Handbook, at least thirty (30) Calendar Days before the intended effective date of the change.

o. Member Education and Outreach
i. The CFSP shall provide education and outreach to Members and Potential Members, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department, the EB, Ombudsman Program, local health departments and/or County DSS may be present.
ii. The CFSP shall develop educational materials to be used by the EB to support CFSP and PCP selection. The materials are subject to review and approval by the Department at least ninety (90) Calendar Days prior to use with Members, Potential Members, and/or Authorized Representatives.
iii. The CFSP shall provide information regarding its planned Member education efforts to the Department for review and approval sixty (60) Calendar Days after Contract Award and annually thereafter.
iv. Any outreach or education related to the proposed Member Incentive Program (as described in *Section V.B.4.s. Member Incentive Program*) must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater Member engagement will not be approved.
v. In support of the Department's health equity goals, the CFSP shall develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the CFSP's goals and strategies for engaging with Historically Marginalized Populations, specific initiatives to address disparities, and expected outcomes of the plan. The Member Engagement and Marketing Plan for Historically Marginalized Populations shall be submitted no later than one hundred twenty (120) Calendar Days after Contract Award and annually thereafter to the Department.

p. Engagement with Consumers
i. The CFSP must have a strong understanding of and capability to meet the needs of its Members. To that end, the CFSP shall establish and maintain mechanisms to communicate with and obtain advisement from consumer groups.
ii. The CFSP shall establish a relationship with the Statewide Consumer and Family Advisory Committee (SCFAC) as set forth in NCGS § 122C-171.
1) The CFSP shall seek input and advice regarding the CFSP's programs and policies from the SCFAC. Topics for discussion and consultation shall include but not limited to:
a) Physical, pharmacy, BH, and I/DD benefits;
b) Coordination with the County DSS to support family preservation and permanency planning;
c) Care Management; and
d) Healthy Opportunities Pilots.

2) The CFSP shall provide annual reports, including quality measure data, appeals and grievance, critical incident reporting, Member satisfaction surveys and ad hoc feedback from Providers to the SCFAC that will enable the SCFAC to review Member experience and quality of care to serve as an early warning system for the CFSP on emerging issues.

iii. The CFSP shall establish a Statewide Member Advisory Committee (MAC) to garner Member and stakeholder input and advice regarding the CFSP's programs and policies.

1) A MAC established by a CFSP whose lead entity also operates a BH I/DD Tailored Plan or a consortium established under NCGS § 122C-116 shall include committee members from each BH I/DD Tailored Plan Region.
2) A MAC established by a CFSP whose lead entity does not operate a BH I/DD Tailored Plan shall include committee members from each Standard Plan Region.
3) Committee members may include Members themselves, their family members, representatives or Guardians, and/or representatives of consumer advocacy organizations.
4) The MAC shall reflect the geographic, racial, and cultural diversity of North Carolina, and include a majority (51%) of Member, consumer and family representatives. Topics for discussion and consultation shall include but should not be limited to:
   a) Physical, pharmacy, BH, and I/DD benefits;
   b) Coordination with the County DSS to support family preservation and permanency planning;
   c) Care Management; and
   d) Healthy Opportunities Pilots.
5) The CFSP shall adhere to the Department's Member Advisory Committee Guidance.
   a) The CFSP shall develop a Member Advisory Committee Charter in accordance with the Department's PHP Member Advisory Committee Guidance and submit to the Department for approval annually, and sixty (60) Calendar Days prior to any significant changes to the Charter.
   b) The CSFP shall develop a Member Advisory Committee Recruitment Plan in accordance with the Department's PHP Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant change to the Plan.
      i) The Recruitment Plan shall define how the CFSP shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by the CFSP.
6) The CFSP shall consult with the MAC at least on a quarterly basis.
7) The CFSP shall provide quarterly reports, including quality measure data, appeals and grievance, critical incident reporting, Member satisfaction surveys and ad hoc feedback from Providers to the MAC that will enable the MAC to review Member experience and quality of care to serve as an early warning system for the CFSP on emerging issues.

iv. The CFSP shall establish a relationship with the DSS' Child Welfare Family Advisory Council (CWFAC).

1) The CFSP shall seek input and advice regarding the CFSP's programs and policies from the CWFAC. Topics for discussion and consultation shall include but not limited to:
   a) Physical, pharmacy, BH, and I/DD benefits;
   b) Coordination with the County DSS to support family preservation and permanency planning;
   c) Care Management; and
   d) Healthy Opportunities Pilots.

2) The CFSP shall provide quarterly reports, including quality measure data, appeals and grievance, critical incident reporting, Member satisfaction surveys and ad hoc feedback from Providers to the CWFAC that will enable the CWFAC to review Member experience and quality of care to serve as an early warning system for the CFSP on emerging issues.

q. Engagement with Beneficiaries Utilizing LTSS

i. The CFSP must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. The CFSP shall establish an LTSS Member Advisory Committee that garners stakeholder input and advice regarding the LTSS covered under the CFSP contract, and meets all provisions noted in 42 C.F.R. § 438.110.

ii. The CFSP shall provide reports that will enable the Committee to review Member experience and quality of care to serve as an early warning system for the CFSP on emerging issues.

iii. The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the CFSP or their representatives and include:

1) Members accessing LTSS;
2) Representatives of LTSS Members (e.g., Authorized Representatives);
3) LTSS providers;
4) Care managers serving Members with LTSS needs;
5) DSS and County DSS representatives; and
6) CFSP staff involved in the authorization of LTSS and/or Care Management of LTSS Members.

iv. The CFSP shall adhere to the Department's Member Advisory Committee Guidance.

1) The CFSP shall develop a LTSS Member Advisory Committee Charter in accordance with the Department's CFSP Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Charter.
2) The CFSP shall develop an LTSS Member Advisory Committee Recruitment Plan in accordance with the Department's Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Plan.
   a) The Recruitment Plan shall define how the CFSP shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by the CFSP.

v. The CFSP shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.

vi. The CFSP shall provide quarterly reports on quality measure data, appeals and grievance, critical incident reporting, member satisfaction surveys and ad hoc feedback from providers to the LTSS Member Advisory Committee that will enable the LTSS Member Advisory Committee to review Member experience and quality of care to serve as an early warning system for the CFSP on emerging issues.

vii. The CFSP shall designate an existing staff member as a single point of contact who will be responsible for reporting concerns related to quality of care delivered to Members obtaining institutional and community-based LTSS to the state's Long-Term Care Ombudsman or Medicaid Managed Care Ombudsman Program, as applicable.

viii. The CFSP shall require care managers and other Member services and provider relations staff to report concerns related to quality of care delivered to Members obtaining institutional and community-based LTSS to a single point of contact designated by the CFSP.

ix. The CFSP shall help coordinate resolution of concerns within thirty (30) Calendar Days related to quality of care delivered to Members obtaining institutional and community-based LTSS with the Member, Member's authorized family member(s), the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or MAC, as appropriate.

r. Health Education and Promotion Programs
   i. The CFSP shall develop Member health education and promotion programs that address prevention, wellness, and early intervention of illness and disease.
   ii. The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.
   iii. The CFSP shall make the health education and promotion programs available to Members through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
   iv. The Department may select specific educational and health promotion topics for the CFSP to implement that align with the Department's priorities or the annual update to the Quality Strategy.

s. Member Incentive Program
   i. The CFSP may offer healthy behavior incentive programs to Members, provided that the following criteria are met:
      1) The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy.
      2) The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
      3) The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed seventy-five dollars and zero cents ($75.00).
   ii. Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
   iii. Prior to implementation, the CFSP shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the Quality Assurance and Performance Improvement (QAPI).
   iv. The CFSP shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (i) the program meets the requirements of 1112 of the Social Security Act; and (ii) the program meets the criteria determined by the Department.

5. Marketing

a. The Department views CFSP marketing activities as a method to help publicize Medicaid Managed Care and educate Potential Members about health plan options, while ensuring the protection of Members from coercive or misleading practices.
b. The CFSP shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the CFSP to ensure that Members receive accurate verbal and written information to make an informed decision on whether to enroll or reenroll in the CFSP.
c. The CFSP shall submit its marketing plan to the Department for review and approval sixty (60) Calendar Days following Contract Award and on an annual basis thereafter.

d. The CFSP shall not market nor distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i). Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
e. The CFSP shall ensure that marketing materials are accurate and does not mislead, confuse, or defraud Members or the Department. 42 C.F.R. § 438.104(b)(2).
f. The CFSP shall establish and maintain, a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented shall be the responsibility of the CFSP.
g. If the CFSP chooses to market, the CFSP shall distribute marketing materials to the entire State. 42 C.F.R. 438.104(b)(1)(ii).
h. The CFSP shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the Member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
i. The CFSP shall ensure that all marketing materials and marketing strategies shall abide by the CFSP's Non-discrimination Policy. In addition, the CFSP shall not discriminate against Members or Potential Members who may:
    i. Live or receive health care in rural or underserved areas; or
    ii. Experience income disparities.
j. The CFSP shall assign a unique marketing code to all marketing materials distributed to Members.
k. Marketing Materials and Activities
    i. Permissible Marketing Activities
        1) The CFSP may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
        2) The CFSP may participate in community-based marketing events or activities (e.g., health fairs, community events, SOC Community Collaboratives).
        3) The CFSP may sponsor outreach activities and events, including as a financial sponsor.
        4) The CFSP may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
        5) The CFSP may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
    ii. Prohibited Statements, Claims, and Activities (Written or Verbal)
        1) The CFSP shall not claim that a Member must enroll in the CFSP to obtain benefits or to not lose benefits. 42 C.F.R. § 438.104(b)(2)(i). However, the CFSP may inform the Member that certain benefits are available only through enrollment in a CFSP (e.g., CFSP Care Management) so that the Member may make an informed decision.
        2) The CFSP shall not claim that the CFSP is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).
        3) The CFSP shall not use the Department or State logo in marketing materials.
        4) The CFSP shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
        5) The CFSP shall not reference Standard Plans, BH I/DD Tailored Plans or other Contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department or other plans in any of its marketing materials.

6) The CFSP shall not cross-market with a Standard Plan or BH I/DD Tailored Plan.
7) The CFSP shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).
8) The CFSP shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.
9) The CFSP shall not market materials or activities that are discriminatory or that target Potential Members based on health status, geographic residence, location of the provision of possible services or income.
10) The CFSP shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
11) The CFSP shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
12) The CFSP shall not engage in activities that seek to target members currently enrolled in other BH I/DD Tailored Plans, Standard Plans, NC Medicaid Direct or the Tribal Option.
13) The CFSP shall not offer Choice Counseling or seek to enroll Potential Members in the CFSP. This is the sole responsibility of the Department and the EB.
14) The CFSP shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
15) The CFSP shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.

iii. References to Studies and Statistics
1) The CFSP shall not use irrelevant facts or inaccurate statistical information in any marketing materials, and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
2) If references to a study or statistics are in included in any marketing materials, the CFSP shall provide reference information (e.g., publication, date, page number) and information about the CFSP's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the Marketing Material.

iv. Nominal Gifts
1) The CFSP may conduct giveaways and distribute nominal gifts to Members and Potential Members.
2) The CFSP shall ensure the following for nominal gifts offered by the CFSP:
a) The gifts do not exceed ten dollars ($10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
b) The gifts are made available to the public and are not in any way connected to enrollment.
c) The gifts are distributed via in-person contacts only (e.g., community events).

v. Marketing of Multiple Lines of Business
1) The CFSP shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.

2) The CFSP shall be permitted to co-market QHPs and Medicaid products, to the extent the CFSP is participating in both markets in the State and within the scope authorized for the CFSP under State law.
3) The CFSP shall not be permitted to market its Standard Plan or BH I/DD Tailored Plan product, as applicable, to CFSP Members.
4) The CFSP shall be permitted to provide information about a QHP to Potential Members who could enroll in such a plan as an alternative to Medicaid Managed Care due to a loss of Medicaid eligibility.

l. Department Approval of Marketing Materials
   i. The CFSP shall submit marketing materials to the Department for review at least ninety (90) Calendar Days before the proposed use of the material.
   ii. If the CFSP makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the CFSP must resubmit the materials, in accordance with this section, for Department review and approval.

m. The CFSP may engage in marketing activities beginning eight (8) weeks prior to the Department's mailing of enrollment notices to CFSP beneficiaries ahead of CFSP launch and shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the CFSP's marketing activities in accordance with *Section VI. Contract Performance.*

6. Member Rights and Responsibilities

a. The Department expects the CFSP to treat Members with dignity and respect, to protect Members' rights, to inform Members of their responsibilities as Members of the plan, and ensure each Member is not subject to any unlawful discrimination in the course of obtaining or receiving services from the CFSP or any network provider of the CFSP.

b. The CFSP shall establish and maintain written policies and procedures that are designed to protect the rights of Members and describe the responsibilities of each Member. The CFSP shall develop and submit to the Department for review a Member Rights and Responsibilities Policy sixty (60) Calendar Days after Contract Award.

c. The CFSP shall include a written description of the rights and responsibilities of Members in the Member Welcome Packet and the Member Handbook.

d. The CFSP shall provide a copy of its Member Rights and Responsibilities Policy to all CFSP employees and network providers.

e. In accordance with 42 C.F.R. § 438.100(b), the CFSP shall ensure its written policies and procedures, at a minimum, afford Members the right to:
   i. Receive information in accordance with 42 C.F.R. § 438.10;
   ii. Be treated with respect and with due consideration for his or her dignity and privacy;
   iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
   iv. Participate in decisions regarding his or her health care, including the right to refuse treatment and Advance Directives under *Section V.A.8. Advance Directives*;
   v. Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
   vi. If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and

vii. Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.

f. The CFSP shall not attempt to influence, limit, or otherwise interfere with the Member's decision to exercise his or her rights as provided in this Contract.

g. The CFSP shall ensure that Members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the CFSP or its network providers treat the Member. 42 C.F.R. § 438.100(c).

h. The CFSP shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against Members in the course of obtaining or receiving services from the CFSP or any network provider of the CFSP. 42 C.F.R. § 438.100(d).

7. Member Grievances and Appeals

a. The Department is committed to ensuring that Members understand and can freely exercise their Appeal and Grievance rights and resolve issues efficiently with minimal burden to the Member or their Authorized Representative. The CFSP shall educate the Member on their rights and provide reasonable assistance with understanding and navigating the Appeals and Grievances processes.

b. Member Grievances and Appeals General Requirements

i. The CFSP shall establish and maintain a grievance and appeals system for reviewing and resolving Member Grievances and Appeals. Components of the system shall include a Grievance process, a plan level Appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F.

ii. The CFSP shall, while adhering to the required Utilization Management Program, employ strategies to resolve Grievance and Appeals at lowest level of escalation that meets a Member's needs and in a manner that does not discourage Member's from exercising their rights.

iii. The CFSP shall adhere to the Department's Transition of Care Policy regarding managing open appeals in effect during the Member's transition as referenced in *Section V.B.3. Transition of Care Across Plans and Delivery Systems.*

iv. The CFSP shall provide Members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section V.G.3. Integration with other Department Partners*.

v. The CFSP shall provide Members reasonable assistance in completing forms and taking other procedural steps related to a plan Grievance or Appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a).

vi. The CFSP shall ensure that the individuals making decisions on Grievances and Appeals:

1) Acknowledge receipt of Grievances and Appeals (including verbal Appeals), unless the Member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).

2) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).

3) If deciding an appeal of a denial is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a grievance or Appeal that involves clinical issues, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).

4) Take into account all comments, documents, records, and other information submitted by the Member or their Authorized Representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).

vii. The CFSP shall allow an Authorized Representative (including providers) or legal Guardian, with the Member's written consent, to request an Appeal or file a Grievance on behalf of a Member. 42 C.F.R.§ 438.402(c)(ii).

viii. The CFSP shall not retaliate if a Member, Authorized Representative, or legal Guardian requests an Appeal or files a Grievance.

ix. The CFSP shall use Department developed templates for all Member notices related to the Member Grievance and Appeals processes that meet applicable notification standards, including but not limited to, the notice of Adverse Benefit Determination, the plan appeal request form, the State Fair Hearing appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii).

x. The CFSP shall define an Appeal, Adverse Benefit Determination, and Grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400.

xi. The CFSP shall provide the information specified in 42 C.F.R. §§ 438.10(g)(xi) on its Grievance, Appeals, and State Fair Hearing procedures to all providers and applicable Subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.

xii. The CFSP shall comply with Chapter 108D of the North Carolina General Statutes for all Appeals and Grievance proceedings.

c. Member Grievance Process

i. The CFSP shall develop and maintain a Member Grievance Policy subject to Department review and approval. The CFSP shall submit the Member Grievance Policy to the Department one hundred twenty (120) Calendar Days after Contract Award.

ii. The CFSP shall allow a Member or Authorized Representative to file a Grievance with the CFSP, orally or in writing, at any time. 42 C.F.R. §§ 438.408; 438.402(c)(2)(i), and 438.402(c)(3)(i).

iii. The CFSP's Member Grievance process shall include acknowledgement, in writing, within five (5) Calendar Days of receipt of each Grievance. 42 C.F.R. § 438.408(b)(1), NCGS § 108D-12.

iv. The CFSP shall use the Department-defined Notice of Acknowledgement of Receipt of Grievance to notify the Member or Authorized Representative of receipt of the Grievance.

v. The CFSP shall provide written notice of resolution of the Grievance to the Member and, as applicable the Member's Authorized Representative within thirty (30) Calendar Days from the date the CFSP receives the Grievance. 42 C.F.R. § 438.408(b)(1).

vi. If a Grievance relates to the denial of an expedited Appeal request, the CFSP shall resolve the grievance and provide notice to the Member and, as applicable, the Member's Authorized Representative within two (2) Calendar Days from the date the CFSP receives the Grievance. 42 C.F.R. § 438.408(c)(2).

vii. Consistent with 42 C.F.R. § 438.408(c)(1)-(2), the CFSP may extend the timeframes for resolution of a Grievance by up to fourteen (14) Calendar Days if:

1) The Member or Authorized Representative requests the extension, or the CFSP shows that there is a need for additional information and how the delay is in the Member's interest.

2) If the CFSP extends the timeframes not at the request of the Member or Authorized Representative, the CFSP must complete the following:

a) Make reasonable efforts to give the Member or Authorized Representative prompt oral notice of the delay;

b) Within two (2) Calendar Days, give the Member written notice of the reason for the decision to extend the timeframe and inform the Member or Authorized Representative of the right to file a Grievance if the Member disagrees with that decision; and

c) Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

3) The CFSP shall notify Members and Authorized Representatives of their opportunity to submit a complaint with the Department if the Member or Authorized Representative is dissatisfied with the CFSP's resolution of a Grievance.

viii. Healthy Opportunities Pilot Services Grievances

1) The CFSP shall allow a Member or Authorized Representative to file a grievance related to Healthy Opportunities Pilot Services.

2) Member grievances of Healthy Opportunities Pilot services may include:

a) Grievances regarding eligibility determination for Healthy Opportunities Pilot program or Healthy Opportunities Pilot service(s);

b) Grievances regarding Healthy Opportunities Pilot service authorization; and

c) Other grievances regarding access to, or coverage of, Healthy Opportunities Pilot services.

3) The CFSP shall address, track, and report to the Department all Healthy Opportunities Pilot Service Member grievances consistent with the requirements of this section.

4) The CFSP shall develop a Healthy Opportunities Pilot Member grievance policy that outlines the CFSP's approach to meet the requirements of this section. The CFSP shall submit the policy for review and approval by the Department upon request.

5) The CFSP shall accept, track, and address Members' Healthy Opportunity Pilot Service grievances routed from the Department, Ombudsman, or a Network Lead.

6) If the CFSP receives a Member grievance unrelated to CFSP's Healthy Opportunity Pilot service responsibilities, the CFSP shall route Healthy Opportunity Pilot Service Member grievances to the appropriate entity (e.g., Network Lead for HSO network issues), as applicable, within three (3) Business Days of receipt. The CFSP shall manage grievances for passthrough service authorizations regardless of whether the Member was enrolled with the CFSP at the passthrough service determination and should not route to a Member's prior PHP for resolution.

7) The CFSP shall provide information on its Healthy Opportunity Pilot service Member grievances process to a Network Lead at the Network Lead's request.

d. Notice of Adverse Benefit Determination

i. The CFSP shall give the Member timely and adequate notice of an Adverse Benefit Determination in writing consistent with the notice content and timing requirements below and in 42 C.F.R. § 438.10. 42 C.F.R. § 438.404(a). The CFSP shall give the provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.210(c).

ii. Each notice of adverse action shall conform with 42 C.F.R. § 438.404(b), contain and explain:

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

2) The reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);

3) The Member's right to file an Appeal, including information on exhausting the CFSP's one (1) level of Appeal and the right to request a State Fair Hearing if the Adverse Benefit Determination is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);
4) Procedures for exercising Member's rights to file a Grievance or Appeal. 42 C.F.R. § 438.404(b)(4);
5) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
6) The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).

iii. The CFSP shall use the Department developed template for the Notice of Adverse Benefit Determination.

iv. The CFSP shall provide the Member or Authorized Representative with a Department-developed appeal request form in conjunction with the Notice of Adverse Benefit Determination.

v. Timing of the Notice of Adverse Benefit Determination.
1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the CFSP shall give written notice to the Member, and when applicable, an Authorized Representative at least ten (10) Calendar Days before the date of the Adverse Benefit Determination is to take effect, except as provided in this section. 42 C.F.R. § 438.404(c)(1).
2) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the CFSP shall provide written notice as expeditiously as possible and no later than five (5) Calendar Days before the date of the Adverse Benefit Determination takes effect if:
a) The CFSP has facts indicating that action should be taken because of probable fraud by the Member; and
b) The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).
3) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the CFSP shall provide written notice no later than by the date of the action when any of the following occurs:
a) The CFSP has factual information confirming the death of the Member;
b) The CFSP receives a signed, written statement from the Member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
c) The Member is admitted to an institution where he or she is ineligible under the plan for further services;
d) The Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
e) The CFSP establishes the fact that the Member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
f) A change in the level of medical care is prescribed by the Member's physician. 42 C.F.R. §§ 431.213 and 438.404(c).
4) For denial of payment, the CFSP shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 C.F.R. § 438.404(c)(2). A denial, in whole or in part, of a payment for a service solely

because the claim does not meet the definition of a Clean Claim at 42 C.F.R. § 447.45(b) is not an Adverse Benefit Determination. 42 C.F.R. § 438.400(b)(3).

5) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), the CFSP shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).

6) If the Member's address is unknown and mail directed to him/her has no forwarding address, the CFSP shall have a contingency plan to notify the Member of an Adverse Benefit Determination notification to a Member or legally responsible person regarding termination or reduction of previously authorized Medicaid-covered services no later than the date of the benefit determination.

vi. Internal Plan Appeals

1) The CFSP shall have an established internal Member Appeal process for standard and expedited resolution of Appeals requests.

2) The CFSP shall have only one level of appeal for Members. 42 C.F.R. § 438.402(b).

3) The CFSP shall include the Member and his or her representative or the legal representative of a deceased Member's estate as parties to the Appeal. 42 C.F.R. § 438.406(b)(6).

4) The CFSP shall provide Members and Authorized Representatives a reasonable opportunity, by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the Appeal. For requests for expedited resolution, the CFSP shall inform the Member and Authorized Representative of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)

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

6) The CFSP shall consider all comments, documents, records, and other information submitted by the Member or, his or her Authorized Representative, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

7) The CFSP shall require Members to exhaust the internal Appeal process before requesting a State Fair Hearing. However, if the CFSP fails to adhere to the notice and timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, Members will be deemed to have exhausted the CFSP's internal appeal process and can request a State Fair Hearing. 42 C.F.R. § 438.402(c)(1).

8) Request for Plan Appeals

a) The CFSP shall allow Members, or an Authorized Representative, sixty (60) Calendar Days from the date on the Notice of Adverse Benefit Determination to file a request, verbally or in writing, for an Appeal with the CFSP. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).

b) The CFSP shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard Appeal request, whether received verbally or in writing, within five (5) Calendar Days of receipt of the request. 42 C.F.R. § 438.406(b)(1).

c) Standard resolution of Appeals
    i) The CFSP shall provide written notice of resolution of the appeal to the Member and/or Authorized Representative as expeditiously as the Member's health condition requires and no later than thirty (30) Calendar Days after of receipt of a standard Appeal request. 42 C.F.R. § 438.408(b)(2).
    ii) The CFSP shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing Appeal request form consistent with. 42 C.F.R. § 438.408(e).
d) Extension of standard resolution of appeal
    i) The CFSP may extend the timeframes for standard resolution of an Appeal request by up to fourteen (14) Calendar Days if:
        (1) The Member or Authorized Representative requests the extension, or the CFSP determines that there is a need for additional information and the delay is in the Member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
            (a) If the timeframe is extended other than at the Member's request, the CFSP shall do the following:
                (i) Make reasonable efforts to give the Member verbal notice of the delay;
                (ii) Within two (2) Calendar Days, provide written notice using the Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and
                (iii) Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).
    ii) The Notice of Extension of Timeframe for Standard Appeal Resolution shall include:
        (1) The timeframe for extension;
        (2) The reason for extension;
        (3) A statement on the Member's right to file a Grievance if a Member disagrees with the extension; and
        (4) A statement regarding the availability of assistance with the Appeals process and the ability to call the CFSP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
    iii) The CFSP shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language. The CFSP shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).

vii. Expedited Resolution of Plan Appeals
    1) The CFSP shall establish, maintain and communicate to Members and Authorized Representatives an expedited appeal resolution process for plan appeals for use when there is an immediate need for health services because a standard Appeal could jeopardize the Member's life, physical health or Behavioral Health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).

2) The CFSP shall allow Members or an Authorized Representative to file an expedited Appeal resolution request either orally or in writing within sixty (60) Calendar Days of the date on the Adverse Benefit Determination notice.
3) In accordance with NCGS § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited requests made by a network provider acting as an authorized representative of a Member on behalf of a Member, the CFSP shall presume an expedited appeal resolution is necessary. The CFSP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).
4) If the CFSP denies the request for an expedited plan Appeal, the CFSP shall do the following:
    a) Immediately transfer the Appeal to the timeframes for standard resolution; and
    b) Make reasonable efforts to give the Member or an Authorized Representative verbal notice of the denial and follow up with a written notice of the denial of the expedited resolution request within two (2) Calendar Days of the denial of the expedited appeal, 42 C.F.R. §§ 438.408(b)(2) and 438.408(c)(2)(ii).
5) For expedited resolution of Appeals, the CFSP shall make a determination as expeditiously as the Member's health condition requires but shall provide written notice, and make reasonable effort to provide verbal notice, of resolution no later than seventy-two (72) hours of receipt of the expedited Appeal request. 42 C.F.R. §§ 438.408(b)(2) and 431.230(b).
6) The CFSP shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing appeal request form.
7) Extension of expedited Appeal resolution
    a) The CFSP may extend the timeframes for expedited resolution of an Appeal request by up to fourteen (14) Calendar Days if:
        i) The Member or Authorized Representative requests the extension, or the CFSP determines that there is a need for additional information and the delay is in the Member's interest.
        ii) If the timeframe is extended other than at the Member's request, the CFSP shall do the following:
            (1) Make reasonable efforts to give the Member or Authorized Representative verbal notice of the delay;
            (2) Within two (2) Calendar Days, provide written notice and inform the Member or Authorized Representative of the right to file a Grievance if he or she disagrees with that decision; and
            (3) Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
        iii) The CFSP shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
            (1) The timeframe for extension;
            (2) The reason for extension;
            (3) A statement on the Member's right to file a Grievance if he or she disagrees with the extension; and
            (4) A statement on the availability of assistance with the Appeals process and the ability to call the CFSP with questions. 42 C.F.R. § 438.10(c)(4)(ii).

e. Continuation of Benefits

i. Timely Request for Continuation of Benefits: The CFSP shall continue and pay for the Member's benefits during the pendency of the plan appeal and State Fair Hearing if all of the following occur:

1) The Member, or the Member's Authorized Representative, files the request for an Appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
2) The plan Appeal involves the termination, suspension, or a reduction of previously authorized services;
3) The services were ordered by an authorized provider;
4) The period covered by the original authorization has not expired; and
5) The Member or Authorized Representative timely files for continuation of benefits within ten (10) Calendar Days of the CFSP sending the notice of the Adverse Benefit Determination (or before), or on the intended effective date of the CFSP's proposed Adverse Benefit Determination, whichever comes later. 42 C.F.R. § 438.420(b).

ii. If the CFSP continues the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:

1) The Member or Authorized Representative withdraws the appeal or State Fair Hearing request, in writing;
2) The Member or Authorized Representative does not request a State Fair Hearing and continuation of benefits within ten (10) Calendar Days from when the CFSP mails an adverse CFSP decision regarding the Member's CFSP appeal; or
3) A State Fair Hearing decision adverse to the Member is made. C.F.R § 438.402(c)

iii. The CFSP shall not allow a provider to request continuation of benefits on behalf of a Member. 42 C.F.R. § 438.402(c)(1)(ii).

iv. Recovery of Costs for Services Furnished during the Pendency of the Appeal Process

1) The CFSP shall be permitted to recover the cost of services furnished to the Member during the pendency of the plan appeal and the State Fair Hearing if:
   a) The CFSP notified the Member of the potential for recovery;
   b) The CFSP furnished benefits to the Member solely because of the requirement for continuation of benefits; and
   c) The final resolution of the plan appeal or the State Fair Hearing is adverse to the Member (i.e., upholds the CFSP's Adverse Benefit Determination). 42 C.F.R. § 438.420(d). For purposes of recovering cost of services furnished during the pendency of the appeal, the CFSP shall consider a final resolution to be adverse to the Member when all the following occur:
      i) The Member timely requests benefits to continue during the plan appeal or the State Fair Hearing;
      ii) The CFSP fully upholds its initial decision in its notice of resolution to the Member following the plan appeal; and
      iii) The Office of Administrative Hearings issues a final decision in accordance with NCGS § 150B-34 that fully upholds the CFSP's Adverse Benefit Determination that gave rise to the appeal.
2) If the CFSP chooses to seek to recover the cost of services provided to Members during the pendency of the plan appeal or the State Fair Hearing, the CFSP shall do the following:
   a) Develop a Member hardship exemption process; and
   b) Obtain prior approval from the Department for each instance in which the CFSP seeks to recover the costs of benefits provided to Members under this section which includes an explanation of the services provided to the Member, the amount the

CFSP is seeking to recover and a detailed explanation for why the CFSP is seeking recovery.

f. State Fair Hearing Process
   i. The CFSP shall comply with Chapter 108D and Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
   ii. The CFSP shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.
   iii. The CFSP shall allow Members or, an Authorized Representative, one hundred and twenty (120) Calendar Days from the date on the Notice of Resolution issued by the CFSP upholding, in whole or in part, the Adverse Benefit Determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f).
   iv. The parties to the State Fair Hearing shall include the CFSP and the Member or, when applicable, the Member's Authorized Representative. 42 C.F.R. § 438.408(f)(3).
   v. The CFSP shall designate a mailing and email address with the OAH for all fair-hearing-related communications from OAH and any party to the State Fair Hearing.
   vi. The CFSP will designate an email address for receipt of Department communications regarding State Fair Hearings. The CFSP will have a process in place to ensure that Department communications regarding expedited State Fair Hearing requests made pursuant to NCGS § 108D-15.1 are responded to as soon as possible and in no event later than nine (9) Work Hours from the timestamp of the Department's email communication. The CFSP will respond to Department communications about standard State Fair Hearing requests per the requirement in *Section III.D.45* ***RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION***. The Department shall notify the CFSP as expeditiously as possible, but no later than nine (9) Work Hours of any expedited State Fair Hearing request involving the CFSP.
   vii. The CFSP will have a process in place to upload to the Department all documentation reviewed by the CFSP in connection with the internal plan appeal. For expedited State Fair Hearing requests made pursuant to NCGS § 108D-15.1, the CFSP will upload documentation as soon as possible and in no event later than nine (9) Work Hours from the timestamp on the Department communication requesting the documentation. For standard State Fair Hearing requests, the CFSP will upload the requested documentation per the requirements laid out in *Section III.D.45* ***RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION***.
   viii. Mediation
      1) The CFSP shall notify Members or Authorized Representatives of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
      2) The CFSP shall inform Members or Authorized Representatives that mediation is voluntary and that the Member is not required to request a mediation to receive a State Fair Hearing with OAH.
      3) The CFSP shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
   ix. Effectuation of Reversed Appeal Resolutions
      1) If the CFSP, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the CFSP shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires and no later

than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).

2) If the CFSP, during the plan appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the Member received the disputed services while the appeal was pending, the CFSP shall pay for those services in accordance with the terms of the Contract. 42 C.F.R. § 438.424(b).

g. Appellate Responsibilities

i. The CFSP shall notify the Department within five (5) Calendar Days of being served notice of a Member's request for judicial review, or other Appeal, following an adverse ruling in a State Fair Hearing.

ii. The CFSP is responsible for responding to the request for judicial review, or other Appeal, as well as CFSP's attorney's fees and costs.

iii. If the Department is also a party, the Department is responsible for its response to the request for judicial review. The CFSP will cooperate fully with the Department in its response and defense. To the extent no conflict of interest exists or arises, the CFSP and the Department may agree to joint defense.

iv. The CFSP is responsible for satisfying any judgement, including, payment of benefits, that result from a court's ruling or order in favor of the Member and against the CFSP. The Department will seek indemnification in accordance with the terms of this Contract for any ruling against the Department.

h. Appeals and Grievances Recordkeeping and Reporting

i. The CFSP shall maintain records of all Member Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's Quality Strategy. 42 C.F.R. § 438.416(a).

ii. The record of each Grievance and Appeal shall contain, at a minimum, the following:

1) The name of the person for whom the Appeal or Grievance was filed;
2) A general description of the reason for the Appeal or Grievance;
3) The date received;
4) The date of each review or, if applicable, review meeting;
5) Resolution at each level of the Appeal or Grievance, if applicable;
6) Date of resolution at each level, if applicable;
7) Date of Appeal decision and mail date of Appeal decision;
8) Whether the Appeal was an expedited request, if applicable;
9) Who conducted the review of the Appeal or Grievance and made the determination; and
10) Whether an extension of Appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b).

iii. The CFSP shall maintain accurate records in a manner accessible to the Department and available upon request to CMS. 42 C.F.R. § 438.416(c).

iv. The CFSP shall retain Appeal and Grievance records consistent with the record retention terms of the Contract following the final decision or the close of the Appeal or Grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the retention period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular period, whichever is later.

v. Appeals and Grievance Reporting

1) In accordance with 42 C.F.R. § 438.416, the Department will monitor the CFSP to ensure compliance with all applicable laws and rules pertaining to Member Appeals and Grievances.

2) To support the Department's monitoring efforts, the CFSP shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
   a) Each Notice of Adverse Benefit Determination issued by the CFSP; and
   b) Each Notice of Resolution issued by the CFSP.
3) The CFSP shall provide a report on all appeals and grievances received by the CFSP from Members, or an Authorized Representative, in a form and frequency as described in *Section VII. Attachment I. Reporting Requirements*.

i. Additional Due Process Principles for 1915(i) Services
   i. If the CFSP authorizes a requested 1915(i) service for a duration less than the duration requested in the Care Plan/ISP, the CFSP shall provide written notice with Appeal rights and clinical or administrative reasons for the decision at the time of the limited authorization.
   ii. If the CFSP denies a request for authorization of 1915(i) Services by a Member, in whole or in part, or authorizes a requested 1915(i) service in a limited manner, including the type, level, or duration of service, the CFSP shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 C.F.R. § 438.404:
      1) An Appeal filed by a Member must not prevent any authorized 1915(i) Services from being provided pending the outcome of the Appeal. The CFSP must not prevent the Member from making a new request for 1915(i) Services during a pending Appeal.
   iii. The CFSP shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all Members from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to Appeal the denial, reduction, or termination of a service. The CFSP shall not attempt to influence, limit, or interfere with a Member's right or decision to file or pursue a Grievance or request an Appeal.
   iv. Care Plan/ISP: The CFSP shall ensure that any request for authorization of 1915(i) Services is consistent with and incorporates the desires of the Member.
   v. The CFSP shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to 1915(i) Services and other trainings relevant to due process procedures, whether related to 1915(i) Services or otherwise.

8. Advanced Medical Home (AMHs) as Primary Care Providers (PCPs)

a. AMH Contracting
   i. Background and General Requirements
      1) The majority of primary care practices serving Medicaid beneficiaries are participating in the AMH program in Tiers 1-3.
      2) Under the CFSP, AMH practices will act as primary care providers (PCPs) for CFSP Members.
      3) The CFSP shall pay the Medical Home Fee paid to AMH practices for each Member for whom that AMH is assigned as the PCP. *Section V.E.4.p. Payments of Medical Home Fees to Advanced Medical Homes*.
      4) The CFSP shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices as described in *Section VII. Attachment L.2. CFSP Advanced Medical Home Program Policy* and the Advanced Medical Home Provider Manual.
      5) The CFSP shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the AMH practice and the CFSP.

6) The CFSP shall incorporate any new Department guidance, policy, operational manuals and other program-specific requirements into CFSP operations and AMH contracts, as applicable, and within Department-specified timelines.

ii. AMH Quality Metrics
1) Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for the CFSP, the CFSP shall compile and calculate each of the AMH quality metrics for each AMH practice.
2) The CFSP shall provide feedback on quality scoring results to each AMH practice on both an annual and an interim basis as specified by the Department.
3) The Department will provide the CFSP with the AMH measure set and reporting schedule prior to implementation as described in *Section VII. Attachment L.2. CFSP Advanced Medical Home Program Policy*.

iii. The CFSP must develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics.
1) The CFSP must submit its AMH Performance Incentive Payments Methodology for Department review and approval as follows:
a) One hundred twenty (120) Calendar Days after Contract Award;
b) At least thirty (30) Calendar Days prior to implementation of any material modifications, additions, or deletions to the Methodology; and
c) Annually, to be submitted as part of the VBP Strategy.

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, in instances in which a Member does not select an AMH/PCP at the time of enrollment, assign the Member to an AMH/PCP within twenty-four (24) hours of effectuation date of enrollment in CFSP. The CFSP shall allow AMH/PCPs to set limits on panel size and shall have a process for AMH/PCPs to do so.
1) The CFSP's methodology for assigning Members to an AMH/PCP shall include the following components, in this order, to the extent that such information is available. Prior AMH/PCP assignment;
2) Member claims history;
3) Family member's AMH/PCP assignment;
4) Family member's claims history;
5) Geographic proximity;
6) Special medical needs;
7) Language/cultural preference; and
8) AMH status (Tiers 2 and 3).
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).

C. Benefits

1. Benefits Package

a. Throughout the term of this Contract, the CFSP shall promptly provide, arrange, purchase or otherwise make available all medically necessary services required under this Contract to all its Members enrolled with the CFSP. Services shall be delivered within the standard of care and meet Department quality standards and expectations.

i. Physical health benefits are inclusive of physical health and State Plan LTSS services, including nursing facility services, home health services, private duty nursing services, personal care services, and hospice services.

ii. Behavioral Health (BH) benefits are inclusive of mental health and SUD services.
iii. Intellectual/Developmental Disability (I/DD) benefits refer to services targeted towards individuals with an I/DD.
iv. Pharmacy.

b. The CFSP shall:
i. Cover all services in the North Carolina Medicaid State Plan with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract;
ii. Use the North Carolina definition of medical necessity in 10A NCAC 25A.0201 in making coverage determinations;
iii. Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the Member's diagnosis, type of illness or condition;
iv. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2);
v. Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i);
vi. Develop a comprehensive Utilization Management Program inclusive of a subset of NC Medicaid Direct clinical coverage policies as defined in this Contract;
vii. Implement and adhere to all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policies and protocols as defined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT);* and
viii. Not impose aggregate lifetime dollar limits or annual dollar limits, as defined in 42 C.F.R. § 438.900, on the total amount of benefits that may be paid under the CFSP.

c. Covered Medicaid Services:
i. The CFSP shall cover all services as defined in the Medicaid State Plan with the exception of services carved out under Section 4.(4) of Session Law 2015-245, as amended; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid State Plan covered services are described in *Section VII. Attachment B. Summary of Medicaid Services* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid State Plan).
ii. The CFSP shall not be responsible for providing carved out services to Members as defined in *Section V.C.1. Table 1: Services Carved Out of Medicaid Managed Care*.
iii. Consistent with Session Law 2015-245, as amended, the CFSP shall be responsible for covering behavioral health services that are defined as *Section V.C.1. Table 2: Behavioral Health Services Covered in Standard Plans, BH I/DD Tailored Plans, and CFSP*, as well as any services that the Department obtains authority to provide through a SPA, waiver, or other Medicaid authority to cover and adds to the CFSP benefit package.
1) A crosswalk of the SUD services covered under the Medicaid State Plan to national clinical standards is provided in *Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*.
iv. The CFSP shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.
v. The CFSP shall adhere to the Department's Managed Care Clinical Supplemental Guidance, which references requirements for clinical coverage which supplement NC Medicaid clinical coverage policies.

Section V.C.1. Table 1: Services Carved Out of Medicaid Managed Care[8]	
a.	Services provided through the PACE.
b.	Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs).
c.	Services documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by a Children's Developmental Services Agency or by a provider contracted with a Children's Developmental Services Agency to provide those services.
d.	Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
e.	Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract)[9].
f.	Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames.

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]		
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 (upon approval of State Plan Amendment 19-006 by CMS) • *Partial hospitalization* • *Mobile crisis management*	**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)*	**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**

[8] Codified at NCGS § 108D-35.
[9] The Department is considering pursuing legislative authority to carve these services into managed care.
[10] Pending legislative change to offer some services in the CFSP that are currently only available in Tailored Plans

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]		
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*		
• *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Opioid Treatment Program*[11] • *Ambulatory detoxification* • Research-based BH treatment for Autism Spectrum Disorder (ASD) • *Diagnostic assessment* • *Non-hospital medical detoxification* • *Medically supervised or Alcohol and Drug Abuse Treatment Center (ADATC) detoxification crisis stabilization* • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • Diagnostic Assessment • Comprehensive Clinical Assessment • Clinically Managed Residential Withdrawal Services • Early and periodic screening, diagnostic and treatment (EPSDT) services as covered under 1905(a)	• *Community support team (CST)*[12] • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* **1915(i) SPA services** • Community Transition • Respite • Supported Employment/Individual Placement Supports • Community Living and Supports • Individual and Transitional Support	

Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
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

[11] The CFSP will also be required to cover OBOT services as detailed in *Section VII. Attachment B. Summary of Medicaid Services.*

[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.

Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
N/A		Medically supervised or ADATC detoxification crisis stabilization
4	Medically managed intensive inpatient services	Inpatient BH services
Office-based opioid treatment	Office-based opioid treatment[14]	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Opioid Treatment Program
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

vi. The CFSP shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.

vii. The CFSP shall, in accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA), provide protections to Members who choose to have breast reconstruction relating to a mastectomy, including coverage of:

1) All stages of reconstruction of the breast on which the mastectomy has been performed;
2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

[14] The CFSP will be required to cover OBOT services as detailed in *Section VII. Attachment B. Summary of Medicaid Services.*

3) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

viii. The CFSP shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).

ix. The CFSP shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a Member enrolling in the CFSP.

x. The CFSP shall encourage primary care providers who serve Members under age nineteen (19) to participate in the Vaccines for Children (VFC) program, which allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).

1) The CFSP shall require that primary care providers administer vaccines consistent with the American Academy of Pediatrics (AAP)/Bright Future periodicity schedule.
2) The CFSP shall only pay for the vaccine administration fee for VFC eligible children.
3) Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
4) The CFSP shall adhere to additional VFC requirements as defined in *Section V.D.8. Prevention and Population Health Programs*.

xi. Changes to Covered Benefits

1) The CFSP shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid State Plan and consistent with any approved Medicaid waivers/authorities, except to the extent the service is carved out of Medicaid Managed Care.

xii. Institutions for Mental Disease (IMD) SUD Service

1) Under North Carolina's 1115 waiver authority, the CFSP shall provide coverage for substance use disorder services for Members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.
2) The CFSP shall provide the Department with a bi-weekly report on Members who are residing or have resided in an IMD for SUD treatment as defined in *Section VII. Attachment I. Reporting Requirements* to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by every other Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

xiii. For Members newly enrolled in the CFSP with no immediately prior period of Medicaid Managed Care enrollment or NC Medicaid Direct enrollment with inpatient coverage, the CFSP shall be responsible for any diagnosis-related group based inpatient facility claims if the Member's first day of CFSP enrollment is during the hospital stay.

d. Medical Necessity

i. For North Carolina Medicaid Members, the CFSP shall cover all medically necessary services for its enrolled Members in accordance with *Section V.C. Benefits*.

ii. The CFSP shall provide medically necessary services to all enrolled Medicaid Managed Care Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or behavioral health, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.

iii. The CFSP may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.C.1.e. Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.

iv. The CFSP shall work with providers to ensure that providers identify an appropriate new level of care for a Member who no longer meets the medical necessity criteria for an existing service.

v. The CFSP shall determine whether a service is medically necessary on a case-by-case basis.

vi. For Members under the age of twenty-one (21), the CFSP shall not issue adverse determinations on requests for a medical service coverable under 42 U.S.C. § 1396d(a), (§1905(a) of the Social Security Act) unless the decision is made following a medical necessity review per EPSDT federal standards.

vii. The CFSP shall cover COVID-19 testing according to guidance issued by the Department.

viii. The Department reserves the right to require the CFSP to cover the testing, treatment, and vaccine administration for COVID-19 without cost sharing for Members.

ix. Consistent with 42 C.F.R. § 438.210(a)(5)(ii), the CFSP shall provide medically necessary services that address:

1) The prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder that results in health impairments and/or disability.
2) The ability for a Member to achieve age-appropriate growth and development.
3) The ability for a Member to attain, maintain or regain functional capacity.
4) The opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

e. Utilization Management

i. The CFSP shall develop a utilization management (UM) program for physical health, BH, I/DD, LTSS, and pharmacy services that is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.

ii. UM program staff shall receive ongoing training on the application of the CFSP's utilization management guidelines. The CFSP shall make available written training plans, including dates, subject matter, and training materials to the Department upon request.

iii. UM Program Policy

1) The CFSP shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review one hundred twenty (120) Calendar Days after Contract Award.
2) The UM Program, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
   a) Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
   b) Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
   c) Mechanisms to assess whether Members are receiving the appropriate level of care corresponding to their clinical information, including clinical information submitted by the CFT, as applicable;
   d) Procedures for ensuring UM program staff receive EPSDT training;

e) Authorization of State Plan LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
f) Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
g) Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
h) Protecting Members from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to Appeal the denial or reduction or termination of a service;
i) Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization;
j) Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the CFSP;
k) Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act;
l) Dissemination of guidelines to all affected providers and, upon request, to Members and Potential Members;
m) Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member;
n) The CFSP shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the CFSP shall submit the attestation required by this section annually, unless otherwise directed by the Department. The Department will conduct ad hoc reviews of the CFSP's adherence to the attestation of compliance with UM and clinical coverage requirements on an ongoing basis. The CFSP shall provide an analysis of their compliance with the attestation upon request as follows:
    i) Within thirty (30) Business Days for routine requests; and
    ii) Within seven (7) Business Days for expedited requests.
o) Nothing in this section shall be construed to limit or interfere with the Department's right to individually review and approve any CFSP UM or clinical coverage policy to ensure compliance with the Contract.

3) The CFSP shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.
4) The CFSP shall post the UM Program Policy on their publicly available website for providers and Members, or in other forms as requested by the provider or Member, at no cost. The CFSP shall include a prominent reference to the web address of the UM Program Policy in both its provider and Member Handbooks.
5) The CFSP shall provide training and education to providers including prescribers on changes to the UM Program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.E.3. Provider Relations and Engagement*.
6) The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §438.3(e)(1)(ii), 42 C.F.R. §438.905, and 438.910(b)-(d).

a) Annually, the CFSP shall submit a completed standardized parity analysis workbook, developed by the Department, to demonstrate compliance.

7) The CFSP shall provide a publicly available prior authorization look-up tool for medical services to providers to support timely prior authorization requests from providers. The prior authorization look-up tool should include all medical/Behavioral Health prior authorization requirements and the tool should be accessible without any login from a provider.

iv. The CFSP shall have the option of using the Department's NC Medicaid Direct clinical coverage policies as the basis for the UM program or developing its own for all covered services with the exception of those listed in *Section V.C.1. Table 4: Required Clinical Coverage Policies*.

v. The UM process must support an integrated, holistic look at a Member's physical health, BH, I/DD, LTSS, and pharmacy needs, noting that alternative treatments or supports may be appropriate in light of a Beneficiary's complete clinical and other support needs.

vi. The UM process shall allow for an individualized review of a service request that does not meet the CFSP's general coverage criteria. The review shall be conducted by a physician with experience in treating the Member's specific health condition and apply all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria as appropriate to determine medical necessity. For more details on EPSDT, see *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT).*

vii. The Clinical Practice Guidelines shall:

1) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
2) Consider the needs of Members;
3) Be adopted in consultation with contracting health professionals;
4) Be reviewed and updated periodically as appropriate;
5) Be utilized for decisions for utilization management, Member education, coverage of services and other areas to which the guidelines apply; and
6) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation with LTSS distinction set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. §§ 438.236(b).

viii. The Department will allow "proprietary" UM policies under limited circumstances, with prior approval by the Department.

ix. A chart of all North Carolina Medicaid FFS clinical coverage policies is found in *Section VII. Attachment B. Summary of Medicaid Services*.

x. For a limited number of services, the CFSP shall incorporate existing NC Medicaid Direct FFS clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.C.1. Table 4: Required Clinical Coverage Policies*.

xi. The Department reserves the right to require the CFSP to follow additional NC Medicaid Direct FFS clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.C.1 Table 4: Required Clinical Coverage Policies	
Service	***Scope***
Other Services	
Auditory Implant External Parts	*13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair* *13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair*
Obstetrics and Gynecology	*1E-7: Family Planning Services*
Physician Services	*1A-4: Cochlear and Auditory Brainstem Implants* *1A-23: Physician Fluoride Varnish Services* *1A-36: Implantable Bone Conduction Hearing Aids (BAHA)* *1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions*
Pharmacy	As defined in *Section V.C.3. Pharmacy Benefits*

xii. The CFSP shall make the CMO or designee available to discuss and report on the UM Program, as requested by the Department.

xiii. The CFSP shall use a standardized prior authorization request form developed by the Department.

xiv. The CFSP shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or Member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.

1) Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a clinical assessment.
2) Material misinformation to or intimidation of providers or Members who have the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH Appeals is prohibited. The Care Management process shall not be used to improperly influence, change or prevent a request for a prior approval.
3) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.

xv. The CFSP shall not retract a service authorization after the services, supplies, or other items have been provided, except as provided in NCGS § 58-3-200(c).

xvi. The CFSP shall not retract a prior authorization for emergency services after the services have been provided, except as provided in NCGS § 58-3-190(c).

xvii. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Member's physical health, Behavioral Health I/DD, LTSS, and pharmacy needs. 42 C.F.R. § 438.210(b)(3).

1) Any decision to deny, suspend, terminate, or limit a pediatric subspecialist service shall be reviewed by a Member of the UM program team who have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing.

xviii. As part of the UM program, the CFSP shall adhere to the following prior authorization requirements.

1) To effectively manage the care of its Members, the CFSP shall establish and maintain a referral and prior authorization process that is centered on the Member's PCP.
2) The CFSP shall conduct prior authorization reviews using current clinical documentation and must consider the comprehensive range of the Member's physical health, BH, I/DD, LTSS, and pharmacy needs, noting that alternative treatments or supports may be appropriate in light of a Member's complete clinical and other support needs.
3) The CFSP may require a referral for any medical services not provided by the PCP except where specifically prohibited in the Department-CFSP contract and in federal and state statute and regulations.
4) The CFSP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the LEA.
5) Consistent with 42 C.F.R. § 438.206, the CFSP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
    a) Emergency services
        i) In accordance with 42 C.F.R. § 438.114, the CFSP shall not require Members to obtain a referral or prior authorization before receiving emergency services.
        ii) The CFSP shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
        iii) The CFSP shall not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's PCP or CFSP of the Member's screening and treatment within ten (10) Calendar Days of presentation for emergency services.
        iv) The CFSP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the CFSP's Network.
        v) The CFSP shall not hold a Member with an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
        vi) The CFSP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the CFSP to seek emergency services.
    b) Family planning services
        i) The CFSP shall not require Members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 C.F.R. 438.206(b)(3).
        ii) The CFSP shall not restrict the Member's free choice of family planning services and supplies providers. 42 C.F.R. § 431.51(b)(2).
        iii) The CFSP shall not hold Members liable for payment for family planning services or supplies that are not in the CFSP's network.
        iv) The CFSP shall not require Members to obtain referrals for services provided by women's health specialists in accordance with 42 C.F.R. § 438.206(b)(2) and NCGS § 58-51-38.

v) The CFSP shall not require female Members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.

vi) The CFSP shall allow female Members direct access to a women's health specialist in addition to the Member's designated source of primary care if that source is not a women's health specialist.

vii) The CFSP shall not require providers to obtain prior approval for any obstetrical ultrasound.

viii) Women's routine and preventive health care services may include but are not limited to: initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted infections.

c) BH services

i) For Medicaid State Plan BH and I/DD services, the CFSP shall require providers to use the following BH or other Department approved level-of-care determination and screening as part of the CFSP's UM program. The Department reserves the right to change, in writing, these required screening tools:

(1) Substance Use: American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through six (6); and

(2) Mental Health:

(a) Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.

ii) The CFSP shall not require Members to obtain a referral or prior authorization for the first mental health or substance use assessment completed in a twelve (12) month period.

iii) The CFSP shall make available to all Members a complete listing of its participating mental health and SUD providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.

d) Children's screening services

i) The CFSP shall not require Members to obtain a referral or prior authorization for children's screening services.

ii) The CFSP shall not require Members to obtain a referral or prior authorization for Local Health Department services.

e) Primary care services: The CFSP shall not require Members to obtain a referral or prior authorization for primary care services.

f) School-based clinic services: The CFSP shall not require Members to obtain a referral or prior authorization for services rendered at school-based clinics.

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

6) The CFSP shall ensure Members have and are aware of having direct access to services for which the Department does not allow the CFSP to require referral or prior authorization, as defined in this section.

xix. Service Authorization and Noticing Requirements

1) The CFSP shall provide written notice to Members of any Department-initiated changes to the Medicaid benefits package.
2) The CFSP shall provide written notice, using the Department-developed template, to Members on decisions related to authorization of services. The written notice shall include the following:
   a) The basis for such decisions; and
   b) Sufficient details that inform Members of the decision, which will provide them with information necessary to determine if they wish to Appeal as noted in *Section V.B.7. Member Grievances and Appeals*.
3) For standard authorization decisions, the CFSP shall provide notice as expeditiously as the Member's condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).
4) The CFSP may receive a possible extension of service authorization decision of up to fourteen (14) Calendar Days if the Member or Provider requests the extension or the CFSP justifies a need for additional information and how the extension is in the Member's interest.
5) If the CFSP extends the timeframe beyond fourteen (14) Calendar Days, the CFSP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a Grievance if he or she disagrees with that decision.
6) For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the CFSP shall provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.
7) The CFSP may extend the seventy-two (72) hour time period for service authorization decisions by up to fourteen (14) Calendar Days if the Member or Provider requests the extension or the CFSP justifies a need for additional information and how the extension is in the Member's interest.
8) If the CFSP extends the timeframe beyond seventy-two (72) hours, the CFSP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

xx. UM Policy for DSOHF Facilities

1) The CFSP shall comply with the authorization and admission requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with NCGS § 122C-261(e) and *Section VII. Attachment M. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the CFSP shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with I/DD.
2) 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 NCGS § 122C-261 and any other applicable North Carolina law governing the admission of Members with intellectual disabilities to a state psychiatric hospital.
3) 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 NCGS § 122C-261(e)(4).

4) In determining whether Members with I/DD 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.

xxi. UM Policy for 1915(i) Services

1) For 1915(i) Services only:

a) The CFSP shall submit the Department designated 1915(i) assessment tool and necessary information to the Department or the Department's specified vendor for the purposes of completing the Independent Evaluation to determine eligibility for 1915(i) Services in alignment with requirements at 42 C.F.R. § 441.715(d). The CFSP shall comply with any additional guidance released by the Department on the process for supporting the Independent Evaluation.

b) The CFSP shall ensure that the Independent Assessment is used to guide the development of the Care Plan/ISP, and that the results of the Independent Assessment are not the sole basis for limiting the services requested or approved. The CFSP may use the Independent Assessment in conjunction with other information to reduce or deny requested services.

2) The CFSP shall ensure that any request for authorization of 1915(i) Services is consistent with and incorporates the desires of the member and that such desires are reflected in the Member's Care Plan/ISP as required by 42 C.F.R. § 441.725(b), including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section V.D.2.q. Additional Care Management Requirements for Members Obtaining 1915(i) Services* for additional details.

a) The Member's care manager shall discuss with the member the duration of the services desired by the Member and shall ensure that the Care Plan/ISP requests authorization for each service at the duration requested by the Member during the Contract Year.

b) The Member's care manager shall assist the Member in developing a Care Plan/ISP and shall explain options regarding the 1915(i) Services available to the Member.

3) The CFSP shall inform Members that they may make a new request for 1915(i) Services at any time by requesting an updated Care Plan/ISP.

4) Care managers may not exercise prior authorization authority over the Care Plan/ISP.

5) The CFSP shall issue prior authorizations for all CFSP services covered under the 1915(i) SPA according to the requirements set forth in the service definitions that will be established by the Department.

6) The CFSP shall provide any additional information or reports requested by the Department as required by CMS for the 1915(i).

f. Telehealth, Virtual Patient Communications and Remote Patient Monitoring

i. The CFSP shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid beneficiaries as an alternative service delivery model, where clinically appropriate, in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. The services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration and scope no less than the amount,

duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).

ii. The CFSP may use Telehealth, Virtual Patient Communications and Remote Patient Monitoring tools for facilitating access to needed services in a clinically appropriate manner that are not available within the CFSP's network.

iii. The CFSP shall not require a Member to seek the services through Telehealth and must allow the Member to access an in-person service through an out-of-network provider, if the Member requests.

iv. As part of the UM Program Policy, the CFSP shall develop and submit a Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department no later than one hundred twenty (120) Calendar Days after Contract Award in conjunction with the CFSP's UM Program Policy.

1) The Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy shall include:

a) Eligible providers who may perform Telehealth, Virtual Patient Communications and Remote Patient Monitoring;

b) Modalities covered by the CFSP;

c) Modalities not covered by CFSP;

d) Requirements for and limitations on coverage;

e) Description of each covered modality, including:

i) Compliance with local, state, and federal laws, including HIPAA; and

ii) Process to ensure security of protected health information.

2) The CFSP shall submit a revised Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy to the Department whenever there is a material change to the Policy.

v. The CFSP shall pay at least the in-person rate for the same service delivered via Telehealth (i.e. payment parity).

vi. For all services provided through Telehealth, the CFSP shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

vii. The CFSP shall pilot new approaches to Telehealth, Virtual Patient Communications and Remote Patient Monitoring and Value-Based Payment and shall support providers in optimizing the use of these services in their practices. For purposes of any pilot, the CFSP may propose, for the Department's review and approval, a waiver of payment parity requirements.

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. The CFSP shall submit the Department's standardized ILOS Service Request Form within thirty (30) Calendar Days of Contract Award to the Department for approval.

1) In no instance shall the CFSP reduce or remove ILOS service without approval by the Department within a Contract Year.

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

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 wishes to offer an ILOS previously approved by the Department, the CFSP must still submit the Department's standardized ILOS Service Request Form for approval.

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. 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 not require the Member to utilize an ILOS.

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 within thirty (30) Calendar Days of Contract Award:

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

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

i. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements
   i. The CFSP shall work with the Department and the Member's nursing facility to coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120 for Members admitted to nursing facilities and coordinate transition back to the community if/when the member no longer meets medical necessity criteria for skilled nursing facility.
   ii. The CFSP shall ensure the provision of Specialized Services identified by the PASRR process for Members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this contract as listed in *Section V.C.1.c. Covered Medicaid Services*.
   iii. The CFSP shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the Member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such Specialized Services are delivered.

j. Hysterectomy Statement and Sterilization Consent
   i. The CFSP shall provide hospitals with the ability to check the status of the hysterectomy statement and sterilization consent forms online.
   ii. The CSFP shall provide the capability to capture the NPI of the facility where a sterilization procedure was performed and to display that information in the consent form record for the Member.
   iii. The CFSP shall provide the web-based capability for the rendering provider and service facility provider, including providers associated with the facility, to inquire on the status of the consent by searching with the NPI and Member Medicaid ID.

k. Cost Sharing
   i. The CFSP shall impose the same cost sharing amounts as specified in North Carolina's Medicaid State Plan which are displayed in *Section V.C.1. Table 5: Medicaid Managed Care Cost Sharing* below.
   ii. The CFSP shall not require members to pay for any covered services other than the copayment amounts required under the State Plans.
   iii. The CFSP shall not hold members responsible for any of the following:
      1) CFSP's debts in the event of CFSP insolvency;
      2) Covered services provided to the member for which:
         a) The Department does not pay the CFSP; or
         b) The Department, or CFSP, does not pay the health care provider that furnished the services under a contractual referral or other arrangement.
      3) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the CFSP covered the services directly. 42 C.F.R. § 438.106.
   iv. The CFSP shall track cost sharing obligations of each member and provide to the Department using the Department developed standardized template.
   v. Exceptions for cost sharing:
      1) Consistent with 42 C.F.R. § 447.56, Medicaid cost sharing does not apply to a subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, 1915(c) waiver beneficiaries, and an individual whose medical

assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

2) The Department does not apply cost sharing to Former Foster Youth.
3) The CFSP shall not impose cost sharing on Medicaid BH, I/DD and TBI services, as defined by the Department.
4) Pursuant to Section 11405 of the Inflation Reduction Act (IRA), the CFSP shall not apply cost sharing for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration.

Section V.C.1. Table 5: Medicaid Managed Care Cost Sharing			
Income Level	***Annual Enrollment Fee***	***Service***	***Copay***
Medicaid			
All Medicaid Beneficiaries	*None*	Physician services	$4/visit
		Outpatient services	$4/visit
		Podiatrists	$4/visit
		Generic and brand prescriptions	$4/script
		Chiropractic services	$4/visit
		Optical services/supplies	$4/visit
		Optometrists	$4/script
		Non-emergency Visit to Hospital ER	$4/visit

vi. Cost Sharing Noticing Requirements

1) The CFSP shall provide written notice to members using the Department developed standardized template of any Department-initiated changes to the Medicaid cost sharing requirements. Notification to members shall be provided at least thirty (30) Calendar Days in advance of the effective date of such change.
2) The Department shall provide written notice to members of the aggregate family limit on cost sharing. The Department shall provide written notice to the CFSP and members when a member incurs out-of-pocket expenses up to the aggregate household limit and individual household members are no longer subject to cost sharing for the remainder of the quarter.

l. Electronic Verification System Requirements

i. The CFSP must utilize an Electronic Visit Verification (EVV) system to verify personal care services, including Medicaid State Plan and all waiver 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 in effect by CFSP launch.

v. The CFSP shall deliver the EVV data elements to the Encounter Processing System (EPS) for Personal 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.

m. Moral and Religious Objection

i. The CFSP is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R 438.102(b) have been met.

ii. If the CFSP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the CFSP shall furnish information about the services it does not cover to the Department, and to any other Department partner as directed by the Department, whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R §438.102(b)(1)(i)(A)(2).

2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

a. The CFSP shall cover services, products, or procedures for a Medicaid Member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination. This includes any evaluation by a physician or other licensed practitioner.

b. The CFSP shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under NC Medicaid Direct and as defined in the Department's EPSDT policies.

c. The CFSP shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.

d. The CFSP shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for Medicaid Members under twenty-one (21) years of age.

e. When adjudicating service authorizations for Members under twenty-one (21) years of age, the CFSP shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the Member.

f. Upon conclusion of an individualized review of medically necessary services, the CFSP shall cover medically necessary services that are included within the categories of mandatory and optional

services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The CFSP shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this Contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the CFSP responsible for delivery of the referred service, product, or treatment.

g. The CFSP may provide medically necessary services in the most economic mode possible, if:
   i. The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner;
   ii. The determination process does not delay the delivery of the needed service; or
   iii. The determination does not limit the Member's right to a free choice of providers within the CFSP's Network.

h. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, UM policies, service definitions, or billing codes do not apply to Medicaid Members who are less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians. Note that visits to dentists shall not be billed to the CFSP but shall be billed to NC Medicaid Direct.

i. The CFSP shall:
   i. Require all in-network primary care providers to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule.
   ii. Require all in-network primary care providers to refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to NC Medicaid Direct.
   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;
         b) Screening for Autistic Spectrum Disorders per AAP guidelines; and
         c) Comprehensive, unclothed physical examination.
      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.

j. The CFSP shall ensure and verify that network BH providers coordinate with primary care providers and specialists conducting EPSDT screenings.

k. The CFSP shall not require prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age. The CFSP may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.

l. The CFSP shall comply with the Department's standards for the timely provision of EPSDT services. For purposes of this Contract, the "timely provision of the EPSDT services" shall mean that a Member shall have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks from the date of the request for an appointment.

m. The CFSP shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or Member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.

n. The CFSP shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:
   i. Regular preventive care; and
   ii. Scope of services, products and treatments available when medically necessary to correct or ameliorate a health condition or problem.

o. The CFSP shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) Calendar Days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in *Section V.B.4. Member Engagement.*

p. The CFSP shall perform outreach to Members who are due or overdue for an EPSDT screening service monthly.

q. The CFSP shall effectively inform Members and/or their Parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the *Section V.B.4. Member Engagement*.

r. The CFSP shall not make an Adverse Benefit Determination on a service authorization request for a child until the request is reviewed per EPSDT criteria.

s. While an EPSDT request is under review, the CFSP may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as the CFSP makes clear that the Member has the right to request authorization of the services he or she wants to request.
   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 clinical assessment.
   ii. Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH Appeals is prohibited.
   iii. Nothing in this section should be construed to prevent clinical or treatment discussions.

t. The CFSP shall offer assistance with scheduling appointments for EPSDT services, upon a Member's request.

u. The CFSP shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Children with Special Health Care Needs) for referrals. The CFSP shall also make use of other public health, mental health, and

education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.

v. The CFSP shall develop and maintain an EPSDT Policy. The CFSP shall submit the EPSDT Policy to the Department for review ninety (90) Calendar Days after Contract Award and annually thereafter.

w. Educational and Training Materials
   i. The CFSP shall develop written and verbal educational materials on EPSDT, including educational materials for Members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
      1) The CFSP shall submit the materials to the Department for review and approval as defined in *Section V.B.4. Member Engagement*.
      2) The CFSP may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.
   ii. As part of the Provider Training Plan defined in *Section V.E.3. Provider Relations and Engagement*, the CFSP shall provide training to all network providers where EPSDT is relevant to the providers' area of practice on an annual basis. Training must include information related to:
      1) EPSDT benefits;
      2) EPSDT medical necessity review per federal criteria: standards and processes;
      3) AAP/Bright Futures Periodicity Schedule;
      4) Immunizations;
      5) Required components of an EPSDT screening service;
      6) Providing or arranging for all required lab screenings;
      7) Medical transportation services available to Members;
      8) Outreach activities related to EPSDT provided by the CFSP;
      9) Necessary documentation required for reimbursement of EPSDT services; and
      10) Into the Mouths of Babes/Physician Fluoride Varnish Program.

3. Pharmacy Benefits

a. Prescription drugs play a significant and increasing role in maintaining health and treating illnesses, giving Members the opportunity to become healthier and improve their quality of life. Through current pharmacy program management strategies, the CFSP shall implement a pharmacy benefit which ensures Members and providers access to therapeutically needed medications that will provide the best overall value to Members, providers and the Department.
   i. The CFSP shall administer both point of sale (POS) and Physician's Drug Program (PDP) as a part of the pharmacy benefit. The CFSP shall cover prescription drugs in the same program as the Medicaid FFS pharmacy benefit. The CFSP may, at its discretion, cover the drug under the other program (i.e., POS drugs may be covered by the PDP), unless otherwise prohibited by the Department in the Medication Coverage Restriction List.

b. The CFSP shall:
   i. Cover all covered outpatient drugs for which the manufacturer has a CMS rebate agreement and for which the Department provides coverage. 42 C.F.R. § 438.3(s)(1);
   ii. Adhere to the Department's defined preferred drug list (PDL); and

iii. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2).

c. Drug Formulary and PDL
   i. The CFSP shall not be allowed to maintain a closed formulary as defined in NCGS §58-3-221(c)(1).
   ii. In accordance with NCGS § 108D-65(6)b., the CFSP shall use the same drug formulary established by the Department.
   iii. The drug formulary shall, at minimum, include:
      1) All drugs included the North Carolina Medicaid PDL as posted on the Department's website. The CFSP shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid PDL.
      2) All other covered drugs in drug classes not listed on the Department's PDL except for outpatient drugs excluded by state or federal policy, as defined in 42 C.F.R. § 438.3(s)(1).
   iv. The CFSP may substitute a brand drug with a generic drug when the drug is considered bioequivalent and clinically efficacious unless the brand drug is preferred on the Department's PDL.
   v. Beginning in Contract Year 2, the CFSP may submit additional information or requests for the inclusion of additional drug classes in the Department's PDL for the Department's review and approval.
      1) The CFSP will adhere to the Department defined uniform review and approval process for requests for the inclusion of additional drug classes in the Department PDL.
      2) The CFSP shall use the same drug formulary established by the Department, until provided written approval by the Department.
   vi. In accordance with 42 C.F.R. § 438.10(h)(4)(i), the CFSP shall make available to Members and providers in a machine-readable electronic file and paper format, the following information about the drug formulary:
      1) List of all covered drugs (including over the counter, brand name, and generic prescription drugs); and
      2) Each covered drug's tier (i.e. PDL preferred, PDL non-preferred, and non-PDL).
   vii. Drug formulary updates:
      1) The CFSP will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid PDL. The CFSP shall update their pharmacy claim system within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.
      2) The CFSP shall implement routine PDL changes within thirty (30) Calendar Days of notification of changes to the PDL by the Department (i.e. annual or quarterly updates based on the Department's routine PDL review).
      3) The CFSP shall, at the direction of the Department, perform off-cycle PDL file updates within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.

d. Pharmacy Utilization Management:
   i. As defined herein, the CFSP shall develop a UM program, inclusive of pharmacy benefits.
   ii. For pharmacy services, the CFSP shall follow the existing NC Medicaid FFS clinical coverage policies, prior authorization (PA) criteria, and clinical criteria into the UM program as described in:

1) Clinical Coverage Policies: *Section V.C.3. Table 6: Required Pharmacy Clinical Coverage Policies* below. The CFSP shall not implement any clinical or prior authorization criteria beyond those included in the policies;
2) Prior Authorization Criteria: Drugs and/or drug classes requiring prior approval are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html; and
3) Clinical Criteria: Drugs and/or drug classes subject to clinical criteria are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.

Section V.C.3. Table 6: Required Pharmacy Clinical Coverage Policies
9: Outpatient Pharmacy
9A: Over-the-counter products
9B: Hemophilia Specialty Pharmacy Program
9D: Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17
1B: Physician Drug Program

iii. Consistent with NCGS § 108A-68.1, the CFSP shall not require PA for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.
iv. The UM program shall include PA processes, as defined within Section 1927(d)(5) of the Social Security Act and 42 C.F.R. § 438.3(s)(6), including but not limited to:
   1) The CFSP shall process pharmacy PA requests within twenty-four (24) hours from when the request is received.
   2) The CFSP shall notify the prescriber of the decision by electronic means within twenty-four (24) hours from when the request was received, unless it is necessary for the PA request to be pended to obtain additional information (in which case, the CFSP shall have twenty-four (24) additional hours from the receipt of additional information).
   3) The CFSP shall allow a Member direct access to a drug requiring PA if the physician certifies physician certifies that the Member has previously used an alternative drug not requiring PA and/or the alternative drug has been determined detrimental to the Member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the Member's health or ineffective in treating the condition again. The CFSP shall not void or refuse to renew a provider contract because the provider has provided a certification for a medically necessary drug.
   4) The CFSP shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement in an Emergency Situation, the CFSP must cover a seventy-two (72)-hour emergency supply of the prescription.
   5) The CFSP shall not require a pharmacy to dispense a seventy-two (72)-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber.

6) The CFSP shall allow the pharmacy to bill consecutive seventy-two (72) hour supplies if the prescriber remains unavailable.
7) The CFSP shall reimburse the pharmacy for dispensing the temporary supply of medication and the pharmacy shall only receive one dispensing fee per month for each medication dispensed.
8) The CFSP shall develop and maintain an Emergency Preparedness Protocol, consistent with Required Pharmacy Clinical Coverage Policy 9: Outpatient Pharmacy, to prevent a significant disruption in medication access during a state of emergency or disaster.
9) The CFSP shall align prior authorization requirements as defined in the Opioid Misuse Prevention and Treatment Program.
10) The CFSP shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program, a Standard Plan or a BH I/DD Tailored Plan through the expiration date of the active service authorization.

v. The CFSP shall implement PA policies and procedures and pharmacy point of service edits process consistent with the A+KIDS program as part of its UM program to prevent overprescribing and inappropriate prescribing of antipsychotics in Members under the age of eighteen (18).

vi. As new drugs are approved to the market, the CFSP may require PA for those drugs based on the drug's FDA approved indication(s) and use(s) until the Department determines the need for and establishes clinical coverage and PA criteria.

viii. Beginning in Contract Year 2, the CFSP, after consultation with its or its vendor/Subcontractor's Pharmacy and Therapeutics Committee consistent with NCGS § 58-3-221(a)(1), may submit alternative pharmacy clinical coverage and PA criteria to the Department for review and approval. The CFSP shall:
1) Adhere to the Department-defined uniform review and approval process to request alternative clinical coverage and PA criteria.
2) Seek the Department's approval of alternative prior authorization criteria prior to implementing the alternative criteria.

ix. Pharmacy Prior Authorization Process
1) The CFSP shall develop web-based PA processes, which provides an electronic review system accessible to providers and the Department's staff.
2) The CFSP shall utilize a common PA request form(s), developed by the Department, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.
3) The CFSP's pharmacy claim processing system shall have the ability to integrate Member pharmacy claims and diagnosis history to automate the adjudication of pharmacy claims requiring PA based on criteria requiring the existence of diagnosis or prior pharmacy claims history.

e. Pharmacy Services Website
i. The CFSP shall maintain its own pharmacy services web page available to providers and Members with information regarding the drug formulary and UM Program Policy.
ii. The CFSP shall post to their pharmacy services web page, at a minimum:
1) The drug formulary;
2) UM Policy, including pharmacy clinical coverage and PA criteria; and
3) PA request form(s); and
4) Information about how to access medication during a disaster or emergency.
iii. All additions or changes to the drug formulary, UM Program Policy and PA request form shall be posted thirty (30) Calendar Days prior to the effective date of the requirement or revision.

iv. If the CFSP utilizes a Pharmacy Benefits Manager (PBM), the CFSP's pharmacy services web page may direct providers and Members to their PBM's pharmacy services web page which shall adhere to all the same requirements outlined in this section.

f. Pharmacy Benefit Managers
   i. The CFSP may contract with a pharmacy benefits manager (PBM) to administer the pharmacy benefit.
   ii. If the CFSP utilizes a PBM, the CFSP shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor PBM performance, and ensure the confidentiality of Member information and the Department information that is not public.
   iii. The CFSP shall report all financial arrangements between the CFSP/Subcontractors and all drug-related companies to the Department on an annual basis. Drug-related companies include manufacturers, labelers, compounders, and benefit managers in a manner to be specified by the Department.
   iv. If the PBM is owned wholly or in part by a retail participating pharmacy, chain drug store or pharmaceutical manufacturer, the CFSP shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of Member and the Department proprietary information.
   v. The PBM shall provide a liaison with whom the Department will communicate with directly. The PBM 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.

g. Pharmacy Programs:
   i. The CFSP shall develop and maintain the following pharmacy programs.
      1) Drug Utilization Review
         a) As required by 42 C.F.R. § 438.3(s)(4), the CFSP shall operate a drug utilization review (DUR) program that includes prospective DUR, retrospective DUR, and an educational program for prescribers and pharmacists. The DUR must comply with 42 C.F.R. part 456, subpart K and Section 1927(g) of the Social Security Act.
         b) The prospective DUR program shall:
            i) Operate at pharmacy point of sale; and
            ii) Include, but not be limited to the following:
               (1) Screening for potential drug therapy problems due to therapeutic duplication;
               (2) Drug-disease contraindications;
               (3) Drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs);
               (4) Incorrect drug dosage or duration of drug treatment, drug-allergy interactions;
               (5) Clinical abuse or misuse; and
               (6) Include other parameters as appropriate.
         c) The retrospective DUR program shall, at a minimum:
            i) Address the following:
               (1) Therapeutic appropriateness;
               (2) Over- and under-utilization;
               (3) Use of anti-psychotics in children and youth;
               (4) Psychotropic polypharmacy in children and youth;

(5) Appropriate use of generic products;
(6) Therapeutic duplication, drug-disease contraindication;
(7) Drug-drug interaction;
(8) Incorrect drug dosage;
(9) Incorrect duration of drug treatment; and
(10) Clinical abuse or misuse.

ii) Conduct at least a quarterly review of paid drug Pharmacy Claim and Medical Claim utilization data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and Members; and

iii) Address other programs and initiatives as directed by the Department.

d) The educational program within the DUR for prescribers and pharmacists that includes, at a minimum, the following:

i) Written, verbal, or electronic reminders containing patient-specific or DUR-specific information (or both) and suggested changes in prescribing or dispensing practices;

ii) In-person discussions, with follow up discussions when necessary, between health care professionals who are experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices;

iii) Intensified review or monitoring of selected prescribers or pharmacists; and

iv) Other educational activities as appropriate. 42 C.F.R. 456 subpart K.

e) The CFSP shall implement DUR programs to address opioid misuse. The Department reserves the right to require the CFSP to develop DUR programs for other targeted populations, drug classes and/or disease states.

f) The CFSP shall provide a detailed description of its DUR program activities to the Department on an annual basis. 42 C.F.R. § 438.3(s)(5).

g) The CFSP shall report DUR program data to the Department in a format consistent with the Department's reporting format for the CMS annual report no later than ninety (90) Calendar Days prior to the CMS due date.

2) Opioid Misuse Prevention and Treatment Program is defined in *Section V.D.8. Prevention and Population Health Programs.*

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 based on a flat dispensing fee 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) The calculation used to determine the quarterly generic dispensing rate (GDR) for tiered reimbursement shall be the same used by the Department.

5) A claim level GDR report shall be provided to each pharmacy provider prior to each quarterly dispensing rate adjustment for tiered reimbursement.

6) For 340B 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 twenty-five cents ($0.025) for all other Non-Hemophilia 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 at the same rate at the Medicaid FFS rate.
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 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 twenty-five 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 twenty-five cents ($0.25) 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 $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 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.*

i. Drug Rebates
   i. The Department shall have sole authority to negotiate rebate agreements for all covered drugs in Medicaid Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid Program to the CFSP. The CFSP or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid program. If the CFSP or its Subcontractor has an existing rebate agreement with a manufacturer, all

Medicaid covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.

ii. The CFSP shall submit outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims encounter data to the Department or its Encounter Data Processing vendor on a weekly basis, no later than seven (7) Calendar Days following the date on which the CFSP or its Subcontractor adjudicated the claims for drug rebate invoicing as defined in *Section V.I.2. Encounters*.

iii. The CFSP shall submit all pharmacy and medical drug encounter data for rebate invoicing in a format determined by the Department or its Drug Rebate vendor. At a minimum, the data should be at claims level and include the total number of units by strength by National Drug Code (NDC) of each covered outpatient pharmacy drug, outpatient hospital drug and physician administered drug paid for by the CFSP or its Subcontractor. 42 C.F.R. § 438.3(s)(2).

iv. The CFSP shall submit drug encounters using a HCPCS/CPT code with the following:

1) An NDC that is appropriate for the HCPCS/CPT code based on the drug description, strength and date of service.
2) HCPCS/CPT units and NDC units reported that represent a medically appropriate dosing and package size.
3) Date of service that is not past the termination date of the drug.
4) An NDC that is from a rebate-eligible manufacturer on the date of service of the claim. 42 C.F.R. § 438.3(s)(2).

v. 340B covered entities:

1) The CFSP pharmacy provider contracts shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit national Council for Prescription Drug Programs (NCPDP) code "8" in Basis of Cost Determinations filed 423-DN and 20 in the submission Clarification field 490-DK at the point of sale to identify claims submitted for drugs purchased through the 340B program.
2) The CFSP pharmacy provider contracts shall require 340B covered entities to identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3).
3) The CFSP pharmacy provider contracts shall require that 340B covered entities' written agreements with contracted pharmacies specify that contract pharmacies comply with the point of sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3).
4) The CFSP pharmacy provider contracts shall require contract pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).
5) The CFSP shall report to the Department the commencement, conclusion and final results of all HRSA audits.
6) The CFSP shall review 340B covered entities' HRSA audits and coordinate with the Department to ensure the prevention of duplicate discounts.

vi. The CFSP shall disclose to the Department all financial terms and arrangements for remuneration of any kind that apply between the CFSP and other entities identified in the CFSP Operating Plan and any drug manufacturer, labeler or PBM including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.

1) The Department shall maintain the confidentiality of information disclosed by the CFSP pursuant to this section, to the extent that the information is confidential under North Carolina or federal law.
2) The Department may audit financial terms and arrangements for remuneration of any kind that apply between the CFSP and any drug manufacturer or labeler.

vii. The CFSP shall support the Department with drug rebate dispute resolution processes within the timeframe requested by the Department.
1) The CFSP or its Subcontractor shall assign a single point of contact to research any encounters that are denied on submission to the Department or identified as a dispute by the drug manufacturers and within thirty (30) Calendar Days shall resolve.
2) The CFSP or its Subcontractor shall provide an explanation of such disputes to the Department at the encounter claim level in a spreadsheet.
3) If the encounter claim information is found to be in error, the encounter shall be voided within five (5) Business Days of the determination.

4. Non-Emergency Medical Transportation

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

b. The CFSP shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct and consistent with the NC Non-Emergency Medical Transportation Managed Care Policy.

c. The CFSP shall provide NEMT services for all enrolled Members:
i. By the least expensive mode available and appropriate for the Member;
ii. To the nearest appropriate medical providers; and
iii. For a Medicaid covered service, including services carved out of Medicaid Managed Care provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider).

d. When providing NEMT services, the CFSP shall use the most appropriate form of transportation to meet the needs of the Member.

e. NEMT services shall include:
i. NEMT transportation vendors including public transportation, taxis, van, wheel-chair vans, mini-bus, mountain area transports, or other transportation systems and non-medically necessary ambulance transportation.
ii. Other transportation services including volunteers, Foster Care parents, family members and friends, attendant expenses, ancillary costs and attendant pay, and non-emergency air travel.
iii. Travel related expenses including food, parking, fees/tolls, transportation vouchers (i.e. taxis, ride sharing services, public transit), and mileage.

f. The CFSP shall guarantee the following rights to Members:
i. To be informed of the availability of Medicaid NEMT;
ii. To be informed that there is no cost to the Member;
iii. To be informed of who may accompany a Member without cost;
iv. To be informed that a Member under the age of eighteen (18) does not have to ride alone;
v. To have the CFSP's NEMT Policy, as defined below, explained including:
1) How to request or cancel a trip;
2) Limitations on transportation;
3) Advanced notice requirements; and

4) Expected Member conduct and procedures for no-shows.

vi. To be transported to medical appointments if unable to arrange or pay for transportation and by means appropriate to circumstances;

vii. To arrive at provider in time for the scheduled appointment; and

viii. To request an Appeal, as defined in the Contract, if the request for transportation assistance is denied.

g. The CFSP shall not require Members to make transportation requests more than two (2) Business Days in advance.

h. The CFSP shall ensure that an attendant is present with:

i. Members under the age of eighteen (18), unless emancipated, at no additional cost to the Member or attendant. The attendant may or may not be the Parent or Guardian.

ii. Members with special medical, physical or mental impediments, at no additional cost to the Member or attendant. The attendant may or may not be the Parent or Guardian.

i. The individuals included in *Section V.C.4. Table 7: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the CFSP.

Section V.C.4. Table 7: Individuals Not Eligible to Receive NEMT Services	
Population	**Additional Detail**
Members in a nursing home	The facility is responsible for providing transportation to their patients.
Members in a PRTF	The facility is responsible for providing transportation to their patients.

j. The CFSP shall develop a network of NEMT providers sufficient to fulfill the requirements as outlined in this section.

k. The CFSP shall provide copies of its contract(s) with Subcontractor(s) providing NEMT services upon Contract Award or within fourteen (14) Calendar Days of signing any new agreement or modification with the CFSP's NEMT Subcontractor(s).

l. The CFSP shall develop, submit and maintain a NEMT Policy. The CFSP shall submit the Policy ninety (90) Calendar Days after Contract Award and annually thereafter, for use with Members.

i. The Policy shall include, at a minimum, the following:

1) Transportation options available to Members;

2) Methods and process by which to request transportation;

3) Driver and vehicle requirements;

4) Process for transportation assessment;

5) Member rights and responsibilities; and

6) Hours of operation.

m. The NEMT Policy shall adhere to the following:

i. Transportation shall be scheduled so that the Member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than the Department's defined wait times after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;

ii. Members cannot be required to make transportation requests in person;

iii. Urgent transportation services are exempt from any advance notice requirement;

iv. The Department's requirements for written materials; and

v. All other requirements defined in this section.

D. Care Management

1. Overview

a. Care Management is crucial to achieving key goals of the CFSP, including integrated, whole-person care and fostering coordination and collaboration with County DSS and among care team members across disciplines and settings.

b. The Department has developed the CFSP Care Management model, described in *Section V.D.2. CFSP Care Management*, as the predominant Care Management model for the CFSP population.

c. The CFSP shall be responsible for implementing the CFSP Care Management model as described in *Section V.D.2. CFSP Care Management* and engaging its Members in CFSP Care Management.

d. The CFSP shall provide Care Management that accounts for the unique needs of each Member in the CFSP. The CFSP Care Management model shall support all Members in accessing health and social services, including those services needed to help achieve family preservation and permanency planning goals.

e. The CFSP shall ensure prompt coordination and provision of services when Members enter out-of-home placement, change placements, return home, Age Out of County DSS Custody or otherwise Exit County DSS Custody, or are adopted.

f. The CFSP shall deliver Care Management services in a way that promotes health equity and supports Historically Marginalized Populations in the child welfare system as described in *Section V.D.5 Care Management Policy*.

g. The CFSP shall ensure Care Management includes active engagement and coordination with County DSS in order to support Members' family preservation and permanency goals.

h. The CFSP shall comply with forthcoming Department processes to evaluate the impact and effectiveness of CFSP Care Management.

i. Beyond CFSP Care Management, the CFSP shall be responsible for delivering Care Coordination and managing Care Transitions for all Members, regardless of whether they participate in CFSP Care Management, as described in *Section V.D.3. Care Coordination and Care Transitions for all Members*.

j. The CFSP shall also provide additional Care Management and Care Coordination functions as detailed in *Section V.D.4. Other Care Management Programs, Section V.D.6. System of Care,* and *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings*.

k. The CFSP shall also meet the requirements set forth in *Section V.D.5 Care Management Policy, Section V.D.8. Prevention and Population Health Program, Section V.D.9. Healthy Opportunities*, *Section V.D.10. Relocation of Members Following Emergency Residential Facility Closures*, and *Section V.D.2. CFSP Care Management*.

2. CFSP Care Management

a. Objectives

i. The objectives of the CFSP Care Management model are to:

1) Provide a person- and family-centered approach to the provision of health care services for Members, involve supports in the Member's life (e.g., Parent(s), Guardian(s), and

Custodian(s), and/or other caregivers), and ensure needed services are easily accessible to Members so that they have the fullest opportunity to lead healthy and productive lives;

2) Serve all Members enrolled in the CFSP and support each Member in accessing services that meet their individualized needs and help achieve their individual health goals;
3) Provide comprehensive management of each Member's healthcare needs, including physical health, Behavioral Health I/DD, LTSS, and pharmacy needs and Unmet Health-Related Resource Needs, in close coordination between the Member, the CFSP, the Department, and, as applicable, County DSS, subject to all applicable federal and state privacy laws;
4) Ensure that CFSP Care Management is available to all CFSP Members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services as defined in *Section V.D.2.u.III.5. Duplication of Care Management*; and
5) Align with the North Carolina System of Care framework.[15] The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with BH needs.

b. Delivery of CFSP Care Management
   i. The Care Management model shall be available to all Members regardless of geographic location, including to Members in out-of-state placements, and provide coordination across healthcare settings and Foster Care placements, as applicable. The CFSP shall also coordinate closely with County DSS, specifically, a Member's assigned Child Welfare Worker, as applicable, while ensuring maintenance of all federal and state privacy laws.
   ii. CFSP Care Management shall be administered primarily by the CFSP, with Care Management responsibilities residing with the CFSP.
   iii. The CFSP shall seek approval from the Department before delegating any functions described in *Section V.D.2. CFSP Care Management*. Any delegation arrangement must ensure that delegated entities are meaningfully integrated as part of the CFSP's statewide Care Management model and that any Care Management delivered by those entities appears seamless and fully integrated to the Member. This includes, at minimum, ensuring smooth coordination of care for Members who move across the state and seamless coordination between care managers and County Child Welfare Workers. The Department reserves the right to prohibit any delegation arrangement that does not sufficiently integrate delegated Care Management entities into the CFSP's statewide model. The Department will issue further guidance detailing the processes for requesting Care Management delegation and specific criteria for the Department to approve such arrangements.
   iv. Except for Members receiving Care Management services described in *Section V.D.2.u.III.5. Duplication of Care Management*, the CFSP shall provide Care Management regardless of the Member's physical location, Foster Care placement, or treatment setting.

c. Care Management
   i. CFSP Care Management shall be administered by a "care manager" employed by the CFSP, unless the CFSP delegates care management functions to another entity as described in *Section V.D.2.b.iii.*
   ii. All Members enrolled in the CFSP shall be assigned a care manager, unless they are receiving duplicative Care Management services as defined in *Section V.D.2.u.III.5. Duplication of Care Management*.

[15] https://www.ncdhhs.gov/providers/provider-info/mental-health/child-and-family-mental-health-services

iii. The care manager shall lead the delivery of Care Management functions described in *Section V.D.2. CFSP Care Management* including delivering the Care Management Comprehensive Assessment, leading the development of the Care Plan/ISP, leading the formation of the Care Team, and conducting ongoing Care Management and transitional Care Management.
iv. The care manager shall be responsible for coordinating closely with a Member's assigned County Child Welfare Worker, as applicable, as described in *Section V.D.2.f. Collaboration with County DSS.*
v. Subject to agreement by County DSS, the CFSP shall ensure that a share of care managers are physically co-located in County DSS, as described in *Section V.D.2.f.i. Co-Location*. The Department will issue future guidance detailing expectations for co-location in County DSS.
vi. The CFSP shall ensure that all care managers meet minimum qualifications described in *Section V.D.2.s.v. Care Manager Qualifications*.
vii. The care manager shall be responsible for conducting in-person Care Management, when possible, as described in *Section V.D.2.m. Ongoing Care Management.*
viii. The CFSP shall be responsible for ensuring that eligible Members have access to Care Management (including in-person Care Management, as appropriate), regardless of their geographic location, including Members that are in out-of-state placements.
ix. The Department shall require the CFSP to coordinate with the EBCI Family Safety Office on the delivery of Care Management for Members from a federally recognized tribe who have opted-in to the CFSP; the Department will issue future guidance detailing Care Management expectations for this population.

d. Eligibility for CFSP Care Management
i. All Members are eligible for CFSP Care Management, with the following exceptions for Members participating in services that are duplicative of CFSP Care Management:
1) Members obtaining Assertive Community Treatment (ACT) as described in *Section V.D.4.f. Members Obtaining ACT*; and
2) Other services as determined by the Department.
ii. The CFSP shall establish mechanisms in accordance with requirements established by the Department to track the percentage of Members actively engaged in CFSP Care Management.
iii. The CFSP shall be responsible for ensuring that Members in out-of-state placements, including both kinship and institutional placements (e.g., PRTFs), receive the same level of Care Management as Members residing in North Carolina.
1) The CFSP shall ensure that such Members receive in-person Care Management described throughout *Section V.D.2. CFSP Care Management*, as applicable.
2) In instances where in-person Care Management is not appropriate based on the Member's needs or if in-person contact is not feasible based on the Member's location (or other factors), the CFSP may request from the Department an exception to in-person Care Management requirements.
3) CFSP requests for exceptions to in-person Care Management requirements must be made on an individual Member-basis and must include a proposed alternative approach for ensuring that the Member receives an appropriate level of Care Management, either through other in-person resources contracted by the CFSP or through virtual modalities.
4) The CFSP shall not disregard any in-person contact requirements described in *Section V.D.2. CFSP Care Management* until an alternative Care Management approach is approved by the Department.
iv. The CFSP shall ensure Members enrolled in ACT and Members who do not engage in CFSP Care Management (including Members who are not reachable or decline CFSP Care

Management) receive Care Coordination services, as described in *Section V.D.3. Care Coordination and Care Transitions for All Members*.

e. Initiation of Care Management
   i. The CFSP shall ensure that all Members are assigned a care manager within twenty-four (24) hours of the CFSP receiving notification of the Member's enrollment.
   ii. The CFSP shall submit to the Department its methodology for assigning Members to a care manager.
   iii. The CFSP shall make best efforts to prioritize the following factors, in order, when assigning each Member to a care manager:
      1) Member's request for a specific care manager;
      2) The specialized needs of individual Members (e.g., care manager has experience managing Members of a similar age and/or those with similar clinical and social needs);
      3) The care manager is employed by the same organization as the Member's PCP (in instances where the CFSP has chosen to delegate aspects of the CFSP Care Management model);
      4) The same care manager is assigned to family members enrolled in the CFSP (e.g., child in Foster Care is assigned to the same care manager as their Parent(s), Guardian(s), or Custodian(s) who is also enrolled in the CFSP);
      5) The care manager is based out of the same County DSS as the Member's assigned County Child Welfare Worker; and
      6) Geographic proximity (if the care manager is not staffed to the same County DSS as the Member's assigned County Child Welfare Worker).
   iv. The CFSP shall have discretion to modify the prioritization of care manager assignment factors based on care manager availability and existing caseloads.
   v. The CFSP shall permit Members to request a change in their assigned care manager at any time and without limit.
   vi. At least thirty (30) Calendar Days prior to CFSP launch, the CFSP shall send Members a CFSP Care Management enrollment packet, with information on their care manager assignment.
   vii. After the initial launch of the CFSP, the CFSP shall complete care manager assignments within twenty-four (24) hours and send CFSP Care Management enrollment packets to new Members within fourteen (14) Calendar Days of the Member's enrollment in the CFSP.
   viii. The CFSP Care Management enrollment packet must include:
      1) Information on the CFSP Care Management program;
      2) The nature of the care manager relationship;
      3) Information on the Member's CFSP care manager assignment;
      4) Process and options for changing their CFSP care manager assignment;
      5) Circumstances under which Member information will be disclosed to third parties; and
      6) The availability of the Grievance and Appeals process as described in *Section V.B.7. Member Grievances and Appeals.*
   ix. In instances where a Member has relocated permanently, the CFSP may, with the Member's consent, re-assign the Member to a care manager located closer to the Member's place of residence. "Relocated permanently" for this requirement means when a Member moves from one place to another without expecting to return to their original or previous location.
   x. Members must not be assigned to a care manager who is related by blood or who serves as the Member's Parent, Guardian or Custodian.
   xi. The CFSP shall submit its policies and procedures for care manager assignment as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).
   xii. Consolidation of Medical Records

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

f. Collaboration with County DSS

i. Co-Location

1) Subject to agreement by County DSS, the CFSP shall be required to co-locate a share of care managers at a level to be determined by the Department across North Carolina's network of County DSS.
2) The CFSP shall maintain an up-to-date list with contact information of County DSS and individual County Child Welfare Workers. The list shall be made readily available to all care managers (and other CFSP staff, as appropriate), regardless of location.
3) The CFSP shall not require Members to travel to a County DSS to receive Care Management services. Care managers may provide Care Management onsite at a County DSS if appropriate and agreed to by the Member, but Members must have the option to receive in-person Care Management visits in the community.
4) The Department will develop additional guidance about co-location in collaboration with the North Carolina Association of County Directors of Social Services (NCACDSS), including timing for operationalizing co-location across County DSS, the share of care managers who must be co-located in County DSS, and the distribution of co-location between urban and rural areas.

ii. Coordination with County Child Welfare Workers

1) For all Members enrolled in the CFSP with an assigned County Child Welfare Worker, the care manager shall arrange an initial meeting with the Member's assigned County Child Welfare Worker (in-person, by video, or telephonic).
2) The CFSP shall not be subject to the requirements in *Section V.D.2.f.ii. Coordination with County Child Welfare Workers* for Members who do not have an assigned County Child Welfare Worker.
3) Initial meetings shall occur on the following timeframes:
   a) For 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, or earlier if necessary, to appropriately manage the Member's healthcare needs.
   b) Following the first ninety (90) Calendar Days after CFSP launch: within seven (7) Calendar Days of CFSP enrollment or earlier if necessary, to appropriately manage the Member's healthcare needs.
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));
      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; and
viii) If the care manager determines that any evaluations/assessments are not required, the care manager must document the reason.

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; and
(5) Other information necessary for informing the assessment and care planning processes.
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.

5) Agree on explicit next steps and roles and responsibilities to ensure Member receives needed services in a timely fashion. For Members with an assigned County Child Welfare Worker, the care manager shall schedule and attend meetings with the Member's assigned County Child Welfare Worker at least monthly, unless an alternative schedule is mutually agreed to by the County Child Welfare Worker and the care manager based on the Member's condition.
6) During regular monthly meetings, the care manager shall be required to gather updates on the following:
a) For all Members:

i) Key changes in the Member's healthcare needs, including BH and Unmet Health-Related Resource Needs;
ii) Key updates on Member's family preservation and permanency planning process; and
iii) Other information necessary for informing the Member's Care Plan/ISP.

b) For Members in County DSS custody:
i) Member's placement status; and
ii) Any changes regarding restrictions to communicating with a Member's Parent(s), Guardian(s), or Custodian(s), including termination of parental rights or court order restricting communication.

7) The CFSP shall ~~ensure~~ make "best efforts" to communicate ~~communication~~ 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 (e.g., Member is expelled or is required to change schools);
f) Member becomes involved with the justice system; or
g) Member is boarding in County DSS Office or other location awaiting access to medically necessary behavioral health treatment.

iii. In the event of a placement crisis, CFSP is responsible for coordinating care and ensuring placement is achieved within twenty-four (24) hours of determining medical necessity is met for any Medicaid State Plan enhanced behavioral health, residential treatment, and PRTF service, or an alternative service(s) deemed clinically appropriate to serve the member.

iv. The Department will develop policies and procedures collaboratively with County DSS that require the CFSP to notify the Department when a County DSS or individual County Child Welfare Worker is unresponsive to coordination efforts with CFSP care managers as described in *Section V.D.2.f.ii. Coordination with County Child Welfare Workers*.

v. The CFSP shall submit its policies and procedures for collaboration and coordination with County DSS as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

vi. Regional Liaison to County DSS
1) The CFSP shall establish a minimum of one (1) Regional Liaison to County DSS for each DSS Region[16].
2) The Regional Liaison to County DSS shall serve as the primary contact with County DSS, including County Directors of Social Services and County Child Welfare Workers, to triage and escalate issues with CFSP care managers, and Member and/or CFSP-related questions.

g. Risk Stratification

[16] https://www.ncdhhs.gov/cws772022a1/download?attachment

i. The CFSP shall be required to develop a methodology for risk stratifying its Members in order to match intensity of Care Management to each Member's needs (e.g., stratifying institutionalized Members as high-risk).

ii. The CFSP's risk stratification methodology must:

1) Stratify Members into a minimum of two (2) tiers, one of which must be a "high-risk" tier. The CFSP may establish additional risk tiers at its discretion.

2) Include, at minimum, Members that meet the following criteria in the high-risk tier:

a) Otherwise meet BH I/DD Tailored Plan eligibility criteria;

b) Currently admitted to an institutional level of care or other congregate setting, including but not limited to an ACH, a state psychiatric hospital, PRTF, Residential Treatment Levels II (Program Type), III, and IV, or congregate setting operated by DSS;

c) Transitioned from an institutional or other congregate setting level of care within the past three (3) months;

d) Visited the ED two (2) or more times within the past three (3) months or admitted to an inpatient level of care within the past three (3) months;

e) Experienced two (2) or more placement changes in any three (3) month period or three (3) or more changes in any one (1) year period;

f) Experienced a BH crisis within the past three (3) months;

g) Been expelled from school within the past three (3) months;

h) Have been arrested or involved with the justice system (adults) or juvenile justice system (children/youth) within the past twelve (12) months;

i) Are an infant who is substance affected;

j) Have significant unmet mental health and/or substance use disorder needs, as defined by the CFSP;

k) Have a Special Health Care Need, consistent with definition in *Section III.A. Definitions* for Children with Special Health Care Needs and Beneficiary with Special Health Care Needs;

l) Children with Medical Complexity (CMC), as defined in *Section III.A. Definitions;*

m) Individuals with LTSS needs;

n) Individuals with high Unmet Health-Related Resource Needs, defined at a minimum to include:

i) Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;

ii) Members experiencing or witnessing domestic violence or lack of personal safety; and

iii) Members showing Unmet Health-Related Resource Needs in three or more Healthy Opportunity domains on the Care Needs Screening; and

o) High-risk pregnant women.

iii. The CFSP shall not rely solely on a cost-based risk stratification model (i.e., the model must account for Care Management needs).

iv. For all Members identified as high-risk, the CFSP must make best efforts to ensure the Member receives the minimum required Care Management contacts described in *Section V.D.2.m.xi.*

v. The CFSP shall submit its risk stratification methodology as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

h. Outreach and Engagement

i. The CFSP shall require that care managers initiate contact with assigned Members who have recently been enrolled in CFSP Care Management to conduct Medication Reconciliation and management described in *Section V.D.2.i. Medication Reconciliation and Management* and complete the Care Management Comprehensive Assessment according to the timeframes described in *Section V.D.2.j. Care Management Comprehensive Assessment*.

ii. The care manager shall educate the Member about the benefits of Care Management and work to engage the Member in a Care Management Comprehensive Assessment and care planning.

1) When starting the Care Management Comprehensive Assessment, contact may be telephonic, through two-way real time video and audio conferencing, or in-person.

iii. The CFSP shall develop policies for communicating and sharing information between Members and their families, including tailored policies for Members in County DSS custody and their Parents(s), Guardian(s) or Custodian(s), with appropriate consideration for language, literacy and cultural preferences, including sign language, closed captioning and/or video capture.

iv. The CFSP shall submit its policies and procedures for outreach and engagement as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

v. The CFSP care manager shall adhere to any applicable privacy restrictions or other restrictions in place regarding communication for Members in County DSS custody.

i. Medication Reconciliation and Management

i. The care manager shall utilize nationally-recognized practices for conducting Medication Reconciliation and management for children and youth served by the child welfare system such as those described in "Best Practices for Medication Management for Children & Adolescents in Foster Care" from the North Carolina Pediatric Society/Fostering Health NC.[17]

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 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.

2) Following the first ninety (90) Calendar Days after CFSP launch: within seven (7) Calendar Days of CFSP enrollment for all Members.

3) Upon request by the Member's Parent(s), Guardian(s), or Custodian(s), as applicable.

iii. As appropriate, the care manager shall involve the appropriate CFSP clinical staff following Medication Reconciliation in order to assess the clinical appropriateness of the Member's medication regimen, as described in *Section V.D.2.i.iii.*

iv. The CFSP care manager shall assist the Member with refilling prescribed medication(s) as needed, including connecting the Member to their PCP or local pharmacy, as appropriate.

v. The Medication Reconciliation and management requirements described in *Section V.D.2.i. Medication Reconciliation and Management* shall also apply to Medication Reconciliation and Management responsibilities described in *Section V.D.2.m. Ongoing Care Management*, *Section*

[17] Available at https://www.ncdhhs.gov/media/12749/download?attachment [18] The Care Management Comprehensive Assessment is unrelated to the comprehensive clinical assessment and does not serve as a means to approve services.

V.D.2.n. Transitional Care Management, and *Section V.D.2.k. Development of Care Plan/Individual Support Plan*.

j. Care Management Comprehensive Assessment[18]
   i. The Care Management Comprehensive Assessment shall serve as the federally required initial care needs screening. 42 C.F.R. 438.208(b)(3).
   ii. The care manager shall be responsible for conducting the Care Management Comprehensive Assessment.
   iii. The CFSP shall ensure that the Care Management Comprehensive Assessment is conducted in a location that meets the Member's needs.
   iv. The CFSP shall ensure that care managers make best efforts to complete the Care Management Comprehensive Assessment in person, allowing, in limited instances, for care managers to complete the Care Management Comprehensive Assessment via technology conferencing tools (e.g., audio and/or audio-video tools).
   v. The CFSP shall make its best effort to complete the Care Management Comprehensive Assessment 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) "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home, working with a known provider to meet the Member at an appointment, or working with the County Child Welfare Worker, as applicable, to contact the Member if the first attempt is unsuccessful.
      4) The Department will provide further guidance on processes for Members who will require Warm Handoffs at CFSP launch.
      5) The CFSP shall attempt a Care Management Comprehensive Assessment one time per month for Members the care manager has been unable to reach despite best efforts.
      6) The CFSP shall attempt a Care Management Comprehensive Assessment at least annually for Members who have actively declined to participate in CFSP Care Management and are not receiving services duplicative of CFSP Care Management.
   vi. 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 its best effort to conduct a Care Management Comprehensive Assessment (or reassessment, as appropriate) within ninety (90) Calendar Days of the Member Aging Out of County DSS Custody or otherwise Exiting County DSS Custody.
   vii. The care manager shall share the results of the Care Management Comprehensive Assessment with the Member's assigned County Child Welfare Worker, PCP, BH, I/DD, TBI, LTSS, and other known providers, as applicable, within fourteen (14) Calendar Days of completion to inform care planning, provided that the Member consents to the sharing, if required by law. The CFSP shall not withhold necessary services for Members while awaiting completion of the Care Management Comprehensive Assessment.
   viii. The care manager shall ensure that a reassessment for Members is done:
      1) At least annually;

[18] The Care Management Comprehensive Assessment is unrelated to the comprehensive clinical assessment and does not serve as a means to approve services.

2) When the Member's circumstances, needs or health status changes significantly;
3) After Significant Changes in scores on Department-approved level-of-care determination and screening tools (e.g., ASAM, and CANS);
4) At the Member's request;
5) After a health-related "triggering event", including, but not limited to, the following:
   a) Inpatient hospitalization for any reason;
   b) An emergency department (ED) visit since the last Care Management Comprehensive Assessment (including reassessment);
   c) An involuntary treatment episode;
   d) Use of Behavioral Health crisis services;
   e) Becoming pregnant and/or giving birth; or
   f) Any change in Member circumstances that requires an increased need for care, a decreased need for care, or transition into or out of an institution;
6) After a non-health-related "triggering event," including, but not limited to:
   a) Change in Foster Care placement or living arrangement (including Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody) as described in *Section V.D.2.o.ii. Requirements for Members Who Age Out of County DSS Custody or Otherwise Exit County DSS Custody;*
   b) Change in the status of a caregiver (e.g., as a result of change in placement, death, or illness);
   c) Death of a family member, friend, or Caretaker Relative;
   d) Change in school or employment;
   e) Arrest or other involvement with law enforcement/the criminal justice system, including Division of Juvenile Justice and Delinquency Prevention; or
   f) Loss of housing.

ix. When a Member requests a reassessment; experiences a Significant Change in circumstances, needs or health status; experiences a Significant Change in level of care score; or experiences a triggering event, the CFSP shall ensure that the Member receives a reassessment within thirty (30) Calendar Days of when the CFSP detects the change or event. Reassessments triggered by pregnancy or childbirth must address pregnancy-specific SUD and mental health screening covering the physical and BH needs of the infant and mother.

x. In circumstances in which a Care Management Comprehensive Assessment may have been recently performed, reassessment may consist of an addendum or update to a previous Care Management Comprehensive Assessment.

xi. The CFSP shall develop methodologies and tools for conducting the Care Management Comprehensive Assessment, as appropriate for differing Member demographics and needs.

xii. The Care Management Comprehensive Assessment shall address, at a minimum, the following:
   1) Immediate care needs;
   2) Current services and providers across all health needs;
   3) Exposure to ACEs or other trauma;
   4) Member resiliency (e.g., through an externally validated resiliency screening tool);
   5) Risks to the health, well-being, and safety of the Member and others (including minor's sexual activity (as appropriate), potential abuse/exploitation, and primary and secondary exposure to tobacco products and/or aerosols);
   6) Upcoming life transitions (change in Foster Care placement (including Aging Out/otherwise Exiting DSS Custody), school, employment, caregiver/natural supports, etc.);
   7) Functional needs, accessibility needs, strengths and goals;

8) Other state or local services currently used;
9) Physical health conditions;
10) Dental conditions;
11) Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
12) Physical, intellectual or developmental disabilities;
13) Traumatic brain injuries;
14) Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;
15) Family preservation and/or permanency goals and services/supports needed to move toward these goals;
16) Advanced Directives, including advance instructions for mental health treatment;
17) Available informal, caregiver or social supports;
18) Education (including individualized education plan and lifelong learning activities);
19) Standardized Unmet Health-Related Resource Needs questions to be provided by the Department covering four (4) priority domains:
    a) Housing;
    b) Food;
    c) Transportation; and
    d) IPV/Toxic Stress.
20) Any other ongoing conditions that require a course of treatment or regular care monitoring;
21) Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
22) Employment/community involvement;
23) Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
24) Risk factors that indicate an imminent need for LTSS;
25) Caregiver's strengths and needs;
26) Self-management and planning skills; and
27) Receipt of and eligibility for entitlement benefits, such as Supplemental Security Income.

xiii. For Members ages zero (0) up to age three (3), the Care Management Comprehensive Assessment shall address the elements in *Section V.D.2.j. Care Management Comprehensive Assessment* and incorporate questions related to Early Intervention (EI) services for children, including:
    1) Whether the Member is receiving EI services;
    2) Member's current EI services;
    3) Frequency of EI services provided;
    4) Transitional care needs upon conclusion of EI services;
    5) Which local CDSA or subcontracted agency is providing the services; and
    6) Contact information for the CDSA service coordinator.

xiv. For CFSP Members with a mental health disorder and/or SUD who are receiving BH or substance abuse services, including Members with a dual I/DD and mental health or SUD diagnosis, the Care Management Comprehensive Assessment shall incorporate a strengths assessment process that promotes the identification of the functional strengths of each Member, family and community.

xv. The CFSP's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.

xvi. The CFSP shall send a monthly report listing all Members who received the Standardized Unmet Health-Related Resource Needs screening in the form and manner specified by the Department. See *Section VII. Attachment I. Reporting Requirements* for more detail.

xvii. The CFSP shall submit its policies and procedures for Care Management Comprehensive Assessments as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

k. Development of Care Plan/Individual Support Plan

i. Using the results of the Care Management Comprehensive Assessment and the results of the DSS Child Health Summary Components, the care manager shall develop a Care Plan for Members without I/DD and TBI needs. For Members with I/DD and TBI needs, the CFSP shall develop an ISP. 42 C.F.R. § 441.725.

ii. The CFSP shall ensure that all Care Plans and ISPs are developed and presented in a manner understandable to the Member or Authorized Representative, including consideration for the Member's or Authorized Representative's reading level and alternate formats.

iii. The CFSP shall ensure that meetings related to the Member's Care Plan/ISP are held at a location, date and time convenient to the Member and the Member's chosen participants.

iv. The CFSP shall ensure that each Care Plan and ISP is individualized and person-centered and is developed using a collaborative approach with the Member, family members, including a Member's Parent(s), Guardian(s), Custodian(s) as appropriate and applicable, and other agency and natural supports, to the extent applicable and appropriate.

v. The CFSP shall make best efforts to complete an initial Care Plan or ISP within seven (7) Calendar Days of the completion of the Care Management Comprehensive Assessment for Members identified through the CFSP's risk stratification as high-risk and fourteen (14) Calendar Days for all other Members.

1) "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the Member's home, working with a known provider to meet the Member at an appointment, or working with the County Child Welfare Worker to contact the Member if the first attempt is unsuccessful.

vi. The CFSP shall ensure that development of the Care Plan or ISP does not delay the provision of needed services to a Member in a timely manner, even if that Member is waiting for a Care Plan/ISP to be developed.

vii. The CFSP shall ensure that the Care Plan or ISP is regularly updated incorporating input from the Member and Members of the care team, as part of ongoing Care Management, and that the Care Plan will be comprehensively updated:

1) At minimum every twelve (12) months;
2) When a Member's circumstances or needs change significantly;
3) When a Member transitions out of an institutional or other congregate setting;
4) When a Member changes Foster Care placement;
5) When a Member achieves permanency via reunification, guardianship, custody, or adoption;
6) At the Member's request; and
7) Within fourteen (14) Calendar Days of (re)assessment.

viii. The CFSP shall ensure that each Care Plan and ISP incorporates results of the Care Management Comprehensive Assessment (including Unmet Health-Related Resource Needs questions), results of the DSS Child Health Summary Components, claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:

1) CANS;

2) ASAM criteria; and
3) For Members obtaining or seeking to obtain 1915(i) Services: Independent Assessment.

ix. The CFSP shall ensure that each Care Plan and ISP contains, at a minimum:
1) Names and contact information of the assigned County Child Welfare Worker, key providers, care team Members, family members and others chosen by the Member to be involved in planning and service delivery;
2) Measurable Member goals;
3) Clinical needs including, but not limited to, any physical health, Behavioral Health I/DD, LTSS, pharmacy, or dental needs;
4) Interventions including addressing Medication Reconciliation and management, including adherence;
a) Medication Reconciliation and management interventions must include all elements described in *Section V.D.2.i. Medication Reconciliation and Management.*
5) Intended outcomes of interventions and goals;
6) Social, educational and other services needed by the Member;
7) Strategies to increase social interaction, employment and community integration;
8) Permanency planning information from County DSS relevant to physical, behavioral and social needs of the Member;
9) Plan for addressing issues identified during a Child Maltreatment Evaluation, as applicable;
10) Emergency/natural disaster/crisis plan;
11) Strategies to mitigate risks to the health, well-being and safety of the Members and of others;
12) Information about Advance Directives, including advance instructions for mental health treatment, as appropriate;
13) A life transitions plan to address instances where the Member is changing schools, changing Foster Care placement, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition;
14) Strategies to improve self-management and planning skills; and
15) For Members receiving treatment in a congregate setting (e.g., Level II-program, Level III, Level IV, or PRTF), the Member's Care Plan/ISP must also identify:
a) Needed services and supports to facilitate the Member's transition to a family-based placement; and
b) Anticipated timeline for transition to a family-based setting, as clinically appropriate.

x. For Members ages three (3) up to age twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance use services, the CFSP shall ensure:
1) A Child and Family Team (CFT) member is involved in developing the Care Plan/ISP and facilitating the planning process;
2) The care manager shall work with the County Child Welfare Worker and the Member to identify appropriate members of the CFT;
3) The care manager uses the strengths assessment described in *Section V.D.2.j.xv.* to build strategies included in the Care Plan or ISP that address the critical needs and unique strengths of the Member and family as identified by and in cooperation with the CFT. These strategies shall be included in the Care Plan or ISP; and
4) The Care Plan or ISP is regularly updated to respond to changes with the Member and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.

xi. The CFSP shall ensure that each Care Plan/ISP is documented and stored and made available to the Member and the following representatives within twenty-four (24) hours of completion of the Care Plan or ISP:
    1) Care team members, including the Member's PCP, other physical health, BH, I/DD, LTSS, and pharmacy providers;
    2) Other providers delivering care to the Member;
    3) The assigned County Child Welfare Worker, as applicable;
    4) The Member's Guardian ad litem, as applicable;
    5) The Member's legal representative (as appropriate);
    6) The Member's Parent(s), Guardian(s), Custodian(s) and other caregiver (as appropriate, with consent);
    7) Social service providers (as appropriate, with consent); and
    8) Other individuals identified and authorized by the Member or their Authorized Representative.

xii. The CFSP shall submit its policies and procedures for Care Plan/ISP development with Members as part of its Care Management Policy (see *Section V.D.5. Care Management Policy*).

l. Care Team Formation

i. The CFSP shall ensure that the care manager establishes a multidisciplinary care team for each Member based on the Member's needs. The Member's care team shall support each Member in meeting their individual needs, as well as needs related to promoting family preservation and permanency planning, as applicable.

ii. The CFSP shall ensure that the multidisciplinary care team consists of, at minimum, the following:
    1) The Member;
    2) The assigned care manager;
    3) Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, Family Navigators, parents or guardians of an individual with an I/DD or a TBI or a BH condition);
    4) PCP;
    5) County Child Welfare Worker, as applicable; and
    6) In addition, for Members who are minors, a Member's Parent(s), Guardian(s), or Custodian(s), as applicable and appropriate in alignment with Federal and state laws.

iii. The CFSP shall ensure that the care team described above meets as often as is appropriate based on the Member's needs.

iv. For all Members, the CFSP shall make best efforts to ensure that least two (2) meetings with the care team members described above occur per calendar year.

v. The CFSP shall make best efforts to ensure that care team meetings occur in-person. If necessary, the CFSP may include one or more participants in the meeting via technology conferencing tools.

vi. The CFSP is encouraged to include the following members in the care team (including participation in care team meetings), as appropriate:
    1) BH Provider(s);
    2) I/DD and/or TBI Provider(s);
    3) Dentist(s);
    4) Other specialists;
    5) Nutritionists;
    6) Pharmacists and pharmacy techs;

7) The Member's obstetrician/gynecologist;
8) Member advocates/supports;
9) Other providers, as determined by the care manager and Member; and
10) Appropriate school personnel (i.e., teachers, aides, counselors)

vii. For Members ages three (3) to twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance abuse services, the CFSP shall ensure that the CFT is incorporated into the care team.
1) The CFT shall be built around the Member and the Member's family to meet their unique needs, and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the Care Plan.
2) The CFT shall be convened at least once every thirty (30) Calendar Days.

viii. The CFSP shall require timely communication across the care team.

m. Ongoing Care Management
i. The CFSP shall establish policies and procedures to deliver care to, and coordinate services for, Members in accordance with 42 C.F.R. § 438.208 and, if applicable, NCGS § 122c-115.4, regardless of risk or need.
ii. The CFSP shall ensure that each Member who is actively engaged in CFSP Care Management receives Care Management according to their Care Plan or ISP.
iii. Care Management shall be defined as follows:
1) Ensuring Members have regular well visits in accordance with North Carolina Health Check guidelines, the American Academy of Pediatrics (AAP) Health Care Standards for children in Foster Care, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, or other professional best practices, as appropriate.[19,20,21].
2) Coordinating and providing referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by the CFSP or NC Medicaid Direct:
a) Physical health;
b) BH (including medically necessary residential treatment services, Behavioral Health Crisis Services, and therapeutic foster care);
c) I/DD;
d) LTSS;
e) TBI;
f) Pharmacy;
g) Vision; and
h) Dental.
3) Promptly escalating any network capacity issues that threaten Member access to needed services (e.g., being unable to identify an open residential treatment slot) to the CFSP's network department for possible further escalation to the Department, as described in *Section V.E.1.g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207).*
4) Having the ability, twenty-four (24) hours per day, seven (7) days per week to (1) share information such as Care Plans/ISPs and Advance Directives, and (2) coordinate care to place the Member in the appropriate setting (including medically necessary residential

[19] https://files.nc.gov/ncdma/documents/Providers/Programs_Services/EPSDT/Program-Guide-2020.pdf
[20] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx
[21] https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx

treatment services) during urgent and emergent events. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

5) Coordinating social services provided by community and social providers to address a Member's Unmet Health-Related Resource Needs (in close coordination with the assigned County Child Welfare Worker, as applicable).
6) Ensuring that Members have scheduled physical exams, well-child visits, dental visits and screenings, and immunizations based on the appropriate age-related frequency.
7) Ensuring that Members receive age appropriate, evidenced-based developmental screenings (e.g., Survey of Well-being of Young Children, Ages & Stages Questionnaires, etc.).
8) Conducting a Care Management Comprehensive Assessment at least every twelve (12) months, or more frequently as appropriate, as described in *Section V.D.2.j. Care Management Comprehensive Assessment*.
9) Conducting continuous monitoring of progress toward goals identified in the Care Plan or ISP through in-person and collateral contacts with the Member and the Member's supports, including Parent(s), Guardian(s), Custodian(s), as applicable, other informal and formal caregivers, and routine care team reviews.
10) Conducting medication management, including regular Medication Reconciliation (conducted by appropriate care team Member) and support of medication adherence.
    a) Medication Reconciliation and management interventions must include all elements described in *Section V.D.2.i. Medication Reconciliation* and *Management.*
11) Regularly updating the Member's compiled medical records, as appropriate, as described in *Section V.D.2.e.xii. Consolidation of Medical Records.*
12) Supporting the Member's adherence to prescribed treatment regimens and wellness activities.
13) Communicating and consulting with other providers and the Member and the Member's supports, including Parent(s), Guardian(s), Custodian(s), and informal and formal caregivers, as appropriate.
14) Following up on referrals and addressing barriers to follow-up care, as necessary.
15) Conducting transitional Care Management as described in *Section V.D.2.n. Transitional Care Management*.
16) Facilitating timely communication across the care team, including case conferencing.

iv. For Members receiving BH services, ongoing Care Management shall also include the following, based on System of Care principles:
    1) Promotion of family-driven, Member-guided service delivery and development of strategies built on social networks and natural or informal supports.
    2) Development of strategies that maximize the skills and competencies of a Member's family members to support Member and caregivers' self-determination and enhance self-sufficiency, in coordination with the Member and the Member's Parent(s), Guardian(s), or Custodian(s), as applicable.
    3) Verifiable efforts for services and supports to be delivered in the community within which the Member lives, using the least restrictive settings possible to preserve community and family connections and manage costs.
    4) Development and implementation of proactive and reactive crisis plans in conjunction with the Care Plan/ISP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every Member of the CFT shall be provided a copy of the crisis plan.
    5) Use family and Member-friendly tools to document and demonstrate for the Member and family their progress over the course of treatment.

v. The CFSP shall ensure that the care manager arranges for coverage for services, consultation or referral, and treatment for Emergency Medical Conditions, including, but not limited to, BH crisis, twenty-four (24) hours per day, seven (7) days per week (including if assistance in coordinating services is requested by a County Child Welfare Worker).

vi. The CFSP shall ensure that CFSP Care Management incorporates individual and family supports, including the following, as appropriate:
   1) Training the Member in self-management;
   2) Providing education and guidance on self-advocacy to the Member, family members and support members;
   3) Connecting the Member and caregivers to education and training to help the Member improve function, develop socialization and adaptive skills, and navigate the service system;
   4) Providing information and connections to needed services and supports including but not limited to self-help services, peer support services and respite services;
   5) Providing information to the Member, family members and support members about the Member's rights, protections and responsibilities, including the right to change providers, the Grievance and complaint resolution process, and fair hearing processes;
   6) Health promotion, including promoting wellness and prevention programs (see *Section V.D.8. Prevention and Population Health Programs*);
   7) Providing information on establishing Advance Directives, including advance instructions for mental health treatment, as appropriate, and guardianship options/alternatives, as appropriate;
   8) Connecting Members and family members to resources that support maintaining Member employment, community integration and success in school, as appropriate;
   9) For high-risk pregnant women, inquiring about broader family needs and offering guidance on family planning; and
   10) For high-risk pregnant women with a SUD, beginning discussions about the potential for an Infant Plan of Safe Care.

vii. The CFSP shall establish policies and procedures for coordinating services provided by community and social support providers and submit them as part of its Care Management Policy (*Section V.D.5. Care Management Policy)*, consistent with 42 C.F.R. § 438.208(b)(2)(iv).

viii. The CFSP shall ensure that CFSP Care Management addresses Unmet Health-Related Resource Needs working in close coordination with the County Child Welfare Worker to ensure coordination and minimize duplication, including at a minimum:
   1) Provision of referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including:
      a) Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers);
      b) Food and income supports;
      c) Housing;
      d) Transportation;
      e) Employment services;
      f) Education;
      g) Interpersonal violence services;
      h) Legal services;
      i) Services for justice-involved populations; and
      j) Other services that help individuals achieve their highest level of function and independence.

2) Use of NCCARE360 to identify community-based resources and connect Members to such resources and track closed-loop referrals. The CFSP shall ensure that care managers use NCCARE360, including for the following functionalities:
    a) Act as the Member's community-based organization and social service agency resource repository to identify local community-based resources;
    b) Refer Members to the community-based organizations and social service agencies available on NCCARE360; and
    c) Track closed loop referrals.
3) Provision of comprehensive assistance, available either in-person or electronically, at the Member's preference and depending on what is the most efficient, effective, and feasible approach, securing key health-related services, including assistance at initial application and renewal with filling out and submitting applications, and gathering and submitting required documentation, at a minimum to:
    a) Food and Nutrition Services;
    b) Temporary Assistance for Needy Families;
    c) Child Care Subsidy;
    d) Low Income Energy Assistance Program;
    e) ABLEnow Accounts (for individuals with disabilities);
    f) Women, Infants and Children (WIC) Program; and
    g) Other programs managed by the CFSP that address Unmet Health Related Resource Needs.
4) As part of its Care Management Policy (*Section V.D.5. Care Management Policy*), the CFSP shall submit its policies for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.

ix. The CFSP shall ensure that Members receive Care Management contacts from their care manager (or designee) at a frequency that meets the Member's needs and complies with minimum requirements established by the Department (described below).

x. The Care Management contact requirements shall be based on the minimum risk stratification requirements established by the Department in *Section V.D.2.g. Risk Stratification*.

xi. Except for Members who have actively declined to participate in CFSP Care Management or who are not reachable despite best efforts by the CFSP, as defined in *Section V.D.2.j.vi.,* the CFSP shall ensure that all Members classified as high-risk, as defined in *Section V.D.2.g. Risk Stratification*, by the CFSP risk stratification methodology receive Care Management contacts at least once (1) per month. Contacts may be in-person, telephonic or virtual, as appropriate based on the Member's condition.

xii. Except for Members who are classified as high-risk as described in *Section V.D.2.g. Risk Stratification*, have actively declined to participate in CFSP Care Management, or are not reachable despite best efforts by the CFSP, the CFSP shall ensure that all other Members receive Care Management contacts at least once (1) per calendar quarter. Contacts may be in-person, telephonic or virtual, as appropriate based on the Member's condition.

xiii. Notwithstanding the requirements above, the following Members must receive at least one (1) in-person Care Management contact per month:
    1) Members in Foster Care within ninety (90) Calendar Days of Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody.

xiv. The CFSP shall ensure that care managers make best efforts to attend relevant in-person meetings convened by the County Child Welfare Worker.

xv. Care managers or staff supervised by the care managers, including but not limited to Certified Family Peer Specialists, may conduct Care Management contacts, when appropriate.

xvi. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing. If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the Member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used.

xvii. The administration of the Care Management Comprehensive Assessment may count as a contact.

xviii. Care managers may establish contact schedules that are less frequent than the above requirements if the Member (or Authorized Representative) expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP or visits in accordance with the above requirements could risk disruption in Foster Care placement.

xix. The CFSP shall ensure that in-person contacts occur at a location, date and time convenient to the Member and their chosen participants.

xx. The care manager shall ensure that a Member has a post-partum visit with a physician within fifty-six (56) Calendar Days of delivery to assess for signs of postpartum depression. Postpartum care is further described in the *Obstetrics Clinical Coverage Policy 1E-5*.

xxi. For Members with an opioid use disorder, the CFSP shall ensure that care managers assist in coordinating access to naloxone.

xxii. For Members with unmet BH needs, care managers shall assist County Child Welfare Workers with accessing BH assessments and scheduling, coordinating and obtaining a referral, as needed, to clinically appropriate BH services.

xxiii. Care managers shall ensure that Members have access to needed services that are carved out of managed care, including dental services.

xxiv. Care Management extenders may support care managers in delivering CFSP Care Management by performing activities that fall within the below categories.

1) When an extender performs one of the functions listed below, it may count as a CFSP Care Management contact if phone, video and audio, or in-person contact with the Member is made:
   a) Performing general outreach, engagement, and follow-up with Members;
   b) Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
   c) Engaging in health promotion activities and knowledge sharing;
   d) Sharing information with the care manager and other members of the care team on the member's circumstances;
   e) Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
   f) Participating in case conferences; or
   g) Support the care manager in assessing and addressing Unmet Health-Related Resource Needs.
2) A care manager may not delegate the following responsibilities to a Care Management extender:
   a) Completing the Care Management Comprehensive Assessment;
   b) Developing the Care Plan/ISP;
   c) Facilitation of case conferences;
   d) Facilitation of initial and ongoing meetings with County Child Welfare Worker;
   e) Ensuring that Medication Reconciliation and management occur;

f) Continuous monitoring of progress toward the goals identified in the Care Plan/ISP; and
g) Managing Care Transitions, including creating 90-Day Transition Plans.

n. Transitional Care Management
i. The CFSP shall oversee Care Transitions for all Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i) and in addition to the requirements in this section.
ii. The CFSP shall ensure that the care manager, or other CFSP designee, are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.
iii. The CFSP shall ensure that the Member's care manager carries out the following transitional Care Management functions:
1) Assume coordination responsibility for transition planning;
2) Engage the Member, either in-person or via virtual face-to-face modalities, during an admission to an institution or other congregate setting (e.g., acute, subacute and long–term stay facilities, including residential settings);
3) Be physically present on the day of discharge, either at the discharging facility or the post-discharge placement setting;
4) Conduct outreach to the Member's providers;
5) Obtain a copy of the discharge plan and review the discharge plan with the Member and facility staff;
6) Facilitate clinical handoffs to appropriate clinicians and provider agencies, as necessary;
7) Refer and assist Members in securing needed treatments following discharge, including securing medically necessary residential treatment services;
8) Refer and assist Members in accessing needed social services and supports identified as part of the transitional Care Management process, including access to housing;
9) Assist the Member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts Medication Reconciliation/management and support medication adherence;
10) Medication Reconciliation and management interventions must include all elements described in *Section V.D.2.i. Medication Reconciliation and Management;*
11) Develop a ninety (90) day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the Member, facility staff, and the Member's care team, that outlines how the Member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community. This requirement shall apply to all Members, including any newborn discharged into County DSS custody from the NICU, regular maternity ward, or any other setting;
a) The ninety (90) day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP.
b) To the extent feasible, a Care Management Comprehensive Assessment should be conducted to inform the ninety (90) day post-discharge transition plan.
c) The ninety (90) day post-discharge transition plan must incorporate any needs for training of Parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
d) Development of a ninety (90) day post-discharge transition plan is *not* required for all ED visits, but may be developed according to the care manager's discretion.

e) The CFSP shall communicate with and provide education to the Member and the Member's caregivers and providers to promote understanding of the ninety (90) day post-discharge transition plan.

12) Follow up with the Member within forty-eight (48) hours of discharge;
13) Assist with scheduling of transportation, CPS In-Home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe;
14) Arrange to visit the Member in the new care setting after discharge/transition;
15) If not already completed as part of the development of the ninety (90) day post-discharge transition plan, conduct a Care Management Comprehensive Assessment within fourteen (14) Calendar Days of the discharge/transition or update the current assessment; and
16) Update the Member's Care Plan/ISP in coordination with the Member's care team within ninety (90) Calendar Days of the discharge/transition based on the results of the Care Management Comprehensive Assessment.

iv. The CFSP must conduct relevant transitional Care Management activities during, but not limited to, the following changes in a Member's circumstances:
1) Transitioning out of school-related services;
2) Changes in employment; or
3) Instances where a Member has experienced the loss of a primary caregiver or a change of primary caregiver.

v. For Members transitioning out of a state psychiatric hospital, PRTF, or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, the CFSP shall also meet the requirements described in *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings*.

vi. The CFSP shall submit its policies and procedures for transitional Care Management, including the approach to working with Members with LTSS needs, as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

o. Care Management Requirements for Members Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody and Members Who Lose Medicaid Eligibility

i. Staffing
1) The CFSP shall employ sufficient Care Management staff with expertise in supporting Members who Age Out of County DSS Custody or otherwise Exit County DSS Custody and Members who may lose Medicaid eligibility, including Former Foster Youth who may lose categorical Medicaid eligibility under the "former foster care" group and adult Members who are Parent(s), Guardian(s), Custodian(s) and are no longer working towards reunification (i.e., a court has determined the plan of reunification is not successful or is not consistent with the child's health or safety).
2) Care managers supporting Members who are Aging Out of County DSS Custody or otherwise Exit County DSS Custody and Former Foster Youth who will lose categorical Medicaid eligibility under the "former foster care" group must have expertise in the following, as appropriate:
a) Promoting independent living skills;
b) Navigating and securing housing options, including independent housing;
c) Navigating and obtaining post-high school education;
d) Navigating and securing employment;
e) Providing education and guidance on self-advocacy;
f) Navigating and securing health insurance coverage options beyond the CFSP; and

g) Building natural supports.

ii. Requirements for Members Who Age Out of County DSS Custody or Otherwise Exit County DSS Custody

1) All requirements in this *Section V.D.2.o.ii Requirements for Members Who Age Out of County DSS Custody or Otherwise Exit County DSS Custody* shall apply regardless of age and reason by which a Member leaves County DSS custody, including emancipating from County DSS custody or achieving permanency prior to age eighteen (18) or aging out of County DSS custody at age eighteen (18) to twenty-one (21).

2) All requirements in this *Section V.D.2.o.ii Requirements for Members Who Age Out of County DSS Custody or Otherwise Exit County DSS Custody* are additional to those described in *Section V.D. Care Management*.

3) Requirements in this *Section V.D.2.o.ii Requirements for Members Who Age Out of County DSS Custody or Otherwise Exit County DSS Custody* shall not apply to Former Foster Youth who will lose categorical Medicaid eligibility under the "former foster care" group, with the exception of *Section V.D.2.o.ii.9. Health Passport*.

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 its best effort to conduct a Care Management Comprehensive Assessment (or reassessment, as appropriate) within ninety (90) Calendar Days of the Member Aging Out of County DSS Custody or Exiting County DSS Custody.

5) For Members who remain enrolled in the CFSP after Aging Out of County DSS Custody or otherwise Exiting County DSS Custody, the CFSP shall ensure that all such Members are categorized as high-risk in the CFSP's risk stratification methodology, as described in *Section V.D.2.g. Risk Stratification*, for a minimum of one (1) year.

6) The CFSP shall ensure that all such Members who are categorized as high-risk in the CFSP's risk stratification methodology receive the minimum number of Care Management contacts for Members categorized as high-risk, as described in *Section V.D.2.m.xi*.

7) Transitional Living Plan

a) The care manager shall, at the request of the County Child Welfare Worker and at the discretion of the Member, participate in the initial development of and periodic updates to each Member's Transitional Living Plan.

b) The care manager shall assist the Member and County Child Welfare Worker, working in partnership with the Member's providers, with identifying key healthcare-related goals to include in the Transitional Living Plan.

c) The care manager shall assist the Member and County Child Welfare Worker, working in partnership with the Member's providers, in identifying key health-related resources and supports necessary to achieve the Member's healthcare goals and ensure those goals are included in the Member's Transitional Living Plan.

8) 90-Day Transition Plan

a) The care manager shall participate in the development of each Member's 90-Day Transition Plan with the assigned County Child Welfare Worker, family, providers, and other support persons, at the discretion of the Member and the County Child Welfare Worker.

b) The care manager shall ensure that the Member's 90-Day Transition Plan includes accurate and up-to-date contact information on the Member's care manager, PCP, specialty care, dental home, BH, TBI and I/DD provider(s), and current medications, as applicable.

c) The care manager shall assist the Member and County Child Welfare Worker in identifying key health-related resources and supports necessary to achieve the

Member's healthcare goals, including making referrals to organizations supporting individuals who Age Out of County DSS Custody or otherwise Exit County DSS Custody such as SaySo, and ensure they are included in the Member's 90-Day Transition Plan.

d) The 90-Day Transition Plan meeting should be structured as a CFT meeting. As applicable and appropriate, the care manager shall make best efforts to participate in these meetings in-person.

e) The care manager shall ensure the Member has needed information around healthcare power of attorney/Advance Directives.

f) The care manager shall assist the Member with transferring from a pediatric to adult primary care provider, if necessary.

g) The care manager shall ensure that the 90-Day Transition Plan includes interpersonal violence, life skills, vocational, and educational resources.

9) Health Passport

a) The CFSP shall supplement the 90-Day Transition Plan by creating a detailed "Health Passport" for each Member;

b) The Health Passport shall be made available in a format of the Member's choosing (i.e., electronic, paper, or both), as appropriate;

c) The CFSP shall ensure that each Health Passport includes, at minimum, the following:

i) Critical health care-related information and clear guidance on achieving the Member's healthcare goals as they leave the child welfare system (these may be the same as, or expand upon, those contained within the 90-Day Transition Plan);

ii) Copy of the Member's full Care Plan/ISP, if available;

iii) Summary of scheduled visits and recommended schedule of future visits;

iv) List of prescribed medications (including clear guidance on when medication should be taken); and

v) Copies of all known medical records, including copies of DSS Child Health Summary Component forms, as applicable.

iii. Additional Requirements for Members Who Lose Medicaid Eligibility

1) The CFSP shall develop policies, processes, and procedures to support Members moving out of the CFSP, including Former Foster Youth and others losing categorical Medicaid eligibility, as described in *Section V.B.3. Transitions of Care Across Plans and Delivery Systems.*

2) Former Foster Youth

a) At least six (6) months before the Member loses categorical Medicaid eligibility under the "former foster care" group,[22] the care manager shall make best effort to meet with the Member (in-person or telephonic) to discuss options for health insurance coverage and assist members in signing up for other insurance options (e.g., QHPs as defined in 45 C.F.R. § 155.20) available to them following the birthday on which the Member will lose categorical Medicaid eligibility under the "former foster care" group and plan for transitioning all current healthcare services and medications.

[22] Former Foster Youth who age out of the child welfare system outside of North Carolina remain eligible for Medicaid coverage until they reach the age of 21; Former Foster Youth who age out of the child welfare system in North Carolina until they reach the age of 26.

b) The care manager shall provide the Member with an updated version of the Member's Health Passport, as described in *Section V.D.2.o.ii.9. Health Passport*. The Health Passport shall include the following components.
   i) Critical health care-related information and clear guidance on achieving the Member's healthcare goals as they age out of categorical Medicaid eligibility under the "former foster care" group (these may be the same as, or expand upon, those contained within the 90-Day Transition Plan);
   ii) Copy of the Member's full Care Plan/ISP, if available;
   iii) Summary of scheduled visits and recommended schedule of future visits;
   iv) List of prescribed medications (including clear guidance on when medication should be taken); and
   v) Copies of all known medical records, including copies of DSS Child Health Summary Component forms, as applicable.

c) In addition to required Health Passport components described in *Section V.D.2.o.ii.9. Health Passport*, the CFSP shall include in the Health Passport for Members who will lose categorical Medicaid eligibility under the "former foster care" group a list of healthcare resources that may be available to the Member regardless of insurance status, including the Department's Medication Assistance Program, State-funded mental health and substance use disorder treatment programs, and free and charitable clinics.

iv. Other Members Losing Categorical Medicaid Eligibility
   1) If care manager becomes aware that a Member will lose Medicaid eligibility following changes to a Member's permanency plan (e.g., a Parent who is no longer working toward reunification), the care manager shall make best effort to meet with the Member (in-person or telephonic) to discuss and support, at a minimum:
      a) Identification of alternative options for health insurance coverage and assist members in signing up for other insurance options (e.g., QHPs as defined in 45 C.F.R. § 155.20) or accessing other health services available to them (e.g., State-Funded Services); and
      b) Make referrals to local CBOs that can help support the Member's needs, as applicable.

p. Diversion from Institutional and other Congregate Settings
   i. The CFSP shall ensure that Members are identified who are at risk of requiring care in an institutional setting or ACH and are provided diversion interventions as described below.
      1) The CFSP shall ensure that Members ages eighteen (18) and above seeking entry into an ACH or State Psychiatric Hospital are referred for an eligibility determination for the North Carolina TCL, to be conducted by the BH I/DD Tailored Plan assigned to the county where the Member's Medicaid is administered.
      2) CFSP Members determined eligible for the North Carolina TCL shall be disenrolled from the CFSP and enrolled in a BH I/DD Tailored Plan as described in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy*.
   ii. In the event that a Member who is not actively engaged in CFSP Care Management is eligible for diversion, the CFSP shall make best efforts to conduct outreach to engage the Member in CFSP Care Management and conduct diversion activities.
   iii. The CFSP shall ensure that care managers consult with appropriate medical staff to assess the medical needs of the Member receiving diversion services.
   iv. The CFSP shall ensure that the provision of diversion interventions as described below does not delay the provision of needed services to a Member in a timely manner.

v. Eligibility for Diversion
1) Members eligible for diversion activities through the CFSP include those meeting the following criteria:
a) Have not been determined eligible for the North Carolina TCL;
b) Have transitioned from an institutional or correctional setting, or an ACH for adult Members, within the previous six (6) months;
c) Are seeking entry into an institutional setting; ACH; PRTF; or Residential Treatment Levels II/Program Type, III, and IV; or
d) Meet one of the following additional criteria for Members with I/DD and TBI:
i) Member has a caregiver who may be unable to provide the Member their required interventions;
ii) Member's caregiver is in fragile health, which may include but is not limited to Member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.);
iii) Member with two Parents, Guardians or Custodians if one of those Parents/Guardians/Custodians dies;
iv) Any other indications that a Member's caregiver may be unable to provide the Member their required interventions; or
v) Member is a child or youth with complex BH needs.

vi. Diversion Activities
1) The CFSP shall perform the following diversion activities in a timely manner:
a) Screen and assess the Member for eligibility for community-based services;
b) Educate the Member on the choice to remain in the community and the services that would be available to support that decision;
c) Facilitate referral and linkages to community-based and other support services for assistance;
d) Determine if the Member is eligible for supportive housing, if needed; and
e) For those who choose to remain in the community:
i) Clearly document in the Member's Care Plan that the Member's decision to remain in the community was based on informed choice, and the degree to which the Member's decision has been implemented; and
ii) Refer and provide linkages to services and supports for which they are eligible, including supportive housing.
2) The CFSP shall ensure all diversion activities are documented and stored and made available to the Department for review upon request.
3) Recipients enrolled in and being served under Transitions to Community Living shall be disenrolled from the CFSP and enrolled in a BH I/DD Tailored Plan as described in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy*. The CFSP shall transfer all relevant information to the BH I/DD Tailored Plan as indicated in *Section V.B.3.a.iv.2.b.*

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.

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.

r. Additional Care Coordination Functions for Members Obtaining 1915(i) Services
i. For Members who are not engaged in CFSP Care Management when it is determined they may benefit from 1915(i) Services, the CFSP shall:
1) Conduct outreach to the Member to inform the Member that to obtain 1915(i) Services, they have the choice of engaging in CFSP Care Management or obtaining care coordination services through the CFSP.
a) The CFSP shall make best efforts to engage the Member in CFSP Care Management encompassing 1915(i) care coordination.
2) In cases where a Member obtaining 1915(i) Services is not engaged in CFSP Care Management, the CFSP must provide care coordination for the 1915(i) Services, including meeting requirements for conducting the Independent Assessment and development of Care Plans/ISPs required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.
a) The CFSP shall ensure that care coordination for 1915(i) Services is performed by a care manager meeting the qualifications described in *Section V.D.2.s.v. Care Manager Qualifications*.
ii. For all Members obtaining 1915(i) Services, regardless of whether they engage in CFSP Care Management, the CFSP shall ensure that care coordination includes:
1) Conducting the Independent Assessment using a Department-designated tool to determine need for specific 1915(i) Services. The CFSP shall comply with any additional guidance released by the Department on the Department-designated tool to conduct Independent Assessment.
2) Guiding the development and submission of the Care Plan/ISP, based on assessed need and living arrangements, at least annually:
a) The CFSP shall ensure that the Member's care manager convenes a person-centered planning meeting and completes the Care Plan/ISP in line with federal requirements 42 C.F.R. § 441.725. This is done after the Member is administered the Independent Assessment for initial plans of care.
b) The CFSP shall ensure that the Member's care manager reviews and submits the Care Plan/ISP to the CFSP.
c) The CFSP shall review Care Plan/ISP for compliance with 1915(i) SPA requirements, medical necessity, and the Member's health and safety needs.
d) The CFSP shall approve or deny the Care Plan/ISP within standard service authorization periods except for in the case of initial plans, which must be received within sixty (60) Calendar Days of 1915(i) eligibility determination.
e) In the case where services are immediately needed, an interim plan of care may be completed so that services may be approved with the full Care Plan/ISP being completed afterwards and within the sixty (60) Calendar Days of eligibility

determination for 1915(i) Services. Immediately needed 1915(i) Services may include, but are not limited to, 1915(i) Services that a Member needs in order to:

i) Facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting;
ii) Prevent imminent placement outside the person's current living arrangement;
iii) Address severe co-occurring Behavioral Health (BH) and/or psychiatric conditions that place the person or others at significant risk of harm; or
iv) Prevent imminent loss of competitive integrated employment or an offer of such employment.

f) The CFSP shall ensure that 1915(i) Services begin within forty-five (45) Calendar Days of Care Plan/ISP approval.

3) Monitoring requirements found in the 1915(i) SPA.
4) Explaining the service authorization process.
5) Assisting the Member/Authorized Representative (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP, including providing a list of available providers and arranging provider interviews.
6) Monitoring Care Plan/ISP goals at a minimum frequency based on the target date assigned to each goal.
7) Maintaining close contact with the Member/Authorized Representative (if applicable), providers and other members of the Care Plan/ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
8) Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the Member as required by 42 C.F.R. § 441.710(a)(1)(i).
9) Completing the Independent Assessment prior to the development of the Care Plan/ISP and updating at least annually or as significant changes occur with the Member as required by 42 C.F.R. § 441.720(b).
10) Providing timely notification to CFSP utilization management of updates to eligibility for 1915(i) Services and timely processing of updates to the Care Plan/ISP.
11) Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the positive behavior support plan.
12) Monitoring of service delivery to verify that:
    a) At least one (1) 1915(i) service is utilized at a frequency determined by the Department in the 1915(i) SPA as required by 42 C.F.R. § 441.710(c).
    b) Services are furnished in accordance with the Care Plan/ISP.
    c) Member is offered a choice of 1915(i) service providers.
    d) Member has access to services and supports that meet the Member's needs.
    e) Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-1915(i) service needs (medical care) are addressed and documented as appropriate.
    f) 1915(i) Services utilized do not exceed authorization.
    g) Member is satisfied with the services being rendered.

iii. The CFSP shall monitor service utilization to remain within service authorizations.
iv. The CFSP shall notify the Member's provider of utilization decisions.

s. Staffing and Training Requirements
   i. Care Management Caseload Requirements

1) The CFSP shall be responsible for hiring a sufficient number of care managers and other staff capable of serving as designees in order to comply with required Care Management contact requirements described in *Section V.D.2.m.xi* and *Section V.D2.m.xii.* and co-location requirements, as described in *Section V.D.2.f.i. Co-Location.*
2) The Department will establish through future guidance maximum ratios of high risk and other Members per care manager. The CFSP shall ensure that it has a sufficient number of care managers in place such that it does not exceed the maximum ratios.
3) Care managers may have a "blended" caseload (i.e., a panel of Members across different risk levels).

ii. Local Care Management Staffing
1) The CFSP shall be required to ensure that Care Management occurs in-person as frequently as possible and no less than required in *Section V.D.2.m.xi. and Section V.D.2.m.xii*.
2) The CFSP shall ensure that its Care Management workforce is sufficiently distributed across North Carolina for care managers to reasonably be able to comply with in-person Care Management contact requirements, as described in *Section V.D.2.m.xi. and Section V.D.2.m.xii.,* and co-location requirements, as described in *Section V.D.2.f.i. Co-Location.*
3) To the extent feasible, the CFSP shall ensure that care managers themselves conduct in-person Care Management contacts for assigned Members.
4) In instances where the care manager cannot feasibly conduct the in-person visit, the CFSP may designate another member of the care team to conduct an in-person visit.
5) In instances where a Member has relocated permanently, the CFSP may, in consultation with the assigned care manager and the Member, re-assign the Member to a care manager located closer to the Member's place of residence, as described in *Section V.D.2.e. Initiation of Care Management*.
6) The CFSP shall submit its Care Management staffing plan as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

iii. The CFSP shall ensure that each care manager is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers.
1) Supervisors cannot have a caseload but may provide coverage for vacation, sick leave, or care manager vacancy. They shall be responsible for ensuring that all Care Plans/ISPs are complete, reviewing them for quality control, and providing guidance to care managers on how to meet Members' needs.

iv. The CFSP shall have on-staff clinical consultants to provide care managers and members of the care team with subject matter expertise. The clinical consultants will not be part of the care team for any given Member.
1) The consultants should be available by phone to care managers and members of the care team to advise on complex clinical issues on an ad hoc basis.
2) The following staff must be available for consultation, depending on the Member's need, and licensed in NC:
a) A Child/Adolescent Psychiatrist;
b) A general psychiatrist;
c) A psychologist with expertise in developmental and cognitive disabilities and interventions;
d) A primary care clinician;
e) A pharmacist; and
f) A fully licensed BH clinician with expertise in treating individuals served by the child welfare system.

v. Care Manager Qualifications

1) The CFSP shall ensure that all care managers providing CFSP Care Management to Members meet the following criteria:
   a) Must hold a bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area, or licensure as an RN.
   b) Two (2) years of experience working directly with individuals served by the child welfare system is preferred.
   c) Reside in North Carolina or within forty (40) miles of the North Carolina border.
2) The CFSP shall ensure that all supervising care managers overseeing care managers meet the following criteria:
   a) Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN;
   b) Three (3) years of experience providing care management, case management, or care coordination to individuals served by the child welfare system (either in North Carolina or another state);
   c) Reside in North Carolina or within forty (40) miles of the North Carolina border; and
   d) Supervising care managers overseeing care managers that are conducting in-reach and transition activities as described in *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings* shall also meet the following requirements:
      i) Must be knowledgeable about and competent in successfully securing resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
3) To bolster the care management workforce, the Department will allow the of use care manager extenders, such as community navigators, community health workers, and certified peer support specialists, to support certain CFSP Care Management functions. The purpose of using care manager extenders is to help the CFSP best meet the needs of Members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned Members as well as permit them additional time for Members with intensive or complex needs.
   a) Care manager extenders must have the following qualifications:
      i) At least 18 years of age;
      ii) A high school diploma or equivalent; and
      iii) Meet one of the following requirements:
         (1) Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system;
         (2) Be a person with lived experience with the child welfare system and demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system;
         (3) Be a person with lived experience with a Behavioral Health condition who is a Certified Peer Support Specialist;
         (4) A Parent or Guardian of an individual with an I/DD or a TBI or a Behavioral Health condition and has at least two (2) years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (note that a Parent/Guardian cannot serve as an extender for their family member);

(5) A Parent or Guardian of an individual with lived experience with the child welfare system and has at least two (2) years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (note that a Parent/Guardian cannot serve as an extender for their family member); or

(6) Has two (2) years of paid experience performing the types of functions described in the "Extender Functions" section below, with at least one year of paid experience working directly with the CFSP eligible population.

b) The care management functions of extenders must be directed by the CFSP care manager. The care manager and the supervising care manager must be able to direct all Care Management supports for Members in order to ensure that all services are well coordinated. The Department expects that a range of individuals will be able to meet these qualifications, including, but not limited to:

i) Certified Peer Support Specialists;

ii) Community health workers (CHW), defined as individuals who have completed the NC Community Health Worker Standardized Core Competency Training (NC CHW SCCT);

iii) Individuals who served as Community Navigators prior to the implementation of BH I/DD Tailored Plans;

iv) Family Navigators;

v) Parents or Guardians of an individual with an I/DD or a TBI or a Behavioral Health condition (Parent/Guardian cannot serve as an extender for their own family member); and

vi) A person with lived experience with an I/DD or a TBI or a Behavioral Health condition.

vi. The CFSP shall establish processes to ensure that care managers are able to consult, as needed, with clinicians with significant relevant experience treating individuals with BH, I/DD, TBI, and LTSS/HCBS needs. This may be a supervising care manager or an on-staff clinical consultant, as described in *Section V.D.2.s.iv.2.*, depending on the Member's needs.

vii. The CFSP shall ensure all care managers, care manager extenders and supervising care managers serving Members are trained on all the topics described in this section.

viii. The CFSP shall develop and implement a Care Management training curriculum that includes the following domains at a minimum:

1) Best practices for Care Management for individuals served by the child welfare system:

a) Understanding the unique healthcare needs of youth and children exposed to the child welfare system and who have experienced ACEs or other trauma;

b) Identifying and responding to signs of trauma and abuse and the need to provide trauma-informed Care Management;

c) Medication Reconciliation and Management;

d) Ensuring whole-person care that addresses the Member's physical, BH, I/DD, and TBI needs;

e) Adhering to well-visit and screening periodicity; and

f) The importance of engaging with and leveraging the relationship with the County Child Welfare Worker.

2) CFSP eligibility and services:

a) CFSP eligibility criteria, services available through the CFSP, and differences between Standard Plan, BH I/DD Tailored Plan, Tribal Option, and CFSP benefit packages;

b) Principles of integrated and coordinated physical and BH care and I/DD and TBI services;
c) BH crisis response;
d) Knowledge of North Carolina's 1915(c) waiver eligibility criteria;
e) Eligibility, assessment, and coordination of 1915(i) Services including:
    i) Process for conducting the state-designated assessment for individuals whose physical, cognitive, or mental conditions trigger a potential need for 1915(i) home and community-based services and supports;
    ii) Knowledge of available resources, service options, providers;
    iii) Requirements for ongoing coordination and monitoring of 1915(i) Services; and
    iv) Best practices to improve health and quality of life outcomes consistent with (42 C.F.R § 441.730(c).
f) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members under the age of twenty-one (21).

3) The North Carolina Child Welfare System
a) Key functions of County DSS and County DSS role in supporting Members enrolled in the CFSP;
b) Role of the County Child Welfare Worker;
c) Key aspects of permanency planning, including knowledge of assessments conducted and/or required by County DSS that inform permanency planning;
d) Knowledge of assessments conducted and/or required by County DSS that identify Member's health and health-related needs, including DSS Child Health Summary Components and Plan of Safe Care;
e) Knowledge of assessments conducted and/or required by County DSS as part of the CPS In-Home Family Services Agreement;
f) Mandated reporting of abuse, neglect, or dependency as required by N.C. General Statute § 7B-301; and
g) The role of the EBCI Family Safety Office, the Indian Child Welfare Act and other federal and tribal laws relevant to the tribal child welfare system.

4) Whole-person health and unmet resource needs:
a) Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the Member navigate available social supports and resources at the Member's local level; and
b) Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+) populations, National CLAS Standards, and forms of bias that may affect CFSP Members.

5) Community integration:
a) Independent living skills;
b) Skills to conduct diversion from congregate settings, institutional settings, and correctional facilities;
c) Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community, including North Carolina's TCL eligibility criteria; and
d) Available programs and resources to assist Members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.

6) Health promotion:

a) Common physical comorbidities of CFSP populations;
b) Best practices around childhood screenings, vaccinations, and preventive care;
c) Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease);
d) Common environmental risk factors including but not limited to the health effects of primary, secondary and tertiary-exposure to tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children;
e) Standard of care tobacco treatment, including both counseling and FDA-approved tobacco treatment medications;
f) Self-management and self-help recovery resources (including substance use recovery);
g) Brief tobacco use intervention and referral to treatment roles and responsibilities for Medication Reconciliation and management; and
h) Use of IT in Care Management Comprehensive Assessments, Care Planning, and ongoing Care Coordination and management, including the use of NCCARE360.

7) Other Care Management skills:
a) Transitional Care Management best practices;
b) Supporting health behavior change, including motivational interviewing;
c) Person-centered practices including needs assessment and care planning, addressing LTSS and other needs;
d) Preparing Members for and assisting them during emergencies and natural disasters;
e) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for Members receiving care in the home or community settings, or as Members transition across care settings;
f) General understanding of virtual (e.g., Telehealth) applications in order to assist Members in using the tools; and
g) Understanding needs of the justice-involved population.

8) System of Care:
a) Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the primary care and BH service delivery system;
b) Partnering with families and youth in the Care Plan development, implementation, and evaluation process;
c) Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive, and implementation is shared across sectors;
d) Developing, supporting and expanding relationships among child-serving systems, including child welfare, BH, education, and juvenile justice systems;
e) Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery;
f) CFTs; and
g) High-Fidelity Wraparound.

9) Additional trainings for care managers, care manager extenders and supervisors serving Members with I/DD or TBI:
a) Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers;

b) Understanding HCBS, related planning, and 1915(c) services, including registering for Registry of Unmet Needs (Innovations waiver waitlist);
c) Accessing and using assistive technologies to support individuals with I/DD and TBI;
d) Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services;
e) Educating Members with I/DD and TBI about consenting to physical contact and sex;
f) Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission; and
g) Guardianship and alternatives to guardianship.

10) Additional training for care managers, care manager extenders and supervisors serving children with complex needs:
a) Specialized training in addressing co-occurring mental health disorders and I/DDs.

11) Additional trainings for care managers, care manager extenders and supervisors serving pregnant and postpartum women with SUD or with SUD history:
a) Best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal.

12) Additional training for care managers, care manager extenders (and other individuals conducting in-reach and transition activities, as appropriate) serving Members with LTSS needs:
a) Person-centered needs assessment and care planning related to populations with LTSS needs;
b) Cultural competency for populations with LTSS needs;
c) Independent living;
d) Methods for supporting applicable Member to prepare for pending Medicare eligibility and enrollment;
e) Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission;
f) Methods for effectively coordinating with school-related programming and transition-planning activities;
g) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment, and training members on proper practices, particularly for members receiving care in the home or community-based settings, or as members transition across care settings; and
h) General understanding of virtual (e.g., Telehealth) applications in order to assist members in using the tools.

13) To ensure care manager extenders are sufficiently prepared and capable to perform their duties, care manager extenders' training must include practical training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

ix. The CFSP shall provide annual refresher courses on training topics, based on needs determined by supervising care managers.

x. The CFSP shall identify core modules that care managers must complete before being deployed to serve Members; care managers must complete the remaining training modules within thirty (30) Calendar Days of being deployed to serve Members.

xi. The CFSP shall provide training to its network providers about CFSP Care Management.

xii. The Department reserves the right to require the CFSP to contract with a third-party vendor to administer a training and/or technical assistance program for Network providers and care managers.

xiii. As part of its Care Management Policy (*Section V.D.5. Care Management Policy*), the CFSP shall submit to the Department its CFSP Care Management training plan for approval. This plan should include at a minimum:

1) Policies and procedures for training and qualification of care managers, care manager extenders, and other multidisciplinary team Members;
2) Timing/frequency of trainings;
3) Summary of curriculum;
4) Approach for annual refreshers and ongoing continuing education; and
5) Approach for waiving specific training domains for care managers and supervising care managers based on experience or population served.

t. Data System and Data Sharing Requirements

i. CFSP Care Management Data System Requirements

1) The CFSP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision for Care Management, including the capabilities to:
   a) Consume and use physical health, BH, I/DD, LTSS, and pharmacy claims and encounter data, clinical data, ADT data, risk stratification information, data from Child Welfare Services Agencies, prior authorization data, and/or Unmet Health-Related Resource Needs data;
   b) Share and transmit data with network providers upon request;
   c) Maintain up-to-date documentation of Members actively engaged in CFSP Care Management and assignments of individual Members to care managers;
   d) Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
   e) Electronically document and store Care Plans and ISPs;
   f) Provide role-based access to members of the multidisciplinary care team;
   g) Electronically and securely transmit (at minimum) the Care Management Comprehensive Assessment, Care Plan or ISP, and reports/summaries of care to each member of the multidisciplinary care team to support case conferences;
   h) Track Care Management encounters electronically, including date and time of each attempted encounter, method of attempt (in-person, telephonic), personnel involved, whether the attempt was successful, the intervention provided, and expected outcomes of the intervention;
   i) Track referrals to external agencies or other needed resources; and
   j) Allow care managers to:
      i) Identify risk factors for individual Members;
      ii) Develop actionable Care Plans and ISPs;
      iii) Monitor and quickly respond to changes in a Member's health status;
      iv) Track a Member's referrals and provide alerts where care gaps occur;
      v) Monitor a Member's medication adherence;
      vi) Transmit and share reports and summary of care records with care team Members;
      vii) Support data analytics and performance;
      viii) Transmit quality measures (where applicable); and
      ix) Help schedule and prepare Members for appointments (via, e.g., reminders and transportation).

2) The CFSP shall submit a description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies as part of its Care Management Policy *Section V.D.5. Care Management Policy*.
3) The CFSP shall consume, integrate, and use available Medicare data to advance the whole-person Care Management activities and functions for Members who are dually eligible for Medicare and Medicaid as described in this Contract to the extent possible and applicable.
4) The CFSP shall develop a strategy to share data with Members in a format that is secure, takes into account varying levels of health literacy and promotes Member engagement in care.

ii. Data Sharing with County DSS
1) The CFSP shall be responsible for establishing processes for sharing key data with each County DSS and assigned Child Welfare Workers.
2) The CFSP shall establish processes by mutual agreement for each County DSS to transmit the DSS Child Health Summary Components to the care manager.
3) The CFSP shall establish processes by mutual agreement for each County DSS to digest key data from the care manager, including the comprehensive Care Management assessment and Care Plan/ISP.
4) The CFSP shall make efforts to facilitate for each County DSS a mechanism for secure electronic transmission of DSS Child Health Summary Components and key data collected by the care manager (including the Care Management Comprehensive Assessment and Care Plan/ISP).
5) The CFSP shall accommodate varying levels of technological capacity when establishing data sharing arrangements and shall not require any County DSS to use any particular data transmission mechanism.
6) As requested by a County DSS, the CFSP shall accommodate transmission of data via fax.

iii. ADT Feeds
1) The CFSP shall ensure that care managers have access to an ADT data source that correctly identifies when Members are admitted, discharged or transferred to/from an ED or hospital in real time or near-real time.
2) As part of transitional Care Management, the CFSP shall ensure that there is a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
a) Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
b) Same-day or next-day outreach for all Members; and
c) Additional outreach within several days after the alert to address outpatient needs or prevent future problems for patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or Medication Reconciliations post-discharge).

u. CFSP Care Management Payments
i. The CFSP shall make payments to providers to support the delivery of the CFSP Care Management model according to the requirements in *Section V.E.4. Provider Payments*.
ii. To the extent they are reimbursable under the North Carolina Medicaid Fee Schedule, the CFSP shall be required to make fee-for-service payments available to eligible practices, including physical health, BH, I/DD, LTSS, and pharmacy providers, that participate in Care Management case conferences with the care manager.
iii. Oversight

1) The CFSP shall ensure that all requirements included in this section are met.
2) The CFSP shall create separate departments for UM and Care Management, overseen by separate leadership.
3) The CFSP shall ensure that no care managers are related by blood or marriage or financially responsible for any of the Members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned Members.
4) As part of its UM process, the CFSP must review the utilization patterns of all Members receiving CFSP Care Management.
    a) This UM review must assess whether any patterns exist that suggest that care managers have steered Members toward or away from particular providers.
    b) As part of its standard UM responsibilities, the CFSP must assess whether Members are receiving the appropriate level of care corresponding to their clinical information as described in *Section V.C.1.e.iii. UM Program Policy*.
5) Duplication of Care Management
    a) The CFSP shall ensure that a Member does not receive duplicative Care Management services.
    b) The Department has determined that case management provided through ACT is duplicative of CFSP Care Management. The Department reserves the right to identify additional services that are duplicative of CFSP care management.
    c) When a Member is receiving a service besides one listed in *Section V.D.2.d.i.* that has potential for duplication with CFSP Care Management, the CFSP and the provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
    d) The CFSP shall submit its policies and procedures for ensuring Members do not receive duplicative Care Management from multiple sources as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).
6) In the event the CFSP delegates care management functions to another entity as described in *Section V.D.2.b.iii.*, the CFSP must ensure compliance with federal requirements for conflict-free case management (42 C.F.R. § 431.301(c)(1)(vi) and 42 C.F.R. § 441.730.(b)).
    a) CFSP shall submit its policies and procedures for ensuring conflict-free care management as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).
    b) The CFSP shall provide written notification to members regarding requirements for conflict-free case management, including that:
        i) Members are entitled to choice in the organization where they obtain CFSP Care Management;
        ii) Members are entitled to choice in their 1915(i) service providers; and
        iii) Members cannot obtain both CFSP Care Management and 1915(i) Services through the same provider organization.
    c) The CFSP must submit a draft of this notice to the Department for approval.

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) Prior to providing the following services, the CFSP shall confirm with the County Child Welfare Worker that it has obtained express authorized consent from a Member's Parent(s), Guardian(s), or Custodian(s) or otherwise met the requirements for a Director of a County Department of Social Services to provide consent in accordance with North Carolina General Statute § 7B-505.1 for the following circumstances:
    a) Prescriptions for psychotropic medications;
    b) Participation in clinical trials;
    c) Immunizations when it is known that the Parent has a bona fide religious objection to the standard schedule of immunizations;
    d) Child Medical Evaluations not governed by subsection (b) of § 7B-505.1, comprehensive clinical assessments, or other mental health evaluations;
    e) Surgical, medical, or dental procedures or tests that require informed consent; and
    f) Psychiatric, psychological, or mental health care or treatment that requires informed consent.
3) The CFSP shall confirm with the County Child Welfare Worker that, to the extent possible, it has notified a Member's Parent(s), Guardian(s), or Custodian(s) and sought to obtain consent in accordance with North Carolina General Statute § 7B-505.1 for the following:
    a) Routine medical and dental care or treatment, including, but not limited to, treatment for common pediatric illnesses and injuries that require prompt intervention;
    b) Emergency medical, surgical, psychiatric, psychological, or mental health care or treatment; and
    c) Testing and evaluation in exigent circumstances.
4) The CFSP shall confirm with the County Child Welfare Worker that for any care or treatment provided, that the County Child Welfare Worker has made all reasonable efforts to promptly notify a Member's Parent(s), Guardian(s), or Custodian(s) that care or treatment will be or has been provided and give a Member's Parent(s), Guardian(s), or Custodian(s) frequent status reports on the Member's treatment and the care provided.
5) The CFSP shall provide medical records to the County Child Welfare Worker, as available, to provide to a Member's Parent(s), Guardian(s), or Custodian(s), as requested and consistent with all federal and state laws *(Section V.D.2.e.xii. Consolidation of Medical Records*).

3. Care Coordination and Care Transitions for all Members

a. The CFSP shall be responsible for Care Coordination and Care Transitions for all Members in accordance with 42 C.F.R. § 438.208, regardless of whether a Member does or does not engage in CFSP Care Management (including Members who are not reachable or decline CFSP Care Management), or is ineligible for CFSP Care Management.

b. The CFSP shall establish policies and procedures to deliver care to, and coordinate services for, all Members in accordance with 42 C.F.R. § 438.208 and NCGS § 122c-115.4.

c. The CFSP shall establish policies and procedures applying to all Members to coordinate with services provided by community and social support providers. 42 C.F.R. § 438.208(b)(2)(iv).

d. The CFSP shall provide access and referrals to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.

e. The CFSP shall fulfill responsibilities related to the Healthy Opportunities Pilot Program responsibilities, as outlined in *Section V.D.9. Healthy Opportunities*.

f. The CFSP shall perform the following Care Coordination functions for Members who are not participating in CFSP Care Management:
   i. For Members with identified Unmet Health-Related Resource Needs who are not participating in CFSP Care Management, the CFSP shall, subject to Member consent:
      1) Coordinate services provided by community and social support providers to address Members' Unmet Health-Related Resource Needs; and
      2) Link Members to local community resources and social supports.
   ii. If a Member is excluded from CFSP Care Management because of receipt of a duplicative service as described in *Section V.D.2.d. Eligibility for CFSP Care Management*, the CFSP shall ensure the care manager is responsible for Care Coordination activities that are beyond the scope of the duplicative form of Care Management.
   iii. If a Member is excluded from CFSP Care Management because of receipt of a duplicative service as described in *Section V.D.2.d. Eligibility for CFSP Care Management*, the CFSP shall ensure coordination between the Member's assigned Child Welfare Worker and the duplicative Care Management program.
      1) The CFSP shall ensure that a care manager is responsible for all activities described in *Section D.2.f.ii Coordination with County Child Welfare Workers* for each Member enrolled in a duplicative Care Management service.
      2) The care manager shall be responsible for ensuring that relevant Member updates are shared between the County Child Welfare Worker and the ACT team, as appropriate.
      3) The care manager shall be responsible for ensuring warm handoffs between the ACT team upon enrollment or disenrollment from the duplicative Care Management service.
      4) The care manager shall be responsible for re-engaging the Member in CFSP Care Management following disenrollment from the duplicative Care Management service.
   iv. If a Member is not participating in CFSP Care Management or is excluded from CFSP Care Management because of receipt of a duplicative service as described in *Section V.D.2.d. Eligibility for CFSP Care Management*, the CFSP shall attempt to conduct an initial care needs screening as required by 42 C.F.R. 438.208(b)(3).
   v. In the case that the CFSP is conducting a care needs screening instead of a Care Management Comprehensive Assessment, the CFSP shall meet the following requirements:
      1) The CFSP shall undertake best efforts to conduct the care needs screening within forty-five (45) Calendar Days of the effective date of a Member's CFSP enrollment, consistent with 42 C.F.R. 438.208(b)(3).
         a) "Best effort" is defined as including at least three (3) documented strategic follow-up attempts, such as going to the Member's home, working with a known provider to meet the Member at an appointment, or working with the County Child Welfare Worker to contact the Member if the first attempt is unsuccessful.
      2) The CFSP shall establish an evidence-based or evidence-supported tool to conduct the care needs screening. At a minimum, the tool shall identify:
         a) Chronic health conditions, including chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
         b) Acute health conditions;

c) BH needs (inclusive of substance use disorders, mental health needs, and tobacco use disorders);
d) ACEs that impact developmental growth;
e) I/DD and/or TBI related needs;
f) Risk of requiring LTSS;
g) Detailed medication history, including a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered, and known allergies; and
h) Other factors or conditions (e.g., pregnancy and childhood trauma) about which the CFSP would need to be aware to arrange available interventions for the Member.

3) The CFSP shall include standardized Unmet Health-Related Resource Needs questions to be provided by the Department for use in all care needs screenings, covering four (4) priority domains:
a) Housing;
b) Food;
c) Transportation; and
d) IPV/Toxic Stress.

4) The CFSP shall attempt a care needs screening at least annually for enrolled Members who are not participating in CFSP Care Management.

vi. The CFSP shall make Member referrals to appropriate 1915(c) waiver programs using all information available to it, including Member self-referrals.

vii. The CFSP shall connect Members to programs and resources that can assist in securing employment, supported employment (such as through the Individual Placement and Support-Supported Employment (IPS-SE), apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.

g. Care Transitions

i. The CFSP shall oversee Care Transitions for all Members, including those who do not engage in CFSP Care Management, who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes, consistent with 42 C.F.R. § 438.208(b)(2)(i).

ii. The CFSP shall refer and assist all Members in accessing needed social services and supports identified as part of the Care Transitions, including access to housing, with services and supports critical to the Member's health and safety in place upon transition.

iii. The CFSP shall ensure that its contracts with facilities in the CFSP provider network (hospitals, residential settings, rehabilitation settings, other facility-based treatment settings and LTSS providers) establish policies and procedures for Care Transitions that require the institution to:

1) Permit transition staff (as described further in *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings*), including the care manager, to engage in and help coordinating the discharge planning process.
2) Notify the CFSP of Member admissions/pending discharges in order to integrate the care manager into the discharge/transition planning process.
3) Share relevant information (including the Member's current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team Members and the Member's care team, if applicable.
4) Establish relationships with care managers to facilitate Care Transitions.

iv. The CFSP shall develop a methodology for identifying Members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:
   1) Frequency, duration, and acuity of inpatient and LTSS admissions and ED visits;
   2) Discharges from inpatient, crisis, other facility-based, and residential and/or congregate treatment settings;
   3) NICU discharges; and
   4) Identification of patients by severity of condition, medications, risk score, Unmet Health-Related Resource Needs and other factors the CFSP may prioritize.

v. For Members transitioning out of a state psychiatric facility, PRTF, or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, the CFSP shall also meet the requirements described in *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings.*

h. The CFSP shall submit its policies and procedures for Care Coordination and Care Transitions for all Members as part of its Care Management Policy (*Section V.D.5. Care Management Policy*).

4. Other Care Management Programs

a. Overview
   i. While CFSP Care Management will be the predominant Care Management model for the CFSP population, the CFSP shall offer additional Care Management options targeted towards special populations, as detailed in this section.

b. Local Health Departments
   i. The CFSP shall be required to contract with local health departments (LHDs) during a transitional period that will align with the transitional period established for Standard Plans. Accordingly, until the end of Contract Year 1, the CFSP shall be required to offer a right of first refusal with all LHDs in the State to provide Care Management for High-Risk Pregnancy (CMHRP). The CFSP shall work with LHDs for the provision of CMHRP to high-risk pregnant women who are CFSP Members as follows:
      1) Until the end of Contract Year 1 the CFSP shall offer the right of first refusal to each LHD to provide CMHRP to any Members eligible for CMHRP.
      2) The CFSP shall identify high-risk pregnancies for referral to CMHRP through one or more of the following mechanisms:
         a) Standardized risk screening tool conducted by Providers;
         b) Risk stratification by the CFSP; and/or
         c) Direct referral by Providers, Members or families.
      3) The CFSP shall send all screening information to the applicable LHDs to provide CMHRP within one (1) Business Day of the Member's referral.
      4) Until the end of Contract Year 1, the CFSP shall make best efforts to engage Members participating in CMHRP into CFSP Care Management. Care managers providing CFSP Care Management will address other needs that are not included in the LHD model. A Member can receive CMHRP and CFSP Care Management simultaneously.
      5) For Members enrolled in CMHRP as well as CFSP Care Management simultaneously, the care manager shall coordinate with LHD care managers to ensure all the Members' needs are met, pertinent information is shared, and services are not duplicated between the two programs.
      6) For all contracts developed with LHDs for CMHRP, the CFSP shall use standard contract language provided by the Department, to ensure that CMHRP services include (but are not limited to):
         a) Outreach;

b) Motivational interviewing;
c) Development of person-centered Care Plans;
d) Identification of community resources available to meet the specific needs of the population; and
e) Referrals to childbirth education, oral health, BH or other needed services reimbursed by Medicaid.

7) The CFSP shall be allowed to incorporate additional standards and contract terms that are mutually agreed upon by the LHD and the CFSP.
8) The CFSP shall incorporate all Department-defined Care Management practice standards for CMHRP into each of its contracts with LHDs, as noted in *Section VII. Attachment L.4. CFSP Care Management for High-Risk Pregnancy Policy*.
9) At the conclusion of Contract Year 1 or July 1,2024, whichever is earlier, the CFSP shall have the option to continue to contract with LHDs for CMHRP; or to include CMHRP services within CFSP Care Management for Members experiencing high-risk pregnancy.

ii. In the event of underperformance by an LHD, the CFSP shall follow standard procedures specified by the Department. In the event of continued underperformance by an LHD that is not corrected, the CFSP shall be permitted to terminate the contract with that LHD and the LHD shall have the right to appeal the termination. The CFSP shall notify the Department of underperformance by or contract termination of an LHD. The Department reserves the right to specify the timing and format of this notification.
iii. The CFSP shall participate in Department-led meetings involving the CMHRP program, including requiring attendance by appropriate clinical and operational leadership at meetings.
iv. The CFSP shall incorporate new guidance, policy, operational manuals and other program-specific requirements regarding CMHRP into CFSP operations and LHD contracts, as applicable, and within Department-specified timelines.

c. PMP in Coordination with CCMHRP Women
i. PMP in Coordination with CMHRP Women
1) The CFSP shall be required to participate in Department-led meetings involving the PMP program, including requiring attendance by appropriate clinical and operational leadership at meetings.
2) The CFSP shall be required to track all Department-led PMP programmatic changes, including incorporating new guidance, policy, operational manuals and other program-specific requirements into CFSP operations and PMP contracts, as applicable, and within Department-specified timelines.
3) The CFSP shall adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by the Department.
4) The CFSP shall be responsible for receiving standardized screening tool results from PMP providers and for arranging intake into the CMHRP Women program based on referrals by PMP providers.
5) During Contract Year 1, when a high-risk pregnancy is referred to the CFSP by a PMP provider, Member, family or another entity, the CFSP shall be responsible for arranging intake of the Member into the CMHRP Women program and shall inform the Member's PMP provider that the Member has entered the program.

d. HIV Case Management Providers
i. The CFSP may contract with existing HIV case management providers, at their discretion.
ii. The CFSP shall coordinate with local Ryan White HIV case management programs and providers.

e. High-Fidelity Wraparound
   i. Overview of High-Fidelity Wraparound
      1) The Department recognizes that High-Fidelity Wraparound, an evidence-based intervention targeted toward youth ages three (3) to twenty (20) years old with serious emotional disturbance, has produced cost savings as compared with psychiatric residential treatment facility services and Level III/IV group home services.
      2) The Department is committed to expanding access to High-Fidelity Wraparound with the launch of the CFSP.
      3) The CFSP may offer High-Fidelity Wraparound as an ILOS:
         a) The CFSP must submit an ILOS service request form as defined in the Contract.
         b) If the CFSP does not provide the ILOS service request form for review and approval, capitation payments may be adjusted accordingly.
         c) If the CFSP provided High-Fidelity Wraparound as an ILOS, the CFSP shall provide the Department with a quarterly report on members utilizing High-Fidelity Wraparound as defined in *Section VII. Attachment I. Table 1: CFSP Reporting Requirements*.
      4) If the CFSP offers High-Fidelity Wraparound as an ILOS, the CFSP shall ensure the following:
         a) That provider organizations have the opportunity to choose to seek certification to offer High-Fidelity Wraparound to children with serious emotional disturbance who meet eligibility criteria that will be documented in the Department's forthcoming High-Fidelity Wraparound Policy. Only providers that meet requirements as described in this section may offer High-Fidelity Wraparound;
         b) That the High-Fidelity Wraparound program is subject to requirements for facilitating timely communication across the care team as described in *Section V.D.2.m. Ongoing Care Management; and*
         c) That it has sufficient providers in its Network to meet the needs of Members who are eligible for the services, as defined below in *Section V.D.4.e.ii. Eligibility and Assignment to High-Fidelity Wraparound*.
   ii. Eligibility and Assignment to High-Fidelity Wraparound
      1) Youth ages three (3) through twenty (20) are eligible for High-Fidelity Wraparound if they meet the criteria documented in the Department's High-Fidelity Wraparound Policy.
      2) On an ongoing basis, if the CFSP offers High-Fidelity Wraparound as an In Lieu of Service:
         a) The CFSP shall identify Members who may meet the High-Fidelity Wraparound eligibility criteria and would benefit from the program. The CFSP shall also accept referrals from network providers for Members who may be eligible for and benefit from High-Fidelity Wraparound.
         b) If the CFSP identifies that a Member may meet the High-Fidelity Wraparound eligibility criteria, the CFSP shall contact the Member and the Member's Parent(s), Guardian(s), or Custodian(s) (if applicable and as permitted) to determine interest in High-Fidelity Wraparound.
         c) If the Member and their caretaker/legal Guardian indicate interest in High-Fidelity Wraparound, the CFSP shall determine whether the Member meets the High-Fidelity Wraparound eligibility criteria, as specified in the Department's forthcoming High-Fidelity Wraparound Policy.
         d) If the CFSP determines that the Member meets the High-Fidelity Wraparound eligibility criteria, the CFSP shall refer the Member to a provider that offers High-Fidelity Wraparound for Care Management.
   iii. High-Fidelity Wraparound Services and Fidelity Monitoring
      1) If the CFSP offers High-Fidelity Wraparound as an ILOS:

a) The CFSP shall ensure that all providers offering High-Fidelity Wraparound meet fidelity requirements, as assessed by the Department's contracted vendor performing fidelity monitoring.
b) The CFSP shall ensure that providers offering High-Fidelity Wraparound meet all requirements documented in the Department's High-Fidelity Wraparound Policy, including requirements for staffing, qualifications and training.

f. Members Obtaining ACT
   i. The CFSP shall implement the following protocols for Members obtaining ACT:
      1) Ensure that the Member receives transitional Care Management, as described in *Section V.D.2.n. Transitional Care Management,* in the first and last months of receiving ACT.
      2) Ensure Member is no longer receiving CFSP Care Management effective the month following initial receipt of ACT.
      3) Ensure that when a Member begins obtaining ACT, the Member's care manager shares the Member's Care Plan/ISP with the ACT case manager, with consent.

g. Coordination with Children's Developmental Service Agencies
   i. The CFSP shall coordinate with every Early Intervention (EI) Program CDSA in the State.
   ii. The CFSP shall establish reciprocal information-sharing agreements with CDSAs that reflect parental consent requirements and are compliant with HIPAA and the Family Educational Rights and Privacy Act (FERPA).
   iii. For children who are actively engaged in CFSP Care Management:
      1) The care manager shall coordinate with the CDSA service coordinator, to the maximum extent possible, in order to facilitate information sharing and coordination between the CFSP and the CDSAs.
      2) For any child ages zero (0) to three (3) identified as receiving EI services through the needs assessment, the CFSP shall:
         a) Incorporate the child's Individualized Family Service Plan (IFSP) into the Care Plan or ISP;
         b) Update the child's CFSP Care Plan or ISP to reflect any changes to the IFSP on an ongoing basis;
         c) Request that the CDSA service coordinator take part in the child's CFSP Care Management care team meetings, upon consent of the Parent/legally responsible person; and
         d) Partner with the CDSA service coordinator to identify Unmet Health-Related Resource Needs and connect the family to appropriate social and community-based services, as needed.
      3) For any child age zero (0) up to age three (3) who is not receiving EI services, but whose developmental assessment demonstrates evidence of developmental delay, the CFSP shall provide referral information to the family for an EI evaluation, facilitate a Warm Handoff to the appropriate CDSA, and follow up on the results of the referral and whether an EI evaluation was conducted.
   iv. The CFSP shall ensure that appropriate staff, such as care managers and Member services staff, are generally knowledgeable about EI services and provide referrals to the local CDSA to assist and consult with Members concerning EI services.
   v. In its Care Management Policy (*Section V.D.5. Care Management Policy)*, the CFSP shall detail the plan to ensure referrals to the CDSA and coordination for all children who receive service coordination through a CDSA during Contract Year 1, or a time otherwise defined by the Department, and annually thereafter.

h. Care Management through the Indian Health Service (IHS) or EBCI
    i. At the request of the Department, the CFSP shall enter into a contract with EBCI to perform Care Management or other functions for tribal members and IHS-eligibles as prescribed by the Department, in consultation with EBCI.

5. Care Management Policy

a. The CFSP shall submit its Care Management Policy for review and approval by the Department within one hundred twenty (120) Calendar Days after Contract Award.
b. The CFSP shall submit an updated version of the Care Management Policy prior to CFSP launch and at the beginning of each subsequent Contract Year.
c. The Care Management Policy shall describe the unique challenges faced by the CFSP populations, how the CFSP's Care Management approach will best serve CFSP Members, and the qualifications and experience of key Care Management staff (including, at minimum, the Director of Population Health and Care Management and supervising care managers).
d. The Care Management Policy shall describe in detail the CFSP's:
    i. Processes for determining CFSP Care Management eligibility
        1) CFSP Care Management Staffing Approach:
            a) Approximate number of care managers deployed by county;
            b) Approximate number of care managers per county based in County DSS;
            c) Approach for ensuring sufficient in-person Care Management contacts, including in rural areas, in instances where a Member has moved to a different area of the state, and instances where a Member's care manager may be temporarily unavailable; and
            d) Approach for training care managers to understand their roles and responsibilities with respect to coordinating with County DSS and providing trauma-informed Care Management services to children, youth, and families served by the child welfare system.
        2) Approach for Coordinating with County DSS:
            a) Approach for ensuring frequent, in-person contact between care managers and County Child Welfare Workers;
            b) Approach for sharing key information on timely basis with County Child Welfare Workers; and
            c) List of health-related or other events (e.g., a change in Foster Care placement) that would trigger a check-in between the care manager and the County Child Welfare Worker.
        3) Policies and procedures for Member outreach and engagement;
        4) Process for how Members are notified of the name of their assigned care manager and how to contact them;
        5) Process for how the care manager is made aware of Grievances and Appeals filed by Members or by providers (when providers file an Appeal based on a denial of service);
        6) Strategies to reach out to and engage Members who are hard to contact/locate (because of, for example, incorrect address information, a missing or incorrect phone number, or homelessness);
        7) Strategies that shall be used to document attempted contacts; "robocalls" and automated telephone calls that deliver recorded messages can be part of the outreach strategy, but will not solely be an acceptable form of contacting Members;
        8) Strategies to engage Members who did not engage previously in CFSP Care Management or re-engage Members who left CFSP Care Management;
        9) Policies and procedures for Care Management Comprehensive Assessments, including but not limited to:

a) Strategies to comply with federal care needs screening requirements (42 C.F.R. § 438.208(b)(3));
b) Assessment tools/questions used;
c) Variation in Care Management Comprehensive Assessment based on population (including LTSS);
    i) For Members obtaining State Plan LTSS besides 1915(i) Services; and
    ii) For Members obtaining 1915(i) Services, the approach to incorporating information from the Independent Assessment with the Member's Care Management Comprehensive Assessment.
d) Expected volume of Care Management Comprehensive Assessments monthly and annually;
e) Method of conducting the Care Management Comprehensive Assessment based on Member needs or other factors; and
f) Audits of Care Management Comprehensive Assessments to ensure they meet quality expectations.

10) Policies and procedures for Care Plan/ISP development with Members, including:
    a) Tools used to guide the development of the Care Plan/ISP;
    b) Approach for involving multidisciplinary care team (including CFT, as appropriate);
    c) Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the Member and the Member's Parent(s), Guardian(s), Custodian(s), family members, and/or advocates are actively involved, as applicable and permitted in accordance with Federal and state privacy laws;
    d) Approach for ensuring the use of family and Member-friendly tools to document and demonstrate for the Member and family their progress over the course of treatment;
    e) Approach for Care Plan/ISP development for Members obtaining 1915(i) Services as required by 42 C.F.R. § 441.725; and
    f) Process for and frequency of Care Plan/ISP updates.
11) Policies and procedures for transitional Care Management, including the approach to working with Members with LTSS needs;
12) Policies and procedures for with community resources (including System of Care Community Collaboratives and staff) for all Members as needed, including for those identified as having Unmet Health-Related Resource Needs;
13) Policies and procedures for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360;
14) Training plan, including:
    a) Policies and procedures for training and qualification of care managers, supervising care managers, care manager extenders and other multidisciplinary team Members;
    b) Timing/frequency of trainings;
    c) Summary of curriculum that must include training on providing trauma-informed Care Management services; and
    d) Approach for annual refreshers and ongoing continuing education.
15) Policies and procedures for population health management;
16) Description of risk stratification methodology, including:
    a) Number of risk tiers;
    b) Methodology for determining Member tier; and
    c) Care Management contact expectations for each tier;

17) Description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies;
18) Proposed methodology for calculating costs and outcomes of the Care Management program;
19) Policies and procedures for conflict-free Care Management;
20) Policies and procedures for ensuring Members do not receive duplicative Care Management from multiple sources;
21) Policies and procedures for Care Coordination and Care Transitions for all Members, including:
    a) Ensuring the Member has an ongoing source of care;
    b) Coordination across settings of care; and
    c) Coordination during Member transitions (including transitions to/from a Standard Plan, BH I/DD Tailored Plan, or EBCI Tribal Option to a CFSP, from NC Medicaid Direct into a CFSP, between Foster Care placements, and between community and social support providers).
22) Policies and procedures for providing diversion services as described in *Section V.D.2.p. Diversion from Institutional and other Congregate Settings;*
23) Policies and procedures for providing in-reach and transition services as described in *Section V.D.7.k. In-Reach and Transition Policy;*
24) Specialized Care Management strategies that address the medical and psychosocial needs of infants who are substance affected; address the needs of the infant's mother/ Parent(s), Guardian(s), Custodian(s), including education for Parent(s), Guardian(s), Custodian(s) on the potential psychosocial development of an infant who is substance affected; and ensuring alignment across Care Management delivery for infant and infant's mother/Parent(s), Guardian(s), Custodian(s);
25) Care Management strategies to manage the needs of pregnant and postpartum women with SUD diagnoses/history or mental health diagnoses/history, including strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes, and addiction and recovery treatment approaches;
26) Policies and procedures for referral and coordination for all children who receive service coordination through a CDSA;
27) Approach for coordinating with other State agencies, including, but not limited to, the Department of Juvenile Justice;
28) Strategy for building and managing the High-Fidelity Wraparound provider network;
29) Approach to addressing health disparities and incorporating health equity in support of the Department's health equity goals;
30) Protocols for ensuring that individuals moving between ACT and the CFSP Care Management model experience smooth transitions; and
31) Strategies to deliver Care Management services in a way that promotes health equity and supports Historically Marginalized Populations in the child welfare system.

ii. The CFSP shall modify the Care Management Policy based on EQRO review, Department review, or Care Management improvement activities as part of the QAPI.

6. System of Care

a. System of Care Background

i. The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina's System of Care is to provide evidence-based, trauma-informed/resiliency oriented BH services to all children, youth and their families.

ii. The CFSP shall use a System of Care approach, including use of specific strategies and protocols described in the CFSP System of Care Policy (*Section V.D.6.c. System of Care Policy*) for Members, including those with a mental health disorder and/or SUD who are receiving mental health or substance use services, members with a dual I/DD and mental health disorder, members with dual physical and mental health or SUD diagnoses, members transitioning from child service systems into adult service systems, and members served by the juvenile justice system.

iii. System of Care Values are:
   1) Interagency collaboration;
   2) Data driven;
   3) Individualized strength-based approach;
   4) Family driven and youth guided;
   5) Trauma-informed/resiliency focused;
   6) Evidence based;
   7) Culturally and linguistically responsive; and
   8) Community-based services and supports setting.

b. System of Care Staffing Requirements
   i. The CFSP shall employ the following positions:
      1) One (1) full-time System of Care Manager; and
      2) A minimum of six (6) System of Care Outreach Coordinators.
   ii. The CFSP System of Care Manager shall be responsible for implementing the CFSP's System of Care Policy (see *Section V.D.6.c. System of Care Policy*) statewide and overseeing CFSP System of Care Outreach Coordinators who are responsible for local implementation of the CFSP's System of Care policy (see *Section V.D.6.c. System of Care Policy*). This includes active participation at Community Collaboratives and overseeing training of care managers and System of Care Outreach Coordinators on understanding the System of Care approach and core elements. The System of Care Manager shall also be responsible for the following activities:
      1) Serve as a conduit for State-level Child Welfare concerns regarding systemic service barriers for Members and coordinate a resolution process;
      2) Ensure interests of Members are represented on local Community Collaboratives, and Members contribute to the Community Collaborative's problem-solving function;
      3) Inform System of Care Outreach Coordinators of critical issues and trends negatively impacting service delivery for Members;
      4) Support System of Care Outreach Coordinators' work with Community Collaboratives to influence the development of a broad and appropriate service array to meet the range of BH needs of Members;
      5) Provide data to help address Community Collaboratives' concerns or assumptions. Coordinate involvement of appropriate CFSP staff/committees to inform Community Collaboratives and respond to their concerns and recommendations;
      6) Represent the CFSP on the North Carolina Collaborative for Children, Youth & Families;
      7) Foster participation and involvement of Members at all levels of System of Care, include CFSP, Member and Parent(s), Guardian(s), or Custodian(s) representation at each local collaborative (as appropriate), work with care managers to ensure that Members and families are leading their person-centered planning processes, and provide and support program and policy development leadership opportunities for Members and families;
      8) Develop a plan to promote implementation of the System of Care approach, with System of Care Outreach Coordinators, at the local level;

9) Work with community agencies in identifying and responding to Members' needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system serving Members; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and substance use disorder treatment and recovery services for Members;
10) Coordinate responses for consultation, technical assistance and training need requests of CFSP for the Community Collaboratives, provider agencies, families and other CFSP staff. Deploy CFSP System of Care Outreach Coordinators to either directly provide or facilitate the provision of such activities;
11) Complete and submit CFSP System of Care reports to the Department. These reports shall be submitted to the Department in accordance with the Department's requirements;
12) Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits that will support a high level of statewide coordination, networking, monitoring, and evaluation for and with Department and other plan System of Care staff;
13) Regularly participate in state-level interagency groups such as Child Welfare State groups; State Fostering Health Group; State Juvenile Justice – BH Group; State School-Juvenile Justice partnerships; State Department of Public Instruction groups; Early Childhood Group; and the Community Resilience Building Trauma Advisory Council, with the purpose of identifying and responding to Members' needs, network adequacy and service accessibility needs, and keeping State-level partners informed of changes in the BH delivery system;
    a) Work with the state-level interagency groups to establish a Transition Age Workgroup to review cross-agency policies and protocols and recommendations for policy realignment and/or new policies that would lead to improved services for 18-26 year olds; and
14) Present data to Community Collaboratives on service utilization at least quarterly and upon request; service completion and disruption rates; performance data on the CFSP's implementation of System of Care practice elements; identification of any service access, engagement, and completion disparities by race/ethnicity, gender, sexual orientation, and geographic service areas, as requested by the Collaboratives.

iii. The CFSP System of Care Outreach Coordinators shall be responsible for the following activities:
    1) Support the CFSP System of Care Manager in implementing and overseeing the CFSP's System of Care Policy (see *Section V.D.6.c. System of Care Policy*) at the local level;
    2) Conduct community outreach and provide education to community partners on the specialized needs of Members;
    3) Participate in Community Collaboratives (monthly), Member Advisory Committees and CFACs to represent the interests of Members; and
    4) Communicate to Community Collaboratives critical issues and concerns regarding service delivery for Members and actively participate in Community Collaboratives' efforts to address identified issues and concerns.

iv. The CFSP shall ensure the System of Care Manager meets the following minimum qualifications:
    1) Hold a Master's degree in a human services field;
    2) A minimum of five (5) years of professional experience working in and across child-serving systems (e.g., education, child welfare, BH, juvenile justice or early childhood systems); and

3) Have completed the approved state System of Care Training(s) and CFT Trainings.

v. The CFSP shall ensure the System of Care Outreach Coordinators meet the following minimum qualifications:
   1) Hold a Bachelor's degree in a human services field;
   2) A minimum of two (2) years of professional experience working in and across child-serving systems (e.g., education, child welfare, BH, juvenile justice or early childhood systems); and
   3) Have completed the approved state System of Care Training(s) and CFT Training.

c. System of Care Policy
   i. The CFSP shall submit a System of Care Policy for review and approval by the Department within one hundred twenty (120) Calendar Days after Contract Award and annually thereafter.
   ii. The System of Care Policy shall include the CFSP's policies and processes for implementing the System of Care as required in the *Section V.D.6.c. System of Care Policy* and:
      1) Integration of the System of Care framework into the CFSP's approach for providing services to Members and their Parent(s), Guardian(s), or Custodian(s);
      2) Supporting coordinated multi-system care delivery through:
         a) Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
         b) Conducting outreach to Parent(s), Guardian(s), or Custodian(s)to ensure they are engaged through the Community Collaboratives and other advisory bodies in the service delivery process, and System of Care-related planning, implementation, and quality review;
         c) Instituting effective and timely cross-system communication, including for Members in crisis; and
         d) Collaborating with system partners to ensure that Members receive needed services in the least restrictive setting;
      3) Describing how the CFSP shall work with County DSS and other local and State public agency partners to:
         a) Reduce the number and length of institutional placements for Members receiving BH services;
         b) Reduce the number of Members receiving public BH services who are prescribed multiple psychotropic medications;
         c) Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography;
         d) Identify new treatment-related placements or maintain current treatment-related placements, as appropriate, and address immediate health care needs, for Members who experience or are at a high risk of experiencing a disruption in treatment-related placements; and
         e) Mitigate disruptions and address local system level barriers contributing to disruptions in treatment-related placements for Members.
      4) Describing how the CFSP will develop or strengthen relationships with its local and State public agency partners, youth and/or family members with lived experience with a child in the child welfare system, and family support education and/or youth advocacy groups, including but not limited to:
         a) Local education agency/DPI regional staff/community college systems;
         b) County government;

c) NC Collaborative for Children, Youth & Families;
d) NC Department of Public Safety/Division of Juvenile Justice and Delinquency Prevention/criminal justice;
e) Child welfare system;
f) DCFW system;
g) Public health system;
h) Early childhood system partners;
i) Private and local community-based providers;
j) Child and Family Advisory Committees;
k) Community Collaboratives; and
l) State-level and Standard Plans and BH I/DD Tailored Plans' System of Care staff.

7. In-Reach and Transition from Institutional and Other Congregate Settings

a. In-Reach and Transition Overview
   i. The CFSP shall assume primary responsibility for the in-reach and transition activities described in this section.
      1) In-reach activities shall be conducted with the goal of identifying and engaging Members receiving care in a setting described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services* who may be able to have their needs safely met in a community setting.
      2) Transition activities shall be conducted with the goal of facilitating the relocation of a Member receiving services in a setting described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services* to a community setting, while ensuring the appropriate level of services and supports that Member requires.
   ii. The CFSP shall ensure all in-reach and transition activities are documented and stored and made available to the Department for review upon request.
   iii. The CFSP shall provide the in-reach and transition reports in the form and frequency as described in *Section VII. Attachment I. Reporting Requirements*.

b. Eligibility for In-Reach and Transition Services
   i. The CFSP shall consider the following Members as eligible for CFSP-based in-reach and transition services:
      1) Members residing in a state psychiatric hospital who are not determined eligible for North Carolina Transitions to Community Living (TCL) as described in *Section V.D.7.c.ii.* below;
      2) All Members in a PRTF; and
      3) All Members in Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2.
   ii. For Members ages 21 and above residing in a state psychiatric hospital whose Medicaid coverage is in suspended status, the CFSP shall continue to assume primary responsibility for the in-reach and transition activities described in this section for no more than ninety (90) Calendar Days from the last day of the month in which a Member's Medicaid eligibility is suspended, after which time the BH I/DD Tailored Plan shall assume primary responsibility for in-reach and transition activities for these Members.
      1) The CFSP shall adhere to the requirements in *Section V.B.3. Transitions of Care Across Plans and Delivery Systems* for Members transitioning out of the CFSP.

c. The CFSP shall ensure the Member's care manager performs the following in-reach activities for Members receiving services in a setting described in *Section V.D.7.b. Eligibility for In-Reach and*

Transition Services, beginning within seven (7) Calendar Days of admission and occurring on a regular basis until the Member is referred for transition services described in *Section V.D.7.d.*:

i. Identify candidates for in-reach services. The CFSP, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
   1) Claims and enrollment data;
   2) Facility referrals;
   3) Stakeholder and family/ Parent, Guardian, or Custodian referrals; and
   4) Automatic in-reach trigger points the CFSP shall establish.

ii. For Members age eighteen (18) and above admitted to a state psychiatric hospital, ensure the Member is referred for an eligibility determination for the North Carolina TCL, to be conducted by the BH I/DD Tailored Plan assigned to the county where the Member's Medicaid is administered.
   1) CFSP Members determined eligible for the North Carolina TCL shall be disenrolled from the CFSP and enrolled in a BH I/DD Tailored Plan as described in *Section VII. Attachment L.1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy*.

iii. Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the Member and the Member's family members and/or Parent(s), Guardian(s), or Custodian(s) are accurately and fully informed about community-based options available.

iv. Facilitate and accompany the Member and their family members and/or Parent(s), Guardian(s), or Custodian(s) on visits to community-based services.

v. Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing.

vi. To the maximum extent possible, explore and address the concerns of the Member and/or their Parent(s), Guardian(s), or Custodian(s) who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive community services and supports. Arrange for peer-to-peer meetings when appropriate to address concerns.
   1) For Members who decline the opportunity to transition, the CFSP shall:
      a) Continue to engage the Member and/or their family members or Parent(s), Guardian(s), or Custodian(s) about the opportunity to transition to a more integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
      b) Clearly document that the Member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the Member of available community services, including supportive housing.
   2) Provide the Member and/or the Member's family members or Parent(s), Guardian(s), or Custodian(s) opportunities to meet with other individuals with SMI or SED or co-occurring IDD/TBI (as relevant to the Member) who are living, working and receiving services in integrated settings.
   3) For all Members who have previously declined to participate in CFSP Care Management, the CFSP shall provide information on the opportunity to engage with a care manager.

d. The CFSP shall ensure the Member's care manager performs the following transition activities for Members receiving services in a setting described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services*:

i. Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care.

ii. Collaborate with the following individuals, specialists, and provider types as applicable depending on the Member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
    1) The Member and/or the Member's family or Parent(s), Guardian(s), or Custodian(s);
    2) Facility Providers;
    3) Facility discharge planners;
    4) The Member's community-based PCP, once selected;
    5) Individuals determined to have appropriate shared lived experience;
    6) Educational specialists;
    7) County Child Welfare Worker; and
    8) Other community providers and specialists as appropriate in the transition planning process, including physical health providers and BH providers.
iii. Engage the Member's community-based PCP and other providers as appropriate so that they are actively engaged in the transition planning process prior to Member's discharge.
iv. Assist the Member, prior to discharge, either by phone or in person, to select a qualified community-based PCP and clinical specialists as needed, including by assisting the Member and/or their family members or Parent(s), Guardian(s), or Custodian(s) in developing interview questions to ask potential community providers when they are selecting providers.
v. Collaborate with the Member and/or the Member's family members or Parent(s), Guardian(s), or Custodian(s), individuals determined to have appropriate shared lived experience when available, facility providers, and other relevant community service providers to make arrangements for individualized supports and services needed to be in place upon discharge.
vi. Collaborate with the Member and/or the Member's family members or Parent(s), Guardian(s), or Custodian(s), the facility provider, and selected community provider(s) prior to the Member's discharge to identify and prioritize the most critical services necessary to address the Member's specific needs, including complex BH, primary care and medical needs.
vii. Schedule post-discharge appointments for critical services to occur in a timely manner based upon the Member's identified needs and no later than seven (7) Calendar Days following discharge.
viii. When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
ix. Assist the Member and/or the Member's family members or Parent(s), Guardian(s), or Custodian(s) in initiating selected community service options including but not limited to BH services.
x. Work with receiving providers and/or agencies if applicable, to identify if any specific training is needed by the receiving providers and/or agencies to ensure a seamless transition.
xi. Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), planning for crisis and respite needs, planning and interventions for supporting positive behaviors, supports needed for neurodevelopmental conditions, resource identification and referrals to qualified providers, and training of family or Parent(s), Guardian(s), or Custodian(s) and natural supports prior to the Member's discharge.
xii. Assess settings that the Member is transitioning to, using the checklist developed by the CFSP and approved by the Department as described in *Section V.D.7.k. In-Reach and Transition Policy*.
    1) When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the Member's

individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.

a) If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the Member's discharge.

b) Make best efforts to ensure that the information contained in the discharge service order, the ninety (90)-day post-discharge transition plan and the discharge summary are made available to the community providers who will be serving the Member after discharge.

2) On the day of discharge:

a) Obtain a copy of the discharge plan and review the discharge plan with the Member and/or the Member's family members or Parent(s), Guardian(s), or Custodian(s) and facility staff.

b) Assist the Member in obtaining needed medications and ensure an appropriate care team Member or facility staff conducts Medication Reconciliation/management and supports medication adherence.

3) Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct Member population served, and the discharge and transition responsibilities included in the Department contract including those set forth in this section.

4) Additional required activities for Members residing in a PRTF or Residential Treatment Levels II/Program Type, III, and IV, and Members under age 18 residing in a state psychiatric hospital:

a) Convene the Member's CFT and work with the CFT, including the Member's care manager, if applicable, to add new team Members as needed to ensure an effective and timely transition.

b) Engage the Member's CFT through the entire transition planning process.

c) Ensure PRTF Family Peer Partner is included in transition planning for Members in a PRTF, when applicable.

d) As required as part of CFSP Care Management (see *Section V.D.2.m. Ongoing Care Management*):

i) Provide the Member and their family or Parent(s), Guardian(s), or Custodian(s) linkages to relevant state agencies and systems that support the development and well-being of children, including local school systems.

ii) Provide the Member and the Member's family or Parent(s), Guardian(s), or Custodian(s) with linkages to community-based services and supports that address Unmet Health Related Resource Needs, including:

(1) Disability benefits;
(2) Food and income supports;
(3) Transportation;
(4) Education;
(5) Housing; and
(6) Services for justice-involved populations.

iii) Collaborate with the Member and their family or Parent(s), Guardian(s), or Custodian(s) and all relevant service providers to ensure needed individualized supports and services—including any school- related services, recreational and pro-social activities, supervision plans, and family supports—are in place upon discharge.

iv) Work with the Member and their family or Parent(s), Guardian(s), or Custodian(s) to assess and prepare the Member's home so that it provides the Member with a safe and appropriate community setting.

(1) Assess settings that the Member is transitioning to, using the checklist developed by the CFSP and approved by the Department as described in *Section V.D.7.k. In-Reach and Transition Policy*.

v) Identify and address any barriers to active engagement of a Member's family or Parent(s), Guardian(s), or Custodian(s) in transition planning.

vi) Educate and train the Member and the Member's family or Parent(s), Guardian(s), or Custodian(s) on resource availability, and how to independently access resources to maintain self-sufficiency in caring for the Member in the community.

5) The CFSP shall assign either the Chief Medical Officer, Deputy Chief Medical Officer, or Director of Population Health and Care Management to attend and participate in case discussions and transition planning for Members with complex needs identified by facility clinical leadership, such as Members with co-occurring disorders or a history of severe aggression and/or serious self-harm.

e. Staffing Requirements

i. The CFSP shall ensure that a Member's care manager, or designee, is responsible for coordinating and/or performing in-reach activities described in *Section V.D.7.c.* for Members receiving services in a setting described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services*.

ii. The CFSP shall ensure that a Member's care manager is responsible for coordinating and/or performing transition activities described in *Section V.D.7.d*. for Members receiving services in a setting described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services*.

f. In-Reach and Transition Staff Training

i. The CFSP shall conduct training for care managers conducting in-reach and transition activities as described in *Section V.D.2.s. Staffing and Training Requirements*.

ii. In addition to the training domains described in *Section V.D.2.s. Staffing and Training Requirements*, the CFSP shall develop a separate training module for in-reach and transition staff that addresses the following domains:

1) Full knowledge of the array of available community services and supports that ensure the health and well-being and safe community living for Members receiving in-reach and transition services;

2) Engagement methods including assertive engagement, and active listening skills;

3) Motivating and working with a Member's family or Parent(s), Guardian(s), or Custodian(s) and facility staff; including Cultural and Linguistic Competency needs of a Member and their family or Parent(s), Guardian(s), or Custodian(s); and

4) Developing an interdisciplinary transition plan.

g. The CFSP shall permit care managers conducting in-reach and transition activities to transport Members and their family or Parent(s), Guardian(s), or Custodian(s) when needed to fulfill the required in-reach and transition activities described in this section.

h. The Department reserves the right to establish caseload requirements for CFSP-based care managers conducting in-reach and transition activities and will release any additional requirements in forthcoming guidance.

i. The CFSP shall be subject to any additional in-reach and transition requirements issued by the Department, including those developed as part of North Carolina's Olmstead Plan.

j. The CFSP shall ensure that a Member does not receive in-reach and transition services that are duplicative of other Care Management services the Member is receiving.
   i. When a Member is receiving both in-reach and transition services and another Care Management service besides CFSP Care Management, the CFSP shall ensure that the in-reach and transition staff and provider of the duplicative service explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.

k. In-Reach and Transition Policy
   i. The CFSP shall submit an In-Reach and Transition Policy for review and approval by the Department within one hundred twenty (120) Calendar Days after Contract Award and annually thereafter.
   ii. The scope of this policy includes all CFSP Members eligible for in-reach and transition services as described in *Section V.D.7.b. Eligibility for In-Reach and Transition Services*.
   iii. The In-Reach and Transition Policy shall include the CFSP's policies and processes for implementing in-reach and transition requirements described in *Section V.D.7. In-Reach and Transition from Institutional and Other Congregate Settings*, including:
      1) Policies and procedures for outreach and engagement of Members eligible to receive in-reach and/or transition services;
      2) Training plan for individuals responsible for conducting in-reach and transition activities; and
      3) Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support Member transitions to more integrated settings.
   iv. The In-Reach and Transition Policy shall include a checklist that individuals responsible for conducting transition activities will use to assess the safety and appropriateness of settings that Members will transition to when leaving an institutional setting. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards.

8. Prevention and Population Health Programs

a. Roles and Responsibilities
   i. The CFSP shall take a population-based approach to improving the overall health of Members and work collaboratively with community partners on targeted public health initiatives (e.g., opioid crisis, infant mortality, mental health awareness, nicotine use prevention/cessation).
   ii. The CFSP shall establish prevention and population health programs aligned with the Department's larger public health goals and Quality Strategy.[23] The Department will provide population-level measures to the CFSP, such as measures related to infant and maternal

[23] North Carolina Medicaid Division of Health Benefits Quality Management and Improvement: https://medicaid.ncdhhs.gov/quality-management-and-improvement

mortality, that are intended to inform the CFSP about regional trends and assist the CFSP in performance improvement efforts.

iii. The CFSP shall implement initiatives to increase access to medication-assisted treatment, including initiatives to increase the number of providers offering this treatment.

iv. The CFSP shall promote wellness and prevention by educating Members about and referring them to CFSP prevention and population health management programs and/or other programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the Member's needs and preferences.

v. The Department's selected population health priorities as defined in the Quality Strategy (to be updated on a regular basis by the Department) include:
   1) Asthma;
   2) Early childhood health and development (e.g., childhood immunization, well-child visits);
   3) Tobacco cessation;
   4) Behavioral-physical health integration;
   5) Diabetes management;
   6) Obesity;
   7) Hypertension;
   8) Birth outcomes;
   9) Maternal health; and
   10) Additional prevention and population health management programs to encourage improved health and wellness among Members, such as depression screening and follow-up and, and other interventions that will improve functional status and quality of life among Members with BH issues, I/DD or TBI.

vi. The CFSP shall identify individuals for prevention and population health programs through several mechanisms, including but not limited to:
   1) Care Management Comprehensive Assessment;
   2) Claims analysis and risk scoring;
   3) Member self-referral;
   4) Provider referral;
   5) Caregiver referral; and
   6) Legal representative referral.

vii. The CFSP shall ensure that prevention and population health programs are available to all Members, as appropriate.

viii. The CFSP will be expected to engage as an active partner in Healthy NC 2030, including thorough review and discussion of CFSP-level data and quality performance consistent with *Section V.F.1. Quality Management and Quality Improvement.* The CFSP should incorporate information from LHD Community Health Assessments in the development of their population health programs.

ix. In addition to the Opioid Misuse Prevention and Treatment Program description and Tobacco Cessation Plan (described below), the CFSP shall develop a comprehensive Prevention and Population Health Management Plan that defines the CFSP's methods to promote better health outcomes, including the Department's selected health priorities, and integration with the Department's other public health and human services programs. The Prevention and Population Health Management Plan shall be submitted to the Department for review and approval ninety (90) Calendar Days after Contract Award, and annually or upon request by the Department.

b. Tobacco Cessation Services
   i. The CFSP shall contract with the Department's Quitline vendor at a minimum benefit level defined by the Department that promotes evidence-based standards of care for tobacco cessation. The CFSP contract with the Quitline shall include coverage of the Quitline BH protocol including (seven (7) sessions and twelve (12) weeks of combination Nicotine Replacement Therapy).
   ii. The CFSP shall ensure that Members are given complete information about the coverage of tobacco cessation items and services.
   iii. The CFSP shall partner with the Department to, at a minimum:
      1) Promote the full Tobacco Cessation Benefit to Members;
      2) Partner with the Department and the Department's Quitline vendor on outreach; and
      3) Submit marketing and educational materials for review and approval consistent with the requirements pursuant to the Contract.
   iv. The CFSP shall develop a comprehensive Tobacco Cessation Plan, which at a minimum includes the following strategies to reduce tobacco use across Members:
      1) Promote tobacco-free campuses at contracted facilities as outlined in *Section V.E.2.c. Provider Contracting;*
      2) Ensure tobacco screening and treatment, including nicotine replacement and other appropriate medications, are provided to all relevant Members in both inpatient, other facility-based, and outpatient/community settings;
      3) Ensure tobacco use (including e-cigarettes) and exposure needs are assessed and addressed in all relevant Care Needs Screenings, Comprehensive Assessments and Care Plans/ISPs;
      4) Increase use of 99406 and 99407 CPT codes in all appropriate settings;
      5) Use incentives for Members and providers as allowed by the Contract;
      6) Use the specialized BH Program for tobacco users with one or more BH conditions;
      7) Ensure evidence-based provider training;
      8) A yearly report on efforts and outcomes; and
      9) Promote and educate on the Department's Quitline benefit.
   v. The CFSP shall submit the Tobacco Cessation Plan to the Department for review and approval annually or upon request by the Department.

c. Opioid Misuse Prevention and Treatment Program
   i. The CFSP shall implement:
      1) A comprehensive Opioid Misuse Prevention and Treatment Program;
      2) A Member lock-in program;
      3) A cumulative maximum morphine milligram equivalent dosage limit not subject to utilization management prior approval, as established by the Department in opioid clinical coverage criteria; and
      4) Diagnosis codes, which may be established by the Department, exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM Program.
   ii. Opioid Misuse Prevention and Treatment Program
      1) The program shall:
         a) Align with the North Carolina Opioid Action Plan, including recommendations from NC Payers Council;
         b) Promote appropriate utilization of healthcare resources by monitoring potential abuse or inappropriate utilization of targeted medications;

c) Contain interventions that support and promote safer prescribing of opioids, management of acute and chronic pain with opioid-sparing pharmacologic non-narcotic pharmacologic, and non-pharmacologic modalities; early detection of opioid misuse and intervention; Screening, Brief Intervention and Referral to Treatment; and increased access to naloxone and substance use disorder treatment, including medication-assisted therapy (in alignment with *Section V.C. Benefits*);

d) Promote access to naloxone through formulary structures and benefit design, in alignment with *Section V.C. Benefits* and *Section V.C.3.c. Drug Formulary and PDL;*

e) Increase access substance/opioid use disorder treatment including medication assisted treatment and BH treatment through Telehealth when clinically appropriate, in alignment with *Section V.E.1.c.vi. Telehealth, Virtual Communications or Remote Patient Monitoring Services;*

f) Support programs focused on the treatment and transport to alternative sites of care for people with substance/opioid use disorder (e.g., community paramedicine);

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* for office based opioid treatment (OBOT), SA Comprehensive Outpatient (adult), SA Intensive Outpatient Program (adults and children), and Opioid treatment (adult);

h) Provide non-emergency medical transportation for Members to substance use disorder treatment, in alignment with *Section V.C.4. Non-Emergency Medical Transportation;* and

i) Specifically acknowledge how the CFSP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.

2) The program shall incorporate requirements in the Strengthen Opioid Misuse Prevention (STOP) Act[24] including quantity limits, mandatory electronic prescribing, utilization of the Controlled Substances Reporting System and reporting.

3) The program shall use analytics to identify outlier opioid analgesic prescribers for education, coaching, and/or fraud investigation, as approved by the Department.

4) Include secure storage initiatives such as prescription drug lockboxes and chemical medication disposal kits. Encourage and improve access to information about permanent medication drop box sites, take back days and other places to safely dispose of medications.

5) The program shall describe goals and metrics as specified by the Department to report progress toward goals on at least a biannual basis. Required metrics to be finalized by the Department.

6) The CFSP shall develop an Opioid Misuse Prevention and Treatment Program Policy and submit it to the Department ninety (90) Calendar Days after the Contract Award. The Opioid Misuse and Prevention Program is subject to Department review and approval, and the department may require changes. The Policy shall be made available on a public website and in the CFSP's Provider Manual.

7) Member lock-in program:

a) The CFSP's lock-in program criteria shall comply with the Department lock-in program criteria as defined in NCGS §108A-68.2.

b) The CFSP shall not require Members to be enrolled in the lock-in period for more than two (2) years without reassessing for continued eligibility in the program.

[24] The STOP Act, Session Law 2017-74, https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf, was enacted by the NC General Assembly on June 29, 2017.

c) The CFSP shall report lock-in program outcomes, including but not limited to reduced ED visits and reduced opioid misuse, in a format to be developed by the Department.

d) The CFSP shall accept and enroll all individuals enrolled in NC Medicaid Direct, Tailored Plan, or Standard Plan lock-in program in the CFSP's lock-in program for the remaining duration of the lock-in period.

d. Additional Prevention and Population Health Programs

i. The CFSP shall actively participate in and support the Department's public health initiatives and coordinate with all existing public health and human services programs, including reporting, education and Care Management activities. That includes coordination with the following:

1) Women, Infants and Children (WIC) Program

a) The CFSP shall identify Members potentially eligible for the WIC program based on the following criteria, make referrals to the WIC program, and provide comprehensive application assistance to help Members access the WIC program (as described in *Section V.D.2. CFSP Care Management*) as needed:

i) Pregnant women;

ii) Women up to six (6) months postpartum;

iii) Breastfeeding women up to one (1) year postpartum;

iv) Infants; and

v) Children under age five (5).

b) The CFSP shall establish relationships with the WIC entities.

c) The CFSP shall collaborate with the office of the state WIC director to establish a plan to coordinate these activities and share data as needed to accomplish joint program goals.

2) Newborn Screening Programs

a) Consistent with NCGS § 130A-125 and NCGS § 130A-130.2, the CFSP shall comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and shall ensure that all lab testing for samples drawn for newborn screening under this statute be sent to the NC State Lab for processing.

b) The CFSP shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Section VII. Attachment L.6. CFSP Management of Inborn Errors of Metabolism Policy.*

c) The CFSP shall establish a joint plan with the Department to implement reporting, education and Care Management activities regarding children who screen positive for hereditary and congenital disorders, including sickle cell and anemia, during Contract Year 1 or a time period otherwise defined by the Department.

3) Newborn Hearing Screening Program

a) Consistent with NCGS § 130A-125 and NCGS § 10A NCAC 43F, the CFSP shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the Early Hearing Detection and Intervention (EHDI) Program at https://wcs.ncpublichealth.com.

b) The CFSP shall establish a joint plan with the Department to implement the requirements of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or a time period otherwise defined by the Department.

4) Vaccines for Children (VFC) Program and NC Immunization Registry
   a) Pursuant to Section 317(j) of the Public Health Service Act, 42 U.S.C. § 247b(j), the CFSP shall provide education to providers on the VFC program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.
   b) The CFSP shall educate providers on the use of the NC Immunization Registry.
5) NCDPH Early Intervention Program
   a) The CFSP shall coordinate with the Department's Early Intervention Program specifically around services provided by the Children's Developmental Service Agencies (CDSA).
   b) The CFSP shall collaborate with local CDSAs to ensure smooth coordination and transition of care between children receiving service coordination through the CDSA and other services in the child's ISP (individualized service Plan) provided by the CFSP network providers (i.e. CBRS, OT/PT, SL).
   c) The CFSP shall coordinate with CDSA in each Region that it operates.
   d) The CFSP shall detail the plan to ensure referral and coordination for all children who receive service coordination through the CDSA during Contract Year 1, or time otherwise defined by the Department, and annually thereafter.

ii. The CFSP shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) by Members and to improve the emotional health and well-being of their Members.

iii. The CFSP shall submit a plan annually for Departmental approval, as an appendix to its QAPI, which details how the CFSP will ensure Hepatitis C and HIV screenings occur for Members in accordance with Centers for Disease Control and Prevention (CDC) guidelines. See *Section V.F.1. Quality Management and Quality Improvement*.

e. Informing and Educating Members and Providers
   i. Members
      1) The CFSP shall inform all Members through the Member Handbook and through other mechanisms of the availability and accessibility of Prevention and Population Health Programs, including the use of program services.
      2) The CFSP shall provide Members with information regarding their participation eligibility, how to self-refer, and how to opt into or opt out of a program.
      3) The CFSP shall have the option to notify the Member's PCP (if applicable) of the Member's participation in a Prevention and Population Health Program.
   ii. Providers
      1) As part of the Provider Training Plan, the CFSP is responsible for educating providers regarding the operation and objectives of all Prevention and Population Health programs. The CFSP shall give providers instructions on how to access specific services and benefits.
      2) For those Members receiving Prevention and Population Health Program support, the CFSP will notify their PCP (if applicable) by letter, email, fax or secure web portal of their patient's involvement, unless the Member notified the CFSP not to inform their PCP (if applicable) as described above.

9. Healthy Opportunities

a. Working collaboratively with all Medicaid managed care entities, including the CFSP, the Department envisions establishing North Carolina as a national leader in optimizing the health

and well-being for all by effectively stewarding resources that bridge our communities and our health care system to address all factors that impact health.

b. The Department has identified four (4) priority domains to address Members' Unmet Health-Related Resource Needs: housing, food, transportation and interpersonal violence/toxic stress.

c. The CFSP shall address these priority Healthy Opportunities domains and any other identified Unmet Health-Related Resource Needs to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:

   i. **Care Management**: The CFSP shall establish Care Management competencies, workforce and procedures that enable the care team to comprehensively address Members' identified Unmet Health-Related Resource Needs, including assessing such needs through Trauma-Informed Care; referral, navigation, and follow-up support to connect with community-based resources and social support services; comprehensive application assistance for programs listed in *Section V.D.2.l. Care Team Formation* for which the Member is eligible, select health-related programs, including food assistance; and assistance connecting to resources related to housing, medical-legal partnerships, and employment opportunities and to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers. For full CFSP Care Management requirements, see *Section V.D. Care Management*.

   ii. **Quality**: The CFSP shall report on rates of completed screenings for Unmet Health-Related Resource Needs; conduct at least one (1) non-clinical performance improvement project annually; and incorporate a description of its contributions to health-related resources into its QAPI Plan. For full quality requirements, see *Section V.F.1. Quality Management and Quality Improvement.*

   iii. **VBP**: As part of its Value-Based Payment (VBP) Strategy, the CFSP shall submit a written plan to the Department that indicates how it will incorporate addressing Unmet Health-Related Resource Needs into its overall VBP Strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full VBP requirements, see *Section V.F.2. Value-Based Payments/Alternative Payment Models.*

   iv. **Stakeholder Engagement:** The CFSP shall partner with community organizations, SOC Community Collaboratives, counties, the Department and other stakeholders to understand, support and connect Members with resources available in the communities it serves, including those that address Members' Unmet Health-Related Resource Needs. See *Section V.G. Stakeholder Engagement* for full requirements.

   v. **In Lieu of Services**: The CFSP is encouraged to use ILOS to offer services that are not covered under the North Carolina Medicaid State Plan, but are a medically appropriate, cost-effective alternative to a State Plan covered service. For full In Lieu of Services requirements, see *Section V.C.1.g. In Lieu of Services (ILOS).*

   vi. **Value-Added Services:** The CFSP is encouraged to use Value-Added Services to offer services that improve health through connecting Members with or providing resources, social services and other supports upon receipt of the Department approval. For full Value-Added Services requirements, see *Section V.C.1.h. Value-Added Services.*

   vii. **Contributions to Health-Related Resources**: The CFSP is encouraged to make contributions to health-related resources that help to address Members' and their communities' Unmet Health-Related Needs. See *Section V.D.9.e. Contributions to Health-Related Resources* and below in this section for full requirements.

   viii. **Healthy Opportunities Pilot Program**: The CFSP shall implement the program for its Healthy Opportunities Pilot-eligible enrollees, as described below in this section.

d. The CFSP shall use North Carolina-developed tools to address the four (4) priority domains for Healthy Opportunities including:
   i. **Standardized Unmet Health-Related Resource Needs Questions**: As part of CFSP Care Management, the CFSP shall undertake best efforts to conduct a Care Management Comprehensive Assessment of every Member, and a care needs screening for those Members who actively decline to participate in Care Management, as described in *Section V.D.3. Care Coordination and Care Transitions for all Members*. The Care Management Comprehensive Assessment and care needs screening shall include a set of Department-defined standardized questions, to identify Unmet Health-Related Resource Needs in priority Healthy Opportunities domains.
   ii. **NCCARE 360:**
      1) The CFSP shall use NCCARE360 to:
         a) Act as the community-based organization and social service agency repository to identify local community-based resources;
         b) Identify community-based resources available on NCCARE360 and connect Members to such resources; and
         c) Track the outcome of referrals to ensure that Members are connected to needed resources.
      2) The CFSP will ensure that the CFSP gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support to use NCCARE360 for its Medicaid Members at no cost to the CFSP. All CFSP requirements outlined in this subsection are available through the NCCARE360 Base Package and Base Support.
         a) NCCARE360 Base Package includes:
            i) Unlimited NCCARE360 licenses for CFSP users to assist Medicaid Members;
            ii) Unite Us standard reporting package; and
            iii) Unite Us pre-launch workflow consultation and planning.
         b) NCCARE360 Base Support includes:
            i) One-time in-person training;
            ii) Self-guided e-learning curriculum
            iii) Recurring Unite Us training webinars;
            iv) License maintenance and updates, and
            v) Technical support ticketing.
         c) The CFSP may, at its discretion, add additional NCARE360 product offerings or services other than Base Package and Base Support such as interoperability or integration capabilities, payment interfaces or software, or solutions engineering. The CFSP shall pay for any additional offerings or services above the Base Package and Base Support functionality described in *Section V.D.9.d.ii.2.a-c.* and *Section V.D.9.d.ii.3.a-b.*
      3) The CFSP shall work directly with Unite Us, Inc. to:
         a) Execute necessary agreements with Unite USA, Inc. to access the NCCARE360 licenses and training purchased by the Department.
         b) Ensure that care management staff who will use NCCARE360 receive NCCARE360 training.
      4) Delegated Care Management Entities:
         a) Delegated care management entities are encouraged, but not required, to use NCCARE360 for the functions outlined in *Section V.D.2. CFSP Care Management.*
         b) The Department intends to work with Unite USA, Inc. to facilitate NCCARE360 licensing and training for delegated care management entities.

c) The Department will ensure that any delegated care management entity that chooses to use NCCARE360 for the functions outlined in *Section V.D.2. CFSP Care Management* for Medicaid Members gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support, as outlined in *Section V.D.9.d.ii.2.a-c.* and *Section V.D.9.de.ii.3.a-b.*, to use NCCARE360 for Medicaid Members at no cost to the delegated care management entity. All CFSP requirements outlined in *Section V.D.9.d.ii.2.* are available through the NCCARE360 Base Package and Base Support.

iii. The CFSP shall participate in regular meetings with the Department regarding their use of NCCARE360 during the implementation, onboarding, and training process to discuss progress, challenges, and best practices. The Department may release additional guidance on NCCARE360-related topics such as consent, privacy/security/confidentiality, reporting, and licensure.

iv. **North Carolina "Hot Spot" Map**: The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. The CFSP may use this tool to strategically guide contributions to health-related resources in the communities it serves (Available at: http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b).

e. Contributions to Health-Related Resources

i. The Department encourages the CFSP to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the communities it serves.

ii. The CFSP may count its voluntary contributions to health-related resources towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V.J.2. Medical Loss Ratio.*

iii. The CFSP is encouraged to identify opportunities to contribute to health-related resources in the QAPI plan. See *Section V.F.1. Quality Management and Quality Improvement.*

f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs

i. Through the Healthy Opportunities Pilot, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) priority domains (housing, food, transportation, and interpersonal safety/toxic stress) can be delivered effectively to Medicaid Members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the Healthy Opportunities Pilot is to learn which evidence-based interventions and processes are best matched for a specific population to improve health, lower health care costs, and to inform health care delivery statewide.

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

iii. Each Healthy Opportunities Pilot region will have one Network Lead. Network Lead's role is to develop, contract with and manage a network of service providers called HSOs that can deliver the evidence-based interventions across each of the four (4) priority domains. Each

Network Lead's region of counties it serves is defined in the Network Lead's contract with the Department.

iv. Healthy Opportunities Pilot Periods
    1) The Healthy Opportunities Pilot is divided into Healthy Opportunities Pilot periods for the purposes of contracting, reporting, monitoring, evaluation, and payments and will be communicated to the CFSP prior to launch.
    2) The Department may amend the Healthy Opportunities Pilot periods. The CFSP shall comply with the new periods as adopted through an amendment to the Contract or as otherwise directed through formal notice from the Department at least ninety (90) Calendar Days prior to amending the Healthy Opportunities Pilot period.
    3) If approved by CMS, the Department shall have the option, in its sole discretion, to extend and/or add Pilot Service Delivery Periods. The Department shall notify the CFSP in writing if it is exercising its option to extend and/or add Pilot Service Deliver Periods at least ninety (90) Calendar Days prior.

v. The CFSP shall contract with any Network Lead operating in the CFSP region using a Department developed model contract.
    1) The CFSP shall contract with any Network Lead operating within the CFSP region for the delivery of Healthy Opportunities Pilot services to eligible members residing in the local Healthy Opportunities Pilot region.
    2) The Department reserves the right to modify the counties that constitute a local Healthy Opportunities Pilot region through its contracts with Network Leads.
    3) The Department will inform the CFSP of relevant amendments to the Department's contract with the Network Lead.

vi. The CFSP shall utilize Care Management Teams—employed by or under contract with the CFSP —to execute key Healthy Opportunities Pilot functions.

vii. Designated Care Management Entities and "Care Management Team":
    1) Designated Care Management Entities are encouraged, but not required, to use NCCARE360 for the functions outlined in *Section V.D.2.m.viii.2.*, unless the entity is a "Care Management Team".
        a) "Care Management Team" shall use NCCARE360 for the functions outlined in *Section V.d.9.f.viii.* and *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)*.
        b) The CFSP shall include the requirement for "Care Management Team", as applicable, to use NCCARE360 for functions outlined in *Section V.D.2.m.viii.2.*, *Section V.d.9.f.viii.,* and *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)* in its contracts with such entities.
    1) The Department intends to work with Unite USA, Inc. (doing business as Unite Us) to facilitate NCCARE360 licensing and training for Designated Care Management Entities and "Care Management Team", as applicable.
    2) The Department will ensure that any Designated Care Management Entity that chooses to use NCCARE360 for the functions outlined in *Section V.D.2.m.viii.2.* for Medicaid Members gains and maintains access to the Unite USA, Inc. NCCARE360 Base Package and Base Support, as outlined in *Section V.D.9.d.ii.2.a-c.* and *Section V.D.9.d.ii.3.a-b.*, to use NCCARE360 for Medicaid Members at no cost to the Designated Care Management Entity. All requirements outlined in *Section V.D.2.m.viii.2.* are available through the NCCARE360 Base Package and Base Support.
    3) The Department will ensure that any "Care Management Team" that is required to use NCCARE360 for the functions outlined in *Section V.d.9.f.viii*. and *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)*. for Medicaid Members gains and maintains

access to the Unite USA, Inc. NCCARE360 Base Package and Base Support, as outlined in *Section V.D.9.d.ii.2.a-c*. and *Section V.D.9.d.ii.3.a-b.*, and NCCARE360 Healthy Opportunities Pilot functionality required by the Department, to use NCCARE360 for Medicaid Members at no cost to the "Care Management Team", as applicable. All requirements outlined in *Section V.d.9.f.viii*. and *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)* are available through the NCCARE360 Base Package and Base Support and all requirements outlined in *Section V.d.9.f.viii*. and *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)* will be funded by the Department. Any additional NCCARE360 functionality that is not necessary to support the requirements of the Department will not be funded by the Department.

viii. The CFSP and its "Care Management Team" as applicable, shall be onboarded to and trained on the use of NCCARE360 for the following Healthy Opportunities Pilot-related functionalities, as applicable:
   1) Managing Healthy Opportunities Pilot eligibility determinations and service authorizations;
   2) Referring Members to authorized Healthy Opportunities Pilot services;
   3) Tracking Member access to authorized Healthy Opportunities Pilot services;
   4) Reviewing invoices from HSOs for Healthy Opportunities Pilot services rendered; and
   5) Approving or denying invoices for Healthy Opportunities Pilot services rendered.

ix. Member Outreach
   1) The CFSP shall conduct outreach to educate Members about the Healthy Opportunities Pilots, Healthy Opportunities Pilot services, and how to self-refer for an assessment of Healthy Opportunities Pilot eligibility consistent with the requirements of *Section V.B.4. Member Engagement*.
      a) The CFSP shall incorporate the use of Department-developed outreach and marketing materials in the CFSP's engagement with Providers and Members within the Healthy Opportunities Pilot counties. This shall include, but is not limited to, flyers, handouts and talking points. The CFSP shall submit to the Department for review and approval any modifications made to Department-developed outreach and marketing materials prior to distributing materials to Members and Providers.
   2) The CFSP shall submit to the Department for review and approval a Healthy Opportunities Pilot Member Outreach Plan at a date to be specified by the Department.
   3) The CFSP shall ensure members can be identified as potentially Healthy Opportunities Pilot-eligible via the following pathways:
      a) Care Needs Screening: The CFSP shall undertake best efforts to conduct a care needs screening of every Member within the first ninety (90) Calendar Days of the effective date of CFSP enrollment as described in *Section V.D.3.f.v*.
      b) Population Health Management Capabilities: At least quarterly, the CFSP shall proactively identify potential Healthy Opportunities Pilot enrollees as part of their population health management capabilities and care management risk scoring and stratification processes, including through the following pathways:
         i) Claims/encounters data;
         ii) 834 files;
         iii) Admission, Discharge, Transfer (ADT) feed information;
         iv) Care management systems;
         v) Provider-reported Z codes;
         vi) Enrollment in other programs that may serve as a proxy for Healthy Opportunities Pilot eligibility;
         vii) Other methods as available to each CFSP; and

viii) Any guidance provided by the Department.

c) Existing Care Management/Coordination Team: The CFSP shall ensure potentially-Healthy Opportunities Pilot eligible members can be identified by their care manager during the administration of the Care Management Comprehensive Assessment or in the course of ongoing delivery of care management.

d) No Wrong Door Approach: The CFSP shall accept referrals for potentially Healthy Opportunities Pilot eligible individuals identified through any pathway, including but not limited to a provider, HSO, or self/family member.

x. For potential Healthy Opportunities Pilot enrollees who are not already enrolled in the Healthy Opportunities Pilot or who have not already started the Healthy Opportunities Pilot eligibility assessment and service recommendation process, the CFSP shall:

1) Notify the Member's Care Management Team within ten (10) Business Days of receiving a request to assess the Member for Healthy Opportunities Pilot eligibility and direct the Member's Care Management Team to initiate the PESA as required in *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)*.

a) If the Member does not currently have an assigned Care Management Team, the CFSP shall conduct the initial PESA.

b) If the CFSP determines that the Member is eligible for Healthy Opportunities Pilot services, the CFSP shall ensure that the Healthy Opportunities Pilot enrollee is enrolled into Care Management either with the CFSP or the "Care Management Team" as defined in the Contract.

2) Ensure that the Member's Care Management Team:

a) Undertakes best efforts to conduct outreach to the Member regarding the PESA within three (3) Business Days of receiving a request from a CFSP, provider, HSO, Member, or Member's authorized representative to assess the Member for Healthy Opportunities Pilot eligibility.

i) All outreach attempts shall be documented by the Care Management Team within NCCARE360.

ii) The Department defines "best efforts" as including at least two documented follow-up attempts to contact the Member if the first attempt is unsuccessful.

b) Utilizes tools such as social drivers of health (SDOH) screenings, Comprehensive Assessments, other evidence-based assessment tools, and findings from regular care management check-ins with Members to identify Healthy Opportunities Pilot-eligible individuals.

c) Builds in opportunities for assessing Members' Healthy Opportunities Pilot eligibility at additional checkpoints with Members including:

i) Transitions of care;

ii) Pregnancy and postpartum period;

iii) Regular care manager check-ins; and

iv) When a Member's circumstances or needs change significantly.

xi. Healthy Opportunities Pilot Program Eligibility Criteria

1) The CFSP shall comply with the following Healthy Opportunities Pilot program eligibility criteria:

a) Member must reside in North Carolina;

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

c) Member must have both:
    i) A qualifying physical or Behavioral Health (BH) criteria as specified in the Department's forthcoming Healthy Opportunities Pilot Care Management Protocol: CFSP; and
    ii) A qualifying social risk factor as specified in the Department's forthcoming Healthy Opportunities Pilot Care Management Protocol: CFSP.

2) The CFSP shall ensure that the Care Management Team assesses potentially Healthy Opportunities Pilot-eligible Members for Healthy Opportunities Pilot program eligibility, including qualifying physical/behavioral health qualifying criteria and social risk factor(s) as required in *Section V.D.9.f.xii. Pilot Eligibility and Service Assessment (PESA)*.

3) If the Department makes changes to Healthy Opportunities Pilot eligibility criteria, it will notify the CFSP in writing about proposed changes and allow the CFSP to comment at least thirty (30) Calendar Days prior to submitting the eligibility changes to CMS for approval. Upon approval by CMS of changes to Healthy Opportunities Pilot eligibility criteria, the Department would provide the CFSP with at least thirty (30) Calendar Day notice prior to requiring changes to be in effect.

xii. Pilot Eligibility and Service Assessment (PESA)

1) The CFSP and its "Care Management Team", as applicable, shall use NCCARE360 to document standardized information regarding a Member's Healthy Opportunities Pilot eligibility and services, including each Member's:
    a) Contact information;
    b) Health Plan;
    c) Care manager of record;
    d) Physical/Behavioral Health (BH) and social risk factors supporting Healthy Opportunities Pilot program eligibility;
    e) Recommended Healthy Opportunities Pilot services;
    f) Service-specific eligibility criteria for recommended Healthy Opportunities Pilot services;
    g) Indication of consent, using a Department-standardized consent form, for:
        i) Healthy Opportunities Pilot participation;
        ii) Healthy Opportunities Pilot evaluation;
        iii) Sharing personal information for the purpose of Healthy Opportunities Pilot participation;
        iv) Required documentation for specific services, if needed; and
        v) CFSP decision and rationale on Healthy Opportunities Pilot eligibility determination and service authorization.

2) The CFSP shall limit access to the Member's Healthy Opportunities Pilot-specific information in NCCARE360 to only those staff that require access.

3) Assessing for Healthy Opportunities Pilot Eligibility and Recommending Healthy Opportunities Pilot Service.
    a) The CFSP shall ensure that the Member's Care Management Team uses using NCCARE360 to do the following activities:
        i) Assess and document a Member's Healthy Opportunities Pilot program eligibility (based on the Healthy Opportunities Pilot program eligibility criteria outlined in this section), Healthy Opportunities Pilot service-level eligibility outlined in the Healthy Opportunities Pilot Fee Schedule.
        ii) Recommend the Healthy Opportunities Pilot services from the Fee Schedule that a Member would benefit from based on Member need and the Healthy

Opportunities Pilot services available in the Member's Healthy Opportunities Pilot region.

iii) Document, where appropriate, Member preferences for, and relationships with, particular HSOs.

iv) Assess and document any changes to Member needs or services during the Member's three (3) month Healthy Opportunities Pilot service mix review and six (6) month Healthy Opportunities Pilot eligibility reassessment as required in *Section V.D.9.f.xvii. Healthy Opportunities Pilot Service Mix and Eligibility Reassessment*.

v) Update any time there is change to the Member's Healthy Opportunities Pilot service needs or eligibility.

vi) Transmit the PESA to the Member's CFSP for eligibility and service authorization.

4) Obtaining Healthy Opportunities Pilot Consent

a) The CFSP shall ensure the Care Management Team obtains the following consents from the Member, using a Department-standardized template, prior to authorizing services for the Member and considering the Member enrolled in the Healthy Opportunities Pilot:

i) Consent to receive Healthy Opportunities Pilot services, including an understanding that Healthy Opportunities Pilot services are neither Medicaid benefits nor an entitlement and may be revoked at any time.

ii) Consent to have the Member's personal data, including personal health information, shared with relevant entities involved in the Healthy Opportunities Pilot, including:

(1) The University of North Carolina Sheps Center for Health Services Research for use in the evaluation of the Healthy Opportunities Pilot; and

(2) Organizations in the NCCARE360 network, subject to NCCARE360's privacy and security permissions.

b) The CFSP shall ensure that the Care Management Team:

i) Obtains all required Healthy Opportunities Pilot-related consents from the Member, using a Department- standardized template prior to submitting the PESA and referring the Member to Healthy Opportunities Pilot services.

ii) Documents in NCCARE360 that the Member has provided all required Healthy Opportunities Pilot-related consents listed in this section and uploads the consent form into NCCARE360.

iii) Provides a copy of the consent to the Member (in person, electronically, or by mail) upon request.

iv) Explains that the Member will not have Healthy Opportunities Pilot services reimbursed by the CFSP if a Member does not provide the required consents.

c) The CFSP shall disenroll Member from Healthy Opportunities Pilot and discontinue payment of Healthy Opportunities Pilot services if a Member revokes consent as required in *Section V.D.9.f.xvii. Healthy Opportunities Pilot Service Mix and Eligibility Reassessment*.

d) If a Member disenrolls from the Healthy Opportunities Pilot and then later re-enrolls, the CFSP shall ensure that consent is obtained each time the Member re-enrolls in the Healthy Opportunities Pilot.

5) Healthy Opportunities Pilot Eligibility Determination

a) Within NCCARE360, the CFSP shall accept recommendations from a Member's Care Management Team that the Member is eligible for the Healthy Opportunities Pilot.

b) The CFSP shall verify that a Member is eligible for the Healthy Opportunities Pilot program based on the Healthy Opportunities Pilot eligibility criteria outlined in *Section V.D.9.f.xi. Healthy Opportunities Pilot Program Eligibility Criteria*.

c) The CFSP shall verify within NCCARE360 that the Member has provided all consents required to participate in the Healthy Opportunities Pilot and store the Member's consents.

d) If NCCARE360 is missing information related to the eligibility determination, the CFSP shall work with the Member's Care Management Team to attempt to obtain the missing information.

i) The CFSP shall not deny Healthy Opportunities Pilot eligibility based on missing information without first attempting to obtain the missing information at least three (3) times from either the assigned Care Management Team or of the Member does not have an assigned care management tea, from the Member or the Member's authorized representative.

e) The CFSP shall document the results of the Healthy Opportunities Pilot eligibility determination in NCCARE360, including rationale if the Member is deemed not eligible.

f) The CFSP shall ensure that if a Member is found ineligible for Healthy Opportunities Pilot service(s), the Member's Care Management Team (1) will continue to provide care management or care coordination to the Member, as appropriate, and (2) will refer the Member to non-Healthy Opportunities Pilot services to meet the Member's need(s).

6) Healthy Opportunities Pilot Service Authorization

a) Within NCCARE360, the CFSP shall review the Care Management Team's recommended Healthy Opportunities Pilot services for a Member and verify whether the Member is eligible for the recommended Healthy Opportunities Pilot service(s).

i) The CFSP shall verify that the Member meets the Healthy Opportunities Pilot service-specific eligibility criteria as articulated in the Healthy Opportunities Pilot Fee Schedule.

ii) The CFSP shall review any required documentation or narrative for Healthy Opportunities Pilot services in NCCARE360 if required by the Healthy Opportunities Pilot Fee Schedule (e.g., Member attestation of enrollment in SNAP or recent determination of SNAP ineligibility for a healthy food box).

iii) The CFSP shall make best efforts to validate that no other federal, State, or local service, resource or program is available (including Medicaid State Plan services, Medicaid waiver services, or other resources or programs available to the Member, including those provided by the CFSP) and would better meet the Member's needs at the time of Healthy Opportunities Pilot service authorization.

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

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

b) Within NCCARE360, the CFSP shall authorize or deny Healthy Opportunities Pilot service(s) for the Member, as detailed in the forthcoming Healthy Opportunities Pilot Care Management Protocol: CFSP.
    i) The CFSP shall take into account the Care Management Team's recommendation(s), Member information on file with the CFSP, and the CFSP's remaining budget within the capped allocation of Pilot service funds when deciding whether to authorize or deny a Healthy Opportunities Pilot service.
    ii) If NCCARE360 is missing information needed for Healthy Opportunities Pilot service authorization, the CFSP shall attempt at least three (3) times to obtain the missing information prior to denying services. If the Member has an assigned Care Management Team, the CFSP shall work with the Care Management Team to attempt to obtain the missing information. If the Member does not have an assigned Care Management Team, the CFSP shall work with the Member or the Member's Authorized Representative to obtain the missing information.
c) The CFSP shall document Healthy Opportunities Pilot service authorization or denial in NCCARE360, along with rationale if the service(s) is denied.
d) The CFSP shall adhere to Department-standardized timeframes for authorization or denial of all Healthy Opportunities Pilot services in accordance with *Section VII. Attachment O. Timeframes for Healthy Opportunities Pilot Service Authorization.*
e) In cases where the CFSP denies a Healthy Opportunities Pilot service, the CFSP shall ensure that the Member's Care Management Team continues care management or care coordination for the Member, as appropriate, and refers the Member to other Healthy Opportunities Pilot or non- Healthy Opportunities Pilot services to meet the Member's need(s).
f) The CFSP shall reassess a Member's eligibility for the Healthy Opportunities Pilot program or a Healthy Opportunities Pilot service when a Care Management Team or Member requests to have the Member's eligibility status reassessed in the case that the Member was determined ineligible and there is an indication the Member's health status or social risk factors have changed.
g) The CFSP shall communicate the process for Members to request a reassessment of Healthy Opportunities Pilot eligibility and needed services via the Member service denial notice.

xiii. Healthy Opportunities Pilot Enrollment

1) The CFSP shall consider the Member to be a Healthy Opportunities Pilot enrollee once:
    a) The CFSP has verified that the Member is eligible for the Healthy Opportunities Pilot program; and
    b) The CFSP has authorized at least one Healthy Opportunities Pilot service for the Member.
2) The CFSP shall follow the NCCARE360 work queue to document Healthy Opportunities Pilot enrollment in NCCARE360 according to the Healthy Opportunities Pilot Enrollment Roster Companion Guide.
3) The CFSP shall not communicate to the Healthy Opportunities Pilot enrollee about Healthy Opportunities Pilot enrollment so as to not cause potential Member confusion with Medicaid eligibility or Medicaid Managed Care enrollment. The CFSP shall communicate to the Healthy Opportunities Pilot enrollee about Pilot service authorization(s) as specified in this section.
4) The CFSP shall monitor the Healthy Opportunities Pilot enrollee's enrollment, including when Healthy Opportunities Pilot enrollment began and when the Healthy Opportunities

Pilot enrollee is due for a three (3) month Healthy Opportunities Pilot service mix review and a six (6) month Healthy Opportunities Pilot eligibility reassessment.

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

xiv. Referral to Authorized Healthy Opportunities Pilot Services and Care Management

1) The CFSP shall ensure that each Healthy Opportunities Pilot enrollee is also enrolled in care management, is assigned to a Care Management Team, and receives comprehensive care management that integrates Healthy Opportunities Pilot services with care management for physical/behavioral health needs.

2) The CFSP shall ensure that the Care Management Team:

a) Informs the Healthy Opportunities Pilot enrollee about authorized or denied Healthy Opportunities Pilot services within two (2) Business Days of receiving CFSP authorization.

b) Makes referrals to Healthy Opportunities Pilot-participating HSOs for authorized Healthy Opportunities Pilot services using NCCARE360 within two (2) Business Days of receiving CFSP authorization.

i) Referrals for Healthy Opportunities Pilot services cannot be sent to HSOs until the Care Management Team receives a service authorization from the CFSP through NCCARE360, unless the service is a passthrough (also known as pre-approved Healthy Opportunities Pilot services) Healthy Opportunities Pilot service.

ii) The CFSP shall monitor receipt of invoices from HSOs to ensure that Healthy Opportunities Pilot referrals are occurring, and that Healthy Opportunities Pilot services are being delivered in a timely manner.

c) Includes a referral to an HSO for case management with any referral for a Healthy Opportunities Pilot service that requires case management according to the service descriptions in the Healthy Opportunities Pilot Fee Schedule, e.g., home accessibility and safety modifications, one-time payment for security deposit and first month's rent.

d) Understands the option to send a referral to a particular Healthy Opportunities Pilot-participating HSO or send the referral to all relevant Healthy Opportunities Pilot-participating HSOs using NCCARE360 functionality.

e) Follows-up with the HSO if the referral is not accepted within two (2) Business Days of the referral being sent using NCCARE360 and elevates the issue to the appropriate Network Lead as required, as data is available through operational reporting and within UniteUs dashboards.

f) When an HSO accepts a referral:

i) Informs the Healthy Opportunities Pilot enrollee of the accepted Healthy Opportunities Pilot service referral;

ii) Tracks Healthy Opportunities Pilot services delivered to the Healthy Opportunities Pilot enrollee and coordinates with HSO(s) regarding enrollee progress, as needed;

iii) Incorporates the Healthy Opportunities Pilot enrollee's Healthy Opportunities Pilot service needs and services received into their care plan; and

iv) Escalates any Healthy Opportunities Pilot network issues to both the CFSP and the Network Lead as appropriate (e.g., if the Care Management Team is not able to identify an HSO that is able to accept the referral).

3) For Members ineligible for CFSP Care Management, the CFSP shall:

a) Conduct the above Healthy Opportunities Pilot-related care manager responsibilities directly for those Members obtaining ACT services.

xv. Delivery of Healthy Opportunities Pilot Services

1) Once an HSO begins providing Healthy Opportunities Pilot service(s) to a Healthy Opportunities Pilot enrollee, the CFSP shall ensure that the Care Management Team :

a) Coordinates with the HSO that accepted the referral to track the outcomes of authorized Healthy Opportunities Pilot service(s) and ensure Healthy Opportunities Pilot service(s) are meeting the enrollee's needs, as needed.

b) Updates the Healthy Opportunities Pilot service delivery outcome(s) in the Healthy Opportunities Pilot enrollee's care plan.

xvi. Expedited Referral to Pre-Approved Healthy Opportunities Pilot Services

1) The Department may permit the CFSP to refer eligible Healthy Opportunities Pilot enrollees to a limited set of passthrough Healthy Opportunities Pilot services (also known as pre-approved Healthy Opportunities Pilot services) for a passthrough period of thirty (30) Calendar Days without CFSP authorization, in accordance with future guidance.

xvii. Healthy Opportunities Pilot Service Mix and Eligibility Reassessment

1) The CFSP shall ensure that the Care Management Team:

a) Tracks when the Healthy Opportunities Pilot enrollees it manages care for require Healthy Opportunities Pilot service mix and eligibility reassessments.

b) Makes best efforts to schedule a reassessment with identified Healthy Opportunities Pilot enrollees to occur within thirty (30) Calendar Days of the due date. The Department defines "best efforts" as including at least two documented follow-up attempts to contact the Member if the first attempt is unsuccessful.

i) Service mix and eligibility reassessments may be completed in-person, telephonically, or by video (in compliance with any applicable state or federal laws).

c) Reviews all available data on the Healthy Opportunities Pilot enrollee in preparation for the reassessment. Conducts a reassessment of each of its Healthy Opportunities Pilot enrollee's Healthy Opportunities Pilot service mix at least every three (3) months.

d) Assesses the enrollee to understand if current Healthy Opportunities Pilot services are meeting the Member's needs.

e) Utilizes the Department's standardized Healthy Opportunities Pilot screening questions and/or other assessments to evaluate if the Healthy Opportunities Pilot enrollee needs additional Healthy Opportunities Pilot services, including in other domains.

f) Discontinues a Healthy Opportunities Pilot service if it is no longer meeting the Member's needs. For Healthy Opportunities Pilot services that must be discontinued, the CFSP shall ensure that the Healthy Opportunities Pilot Enrollee's Care Management Team:

i) Documents the service being discontinued and the rationale (e.g., if the service is no longer meeting the Member's need) in the Member's PESA;

ii) Transmits the Member's PESA to the CFSP via NCCARE360 to notify of the discontinued service; and

iii) For members that require new or modified Healthy Opportunities Pilot services in lieu of the discontinued service, submits a recommended Healthy Opportunities Pilot service to the CFSP as part of the PESA.

g) Recommends additional Healthy Opportunities Pilot services for the Member to the Member's CFSP if needed.

h) Conducts a reassessment of each of its Healthy Opportunities Pilot enrollee's Healthy Opportunities Pilot eligibility at least every six (6) months.

i) Recommends the Member's disenrollment from the Healthy Opportunities Pilot to the Member's CFSP if the Member is no longer eligible.

i) Documents the results of the service mix and eligibility reassessments, including by:

i) Documenting and transmitting outcomes of the reassessments to the Member's CFSP via NCCARE360.

j) Makes monthly attempts to conduct the reassessment following the original date if not completed on time.

i) Recommends the Member's disenrollment from the Healthy Opportunities Pilot to the Member's CFSP if Member has not completed a reassessment within six (6) months of the last reassessment, whether the last reassessment is of service mix or eligibility.

k) Makes best effort to communicate the discontinuation of any Healthy Opportunities Pilot services with the Member and identifies other Healthy Opportunities Pilot or non-Healthy Opportunities Pilot services to meet the Member's needs.

2) Upon receiving results of a Member's reassessment from the Care Management Team via NCCARE360, the CFSP shall authorize or deny any new recommended Healthy Opportunities Pilot services and any changes to Healthy Opportunities Pilot eligibility or enrollment, as appropriate, in NCCARE360.

a) The following circumstances can result in Healthy Opportunities Pilot disenrollment:

i) The Member is no longer eligible for the Pilot program or any Pilot service as described in *Section V.D.9.f.xi. Healthy Opportunities Pilot Program Eligibility Criteria*;

ii) The Member is no longer authorized to receive any Healthy Opportunities Pilot service;

iii) The Member has neither responded to an outreach for, nor completed, either a service mix or eligibility reassessment within six (6) months of the last assessment;

iv) The Member's needs have been met and the Member no longer requires Healthy Opportunities Pilot service(s); and

v) The CFSP has expended all available Healthy Opportunities Pilot service delivery funds.

3) The CFSP is not required to conduct or allow a reassessment if the CFSP has dispersed all of their capped allocation for that Healthy Opportunities Pilot Year.

xviii. The CFSP shall update their Care Management Policy to include the CFSP's approach to meet the requirements of this section. The CFSP shall submit the Policy for review and approval by the Department upon request.

xix. Quality Improvement and Healthy Opportunities Pilot Program Evaluation

1) The CFSP shall collaborate with Network Leads regularly and at reasonable request of the Network Lead to support Network Leads' development of training, technical assistance and convenings and to support Network Leads' requirements to improve HSO performance.

2) The CFSP shall provide timely and accurate reports to the Department on regular intervals as noted in *Section VII. Attachment I. Reporting Requirements* to support:
   a) Healthy Opportunities Pilot program evaluation;
   b) Department reporting to CMS; and
   c) Department efforts to monitor, evaluate, and improve Healthy Opportunities Pilot program implementation.
3) The CFSP shall submit timely, complete, accurate data to the Department. The CFSP's data submissions shall conform to all Department requirements regarding:
   a) Data elements contained in the data submission;
   b) File format, including any requirements that specific data be submitted in a machine- readable format and include accompanying metadata;
   c) Cadence and timeliness of data submission;
   d) Data completeness, accuracy, or any other components of data quality or integrity;
   e) Data privacy and security standards and processes; and
   f) Data governance policies, processes, and controls.

xx. Capped Allocation Funding
1) The CFSP shall develop a comprehensive Capped Allocation Funding Management Policy that outlines the CFSP's approach to use the capped allocation payments described in *Section V.E.4.cc.ii. Capped Allocation*. The CFSP shall submit the Policy for review and approval by the Department upon request.
2) The capped allocation provided to the CFSP will include funding for all Healthy Opportunities Pilot regions. The Department will communicate to the CFSP the amount of funding that shall be distributed in each Healthy Opportunities Pilot region in the Department's forthcoming Healthy Opportunities Pilot Payment Protocol: CFSP.
   a) The CFSP shall make a good faith effort to utilize capped allocation resources for each Healthy Opportunities Pilot region as directed by the Department.
   b) The CFSP shall submit information to the Department, upon request, if the CFSP's regional Healthy Opportunities Pilot spending differs from the regional capped allocations provided by the Department. If the CFSP's regional Healthy Opportunities Pilot spending varies more than ten percent (10%) from the regional capped allocations provided by the Department, the CFSP shall adjust its regional spending at the Department's request.

xxi. IPV-Related Services
1) The CFSP shall adhere to those certain conditions, requirements, and standards regarding IPV-Related Services, data referencing or regarding IPV-Related Services and Members receiving such services, and communications to Members receiving IPV-Related services, collectively as set forth in *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards*.
   a) The conditions, requirements, and standards contained in *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* are in addition to, and not in lieu of, all other conditions, requirements, and standards set forth in this Contract, and to the greatest extent possible the provisions of *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* shall be read and interpreted to be conjunctive with the provisions of this Contract; provided, however, that to the extent that the terms of *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* directly conflicts

with a provision of this Contract, the terms of *Section VII. Attachment P. Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* shall govern.

xxii. Healthy Opportunities Pilot Enrollee Communication Requirements

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

10. Relocation of Members Following Emergency Residential Care Facility Closures

a. The Department understands that the safe and prompt relocation of Members residing in licensed child and adult residential care facilities that suddenly close requires coordination across multiple Divisions, local services agencies and the CFSP.

b. The CFSP shall lead the transition of care and relocation of Members in licensed residential care facilities subject to Emergency Closure in accordance with the Department's Operational Guide for a Coordinated Response to a Sudden Closure of a Child Residential Care Facility and for a Coordinated Response to a Sudden Closure of an Adult Residential Care Facility, or as otherwise defined by the Department.[25]

c. Emergency Closures of Child Residential Facilities:
   i. The Department has developed an intra-Departmental Emergency Closures "Child Residential Facilities Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of child residential facilities in order to safely relocate displaced residents and includes Department divisions—DHSR, DMH/DD/SUS, DHB, DSS and the Department's Communication Team—the CFSP and other health plans designated by the Department.
   ii. The CFSP shall coordinate with the Department's Emergency Closures "Child Residential Facility Response Hub" upon notification of an emergency closure of a licensed child residential facility where Members reside.
   iii. The CFSP shall be responsible for relocating Members following Emergency Closures of Child Residential Facilities (and coordinating with any County DSS serving Members admitted to a licensed child residential facility, as applicable) on the following activities:
      1) Identify Members who are residents;
      2) Meet with Members;
      3) Implement a relocation plan for Members;
      4) Link Members to healthcare services, as appropriate;
      5) Review Member medication needs and manage personal items;
      6) Participate in daily morning situation calls;
      7) Submit discharge information to the Department and County DSS contact person;
      8) Follow up with relocated Members; and
      9) Participate in debrief conference call after the closure.

d. Emergency Closures of ACHs:
   i. The Department has developed an intra-Departmental Emergency Closures "Adult Care Home (ACH) Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions—DHSR, DAAS and DMH/DD/SUS—BH I/DD Tailored Plans, Standard Plans, the CFSP, County DSS and the Regional Long Term Care Ombudsman Program these are housed within the Area Authorities on Aging).

[25] The Department's Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Care Facility is available here: https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf Operational Guide for a Coordinated Response to a Sudden Closure of a Child Residential Care Facility is available here: https://www.ncdhhs.gov/media/13904/download?attachment

ii. The CFSP shall coordinate with the Department's Emergency Closures "Adult Care Response Hub" upon notification of an Emergency Closures of a licensed group home where Members reside.

iii. The CFSP shall be responsible for relocating Members following Emergency Closures of ACHs (and coordinating with any County DSS serving Members admitted to the ACH, as applicable) on the following activities:

1) Conduct a site visit of the ACH that is closing;
2) Identify Members who are residents;
3) Meet with Members and/or Guardians;
4) Implement a relocation plan for Members;
5) Link Members to services as appropriate;
6) Review Member medication needs and manage personal items;
7) Participate in daily morning situation calls;
8) Submit discharge information to the Department and the County DSS contact person;
9) Follow up with relocated Members; and
10) Participate in debrief conference call after the closure.

e. Emergency Closures of Group Homes

i. The Department has developed an intra-Departmental Emergency Closures "Group Home Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents. The "Group Home Response Hub" is comprised of the following Divisional partners: DHSR, DMH/DD/SUS, DHB and DAAS.

ii. The CFSP shall coordinate with the Department's Emergency Closure "Group Home Response Hub" upon notification of an Emergency Closure of a licensed group home where Members reside.

iii. The CFSP shall be responsible for relocating Members following Emergency Closures of group homes including:

1) Conduct a site visit of group home that is closing;
2) Identify Members who are residents;
3) Meet with Members and/or Parent(s), Guardian(s), or Custodian(s);
4) Implement relocation plan for Members;
5) Link Members to services as appropriate;
6) Review Member medication needs and manage personal items;
7) Participate in daily morning situation calls;
8) Submit discharge information to the Department;
9) Follow up with relocated Members; and
10) Participate in debrief conference call after the closure.

f. Out of State Placements

i. The CFSP shall coordinate with the Department to suspend admissions to and safely relocate members residing in out of state facilities upon notification by the Department.

E. Providers

1. Provider Network

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

b. The CFSP shall have a robust Provider Network to meet the medical, BH, I/DD, LTSS, and pharmacy needs of all Members across the State including those served by the child welfare system, with limited English proficiency, physical disabilities, BH, I/DD, or TBI needs. The CFSP shall demonstrate that its Network meets the Department's availability, access, and quality goals and requirements and is willing to act to continuously improve its delivery of health care services to Members.

c. Availability of Services (42 C.F.R. § 438.206)
   i. The CFSP shall establish and maintain a Network that is sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner, including those Members with limited English proficiency or physical or mental disabilities. The CFSP shall enter into a written contract with each Network Provider, the terms of which are further specified herein.
   ii. The CFSP shall meet all federal and state provisions for availability, including:
      1) Providing for a second opinion from a Network Provider, or arranging for the Member to obtain one outside the Network at no cost to the Member if requested by the Member and subject to the Utilization Management Program requirements if applicable. The CFSP shall clearly state its procedure for obtaining a second opinion in its Member Handbook.
      2) Adequately and timely covering services out-of-Network for a Member if the CFSP's Network is unable to provide the covered service within its current Network, taking into account the urgency of the need for services. The CFSP shall cover the Member's out-of-Network services for the duration of the Network's inability to provide them in Network.
      3) Coordinating out-of-network Providers for payment of services and ensuring the cost to the Member is not greater than it would be if the services were furnished by a Network Provider.
      4) Ensuring there is sufficient family planning Providers to ensure timely access to covered services.
      5) Providing female Members with direct access to a women's health specialist within the Network for covered care necessary to provide women's routine and preventive health care services; this shall be in addition to the Member's designated source of primary care if that source is not a women's health specialist.
   iii. Relationship between the CFSP and Network Lead for the Healthy Opportunities Pilots
      1) The CFSP shall contract with any Network Lead operating in the CFSP region, as specified in *Section V.D.9.f. Healthy Opportunities Pilots to Address Unmet Health-Related Needs* and 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 HSOs.
      2) The CFSP shall not amend the Department-standardized CFSP-Network Lead model contract except as required by the Department.
      3) The CFSP shall not contract directly with HSOs for the purposes of Healthy Opportunities Pilot program activities, unless directed to do so by the Department.
      4) The CFSP shall not be required to compensate Network Leads for responsibilities related to the Healthy Opportunities Pilot program.
      5) The CFSP shall execute a BAA with each Network Lead using a Department-defined template.
   iv. Tribal Member Services and Indian Health Care Providers (IHCP) (42 C.F.R. § 438.14)
      1) The CFSP shall contract with all IHCPs in the State to ensure timely access to contracted services for the tribal population.

2) The CFSP shall allow any Member eligible to receive services from an IHCP to choose the IHCP as the Member's PCP, if the IHCP has the capacity to provide PCP services. The CFSP shall consider any referral from such IHCP acting as the Member's PCP to a Network Provider as satisfying any coordination of care or referral requirement of the Contract, as described in *Section V.G.1. Engagement with Federally Recognized Tribes*.
3) The CFSP shall provide tribal members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
4) The CFSP shall permit Members to obtain services from out-of-Network IHCPs from whom the Member is otherwise eligible to receive such services.
5) If the CFSP cannot provide timely access to necessary services in state and/or in-Network for tribal members, the CFSP shall provide access to out-of-state and/or out-of-Network IHCPs.
6) The CFSP shall refer tribal members to IHCPs and other sources of CLAS care as determined by the Department. The CFSP enrolling tribal populations shall provide training for CLAS care to all its Network Providers.
7) The CFSP shall permit out-of-network IHCPs to make referrals to Network Providers for any of its Members without prior authorization or a referral from a contracted Provider.
8) The CFSP shall permit IHCPs to refer its Member to any Provider within the IHCP Purchased and Referred Care Network, even if the Provider is not a Network Provider, without having to obtain prior authorization or a referral from a Network Provider.
9) The CFSP shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any Member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

v. Pharmacy Services
1) The CFSP shall ensure its pharmacy Network meets the time and distance standards defined in *Section VII. Attachment E. CFSP Network Adequacy Standards*, as amended by the Department from time to time.
2) The CFSP shall maintain a Pharmacy Provider Network Audit Program. The CFSP shall submit the program to Department for approval ninety (90) Calendar Days after Contract Award and annually thereafter.
3) The CFSP shall not require Members to accept mail order pharmacy services unless mail order is the only dispensing channel for a drug. The CFSP may allow Members to choose to receive prescribed drugs through mail order pharmacy services.
4) The CFSP shall submit its Mail Order Program Policy including a sample of all Member mail order-related correspondence to the Department for approval ninety (90) Calendar Days after Contract Award and annually thereafter. The CFSP shall specifically identify any pharmacy service where mail order is the only dispensing channel for the drug.
a) The request for approval shall be submitted in accordance with the Implementation Plan.
b) The CFSP shall submit any significant changes to its mail order program to the Department for approval at least ninety (90) Calendar Days before implementation target date.
5) The CFSP may contract with a limited specialty pharmacy Network if the CFSP demonstrates that:
a) A specialty drug is only available through a limited Network of pharmacies; and
b) The specialty pharmacy has clinical and Care Coordination programs that improve medication adherence and drug therapy outcomes.

6) The CFSP may contract with 340B covered entities. Drugs purchased through the 340B program shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus dispensing fee as defined in *Section V.C.3. Pharmacy Benefits*.

vi. Telehealth, Virtual Patient Communications or Remote Patient Monitoring Services:

1) The CFSP may use Telehealth Virtual Patient Communications or Remote Patient Monitoring in order to provide access to needed services in a clinically appropriate manner that are not available within the CFSP's Network and in accordance with NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring.

2) The CFSP shall be permitted to include Telehealth in its Request for Exception to the Department's Network adequacy standards, as appropriate.

3) The CFSP shall not require a Member to seek the services through Telehealth and must allow the Member to access an in-person service through an out-of-Network Provider, if the Member requests and an in-Network Provider that meets time/distance standards is not available for an in-person service.

4) Access to Telehealth Providers does not count toward meeting Network adequacy standards, unless approved as part of an exception to Network requirements.

vii. SUD Residential Treatment Services

1) The CFSP shall comply with the SUD residential treatment Provider provisions for Provider contracts found in *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts.*

2) The Department will establish Network adequacy standards for SUD residential treatment services prior to CFSP launch.

viii. 1915(i) Services

1) The CFSP shall ensure that 1915(i) service providers comply with HCBS standards as set forth in 42 C.F.R. § 441.730 and requirements set forth by the Department.

2) Provider agencies shall comply with the applicable provider specifications for services set forth in the 1915(i) SPA.

3) National accreditation is required of most providers of 1915(i) Services per the 1915(i) SPA. Upon contracting with the CFSP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the waiver(s). The organization must be established as a legally constituted entity capable of meeting all of the requirements of the CFSP.

d. Furnishing of Services (42 C.F.R. § 438.206(c))

i. The CFSP shall meet the Network time and travel distance, and appointment wait time standards established by the Department as described in *Section VII. Attachment E. CFSP Network Adequacy Standards,* unless otherwise approved by the Department in accordance with the requirements herein.

1) The CFSP shall monitor Network Providers regularly to determine compliance with the timely access requirements.

2) The CFSP shall take corrective action if it, or its Network Providers, fail to comply with the timely access requirements.

3) The Department is studying the application of Provider-patient ratios and may implement ratios. The Department shall provide the CFSP one hundred twenty (120) Calendar Days prior notice of the ratio requirements.

4) The Department may adopt new or amend the Network time and travel distance, appointment wait time, or other adequacy standards from time-to-time through an amendment to the Contract or through formal notice to CFSP from the Department. The

CFSP shall comply with the new standards as directed by the Department, but the CSFP shall have no less than ninety (90) Calendar Days to comply with any new or amended network adequacy standards adopted by the Department.

ii. The CFSP shall meet and require its Network Providers meet the Department standards for timely access to care and services, accounting for the urgency of need for services.

iii. The CFSP shall not consider Member access to a higher or more restrictive level of care when a lower or less restrictive care setting is clinically appropriate for the Member as compliance with the Department's timely access to care and services standards.

iv. The CFSP shall ensure that Network Providers offer hours of operation that are not less than the hours of operation offered to commercial Members or comparable to Medicaid FFS, if the Provider serves only Medicaid.

1) The Department encourages after hours and weekend hours to address the needs of the Member.

v. The CFSP shall make covered services available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

vi. The CFSP shall establish mechanisms to ensure that its Network Providers comply with the timely access requirements. The CFSP shall monitor Network Providers regularly to determine compliance with the timely access requirements.

1) The CFSP shall take corrective action, as appropriate, based upon a determination of the root cause(s) of the non-compliance if it, or its Network Providers, fail to comply with the timely access requirements.

2) The CFSP shall make these root cause analyses and corrective action plans available to the Department upon request.

3) The CFSP shall make the processes or procedures (including a description of the mechanisms) used to ensure compliance with the timely access requirements available to the Department for review upon request.

vii. The CFSP shall ensure that Network Providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Members with physical disabilities or BH, I/DD, or TBI needs.

viii. The CFSP shall promote the delivery of services by Network Providers in a Culturally and Linguistically Competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are hard of hearing, and regardless of gender, sexual orientation or gender identity as outlined in National Standards for CLAS in Health and Health Care.

1) The CFSP shall assist Providers with meeting these requirements, including educating Providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.

2) The CFSP shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.

3) The CFSP shall ensure that LGBTQ+ Members who obtain covered services are not subject to treatment that does not affirm their orientation/identity.

e. Essential Providers (NCGS § 108D-22(b))

i. The CFSP shall include all Essential Providers located in the state in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.

1) Essential Providers include federally qualified health centers, rural health centers, free clinics, local health departments, and any other Providers as designated by the Department. Subsection (b) of NCGS § 108D-22.
2) Except for a Veterans Home, the CFSP shall submit a request for an alternative arrangement relating to any Essential Provider with whom the CFSP has failed to contract.
3) The CFSP shall contract with newly identified Essential Providers within ninety (90) Calendar Days of notification from the Department of the addition of a new Essential Provider. If at the end of the ninety (90) Calendar Days a contract with the Essential Provider has not been established, the CFSP shall submit a request for an alternative arrangement, in accordance with the Contract, relating to the Essential Provider.

ii. At such time the CFSP is notified by the Department that a Member is determined eligible for and transferred for treatment to a DMVA-operated Veterans Home, the CFSP shall include the Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) in its Network as an Essential Provider and shall reimburse the Veterans Home at the rates established by the Department until such time as the Member is disenrolled as provided in the Contract.

f. Exceptions to Network Requirements

i. Network adequacy measures, in part, the CFSP's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-Network primary care and specialty physicians, and all health care services included under the terms of the Contract. Recognizing that there are conditions which cannot be remedied by the CFSP alone, the Department will permit exceptions to Network requirements in a time-limited manner.

ii. The CFSP may request approval for an alternative arrangement in contracting with an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision. An alternative arrangement request must:
1) Be made for each Essential Provider that the CFSP is proposing to not contract with;
2) Describe efforts to negotiate in good faith;
3) Include justification for the alternative arrangement with a description of how the alternative arrangement will meet Medicaid Member needs; and
4) Include the CFSP's plan to address Member needs and remedy the need for the alternative arrangement including a suggested timeline for implementation.

iii. In accordance with 42 C.F.R. § 438.68(d)(1), the CFSP may request Department approval for an exception to meeting the Department's Network Adequacy Standards in a specific county for a specific Provider type and Member age (adult or pediatric, as applicable). Requests must:
1) Be made in writing;
2) Describe efforts to negotiate in good faith;
3) Include justification for the exception and a description of how Member needs for the specific county and Provider type will be met; and
4) Include the CFSP's plan to address Member needs and remedy the network deficiency, including an estimated timeline to close the Network gap.

iv. The Department's approval of an exception request to the Network Adequacy Standards or an Essential Provider alternative arrangement will include a specific time frame for the approval. Forty-five (45) Calendar Days before an exception/alternative arrangement is set

to expire, the CFSP shall submit a new request for the exception/alternative arrangement or inform the Department the exception/alternative arrangement is no longer needed.

v. The Department is not required to approve a request for an alternative arrangement with an Essential Provider or exception to meeting the Department's Network Adequacy Standards and may deem the CFSP to be out of compliance.

g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)

i. The CFSP shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment across the state in accordance with the Department's Network Adequacy Standards (as found *Section VII. Attachment E. CFSP Network Adequacy Standards)*, state and federal law, and the terms of this Contract.

1) The CFSP's Network Access Plan must:

a) Demonstrate compliance, or, submit plans for compliance before launch of the CFSP, with all the following components:

i) Offers an appropriate range of preventive, primary care, specialty, BH, I/DD, TBI (excluding waiver services), LTSS, and pharmacy services that is adequate for the anticipated number of Members in the CFSP.

ii) Maintains a Network of Providers that is sufficient in number, mix, and geographic distribution to meet the primary care, specialty, BH, I/DD, TBI (excluding waiver services), LTSS, pharmacy, cultural, ethnic and linguistic needs of the anticipated number of Members in the CFSP.

b) Include procedures to address the following:

i) Referrals;

ii) Disclosures and notices to Members of CFSP services and features;

iii) Coordination and continuity of care; and

iv) Transition of care that complies with Department requirements set forth in *Section V.B.3. Transitions of Care Across Plans and Delivery Systems.*

c) Demonstrate the CFSP's efforts to:

i) Address the needs of all Members, including those with limited English proficiency or illiteracy;

ii) Address health disparities and incorporate health equity, including addressing the needs of Historically Marginalized Populations;

iii) Address the needs of Members exposed to trauma, ACEs and served by the child welfare system;

iv) Ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities;

v) Assist the Department, as directed, to assess the capacity of select Providers to ensure that Members residing in these facilities have access to remote communication options and devices to be used for communication with family and Providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select Providers include:

(1) Nursing homes licensed under 10A NCAC 13D;

(2) Behavioral Health (BH) residential treatment facilities licensed under 10A NCAC 27G .1300, .1500, .3100, 3200, .3400, .4100, .4300, .5600; and

(3) ACH licensed under 10A NCAC 13F and 13G.

vi) Support and sustain Providers, including hospitals, in rural and other traditionally underserved areas as well as Providers representative of Historically Marginalized Populations;

vii) Reach agreements with local education agencies that are responsible for providing the education within child and adolescent day treatment programs. This may include, but is not limited to, the list of school districts with which the CFSP has an agreement for day treatment and how these agreements provide adequate coverage; and

viii) Contract with Providers rostered with the NC Child Treatment Program and other entities that train mental health professionals in evidence-based or best practice BH treatments, including but not limited to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Problematic Sexual Behavior Cognitive Behavioral Therapy Adolescent (PBS-CBT), Child Parent Psychotherapy, Parent Child Interaction Therapy (PCIT), and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS).

(1) The CFSP shall include an update on such efforts as part of its annual Network Access Plan submission to the Department, including:

(a) Strategies implemented to maximize access to Providers that provide evidence-based or best practice BH treatments;

(b) Goals to increase the number of such Providers in the CFSP Network;

(c) Efforts to ensure statewide access to such Providers; and

(d) Efforts to reimburse for evidence-based or best practice BH treatments in a manner that supports fidelity to the evidence-based or best practice model(s), taking into consideration direct and indirect care costs.

(2) The CFSP shall establish mechanisms to monitor utilization of evidence-based or best practice BH treatments delivered by such Providers as outlined in *Section V.F.1.e.i. Quality Assessment and Performance Improvement (QAPI) Plan (42 C.F.R. § 438.330*

d) Include the CFSP's:

i) Efforts to establish a Network that meets the Department's CFSP Network Adequacy Standards.

ii) Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all Members on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a calendar quarter.

iii) Factors used to build the Network, including a description of the Network and how the CFSP uses the Medicaid Enrolled Provider data supplied by the Department, or the Department's vendor, in its Network development and Provider contracting process.

iv) Process and methodology to understand the distribution of Member health care needs against available Providers and Provider capacity to serve those needs.

v) Plan to provide timely access to the tribal population to contracted services from a sufficient number of IHCPs.

vi) Plan to provide access to contracted services for NEMT in accordance with the Department's Medicaid Managed Care Policy for NEMT Policy.

vii) Plan to ensure continuity and access to Providers when Members experience transitions in residential placements, including changes in treatment settings and child welfare placements.

viii) Plan to provide in-Network access, compliant with the Department's CFSP Network Adequacy Standards, to children to the full range of age-appropriate

health care Providers, subspecialists, hospitals with pediatric beds, and other facilities, including:

(1) Method for ensuring children's physical health, BH, I/DD, LTSS, and pharmacy needs will be met using appropriate child-focused specialty services that include supports and services from in-Network Providers who have special training in pediatrics or in child health and development as well as Trauma-Informed Care;

(2) Approach to assure children's access to child psychologists, Child/ Adolescent Psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomate status as a Child/Adolescent Psychiatrist), pediatric occupational, physical and speech therapists, pediatric neurologists, and developmental/behavioral pediatricians); and

(3) Report annually to the Department on the number of Members under age eighteen (18) who are prescribed an antipsychotic medication and the proportion who have been assessed at least once in the preceding twelve (12) months in the outpatient setting by a Child/Adolescent Psychiatrist (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a Child/Adolescent Psychiatrist).

ix) Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.

x) Geographical location of Providers in the Network in relation to where Member's reside.

xi) The CFSP shall describe how it will address Cultural and Linguistic Competency for specific populations of the Plan, including youth in the juvenile justice system, Historically Marginalized Populations, people with disabilities, LGBTQ+ Members, and other vulnerable populations.

xii) Strategies to ensure access and availability of services and build sufficient Provider capacity, including but not limited to addressing Department priorities to:

(1) Increase clinically appropriate access to and utilization of evidence- and community-based alternatives to PRTFs and other congregate settings for Members who can be safely served outside of such settings, including how the CFSP shall: consider and approach developing alternative services that support family preservation, reunification, and other permanency goals and reduce out-of-home placements by leveraging mechanisms outlined in *Section V.C.1.g. In Lieu of Services (ILOS)*, educating and training Providers on the available alternatives to PRTFs and other congregate settings, and pursuing efforts to enhance access and develop capacity for such services statewide.

(2) Increase clinically appropriate, timely access to and utilization of Mobile Crisis Management Services, including how the CFSP shall: analyze and monitor response time for mobile crisis delivery, and work with the Department to enhance mobile response for the pediatric population, including by improving response time and requiring pediatric-specific training among Members of the mobile crisis response team.

(3) Improve timely access to in-state PRTFs when PRTF is the most clinically appropriate service, including how the CFSP shall: analyze and monitor

timeliness of admissions to PRTFs, monitor length of stay in PRTFs, identify gaps in access to PRTFs due to bed shortages for specific populations (e.g., male/female, dual diagnosis, medical co-morbidity), work with the Department and BH I/DD Tailored Plans to develop payment strategies to spur conversion of existing beds to meet identified gaps, and support Department-led quality improvement activities.

(4) Increase clinically appropriate access to and utilization of therapeutic foster care and other family-based settings, including how the CFSP shall: analyze and monitor utilization of therapeutic foster care placements, develop clinical practice guideline(s) related to appropriate utilization of therapeutic foster care and education and training of Providers, and pursue efforts to enhance access and develop therapeutic foster care capacity.

(5) Increase clinically appropriate access to and utilization of SUD services that crosswalk to the national standards provided in *Section V.C.1. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*, including how the CFSP shall: analyze and monitor utilization of SUD services, and work with the Department to enhance access to SUD services, particularly for women with children, as well as for adolescents.

(6) Increase clinically appropriate access to and utilization of Coordinated Specialty Care (CSC) programs, including how the CFSP shall: analyze and monitor utilization of CSC, develop clinical practice guideline(s) related to appropriate utilization of CSC and education and training of Providers, and pursue efforts to enhance access and develop CSC capacity with a focus on Members between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect individuals to existing programs, conduct active surveillance of those at-risk).

(7) Improve timely access to Specialty Care, including but not limited to Children's Specialty Hospitals.

(8) Improve timely access to comprehensive clinical assessment to ensure timely determination of level of care needs.

2) The Network Access Plan must be provided as follows:
   a) Thirty (30) Calendar Days after Contract Award;
   b) As specified by the Department;
   c) Annually; and
   d) Within thirty (30) Calendar Days of a significant change including those related to a disaster or emergency situation that results in a major failure or disruption in care, such as those described in *Section V.E.1.g.i.* below.
3) The Network Access Plan shall be subject to Department review and approval. The CFSP shall amend the Network Access Plan as directed by the Department.
4) The Network Access Plan shall demonstrate that CFSP has the capacity to serve the expected enrollment statewide.
5) The Department shall supply the CFSP Member eligibility information, including county of residence and residence zip code for the Medicaid Beneficiary that is in the CFSP-eligible population as of the date of the Department's report. The information will be provided to the CFSP no later than sixty (60) Calendar Days after Contract Award at a date to be defined by the Department for purposes of demonstrating compliance with the time or distance standards found in *Section VII. Attachment E. CFSP Network*

Adequacy Standards during the Readiness Review, and at other times as needed as part of the Network adequacy oversight.

6) The CFSP shall include in its Network Access Plan the CFSP's approach to ensuring access in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic. The CFSP shall describe the disaster or emergency situation, its impact on access to network Providers, and actions that the CFSP is taking to ensure the CFSP continues to meet access standards under the Contract.

ii. The CFSP and its Network Providers shall comply and cooperate with EQRO Network adequacy validations and activities including:

1) Annual validation of the CFSP's Network adequacy and compliance with state and federal Network requirements; and
2) Telephone surveys of Network Providers to verify accuracy of reported data or other aspects of program requirements or performance.

iii. The CFSP shall submit two distinct network files to validate that the Department has accurate visibility into the CFSP's Provider Network:

1) Network Data Details Extract Report
   a) The Network Data Details Extract is a quarterly and ad hoc data extract containing demographic information about Network Providers to support tracking progress towards meeting Network Adequacy standards.
2) CFSP Network File
   a) The CFSP Network File provides a comprehensive list of the CFSP's contracted Providers. The Provider information contained in CFSP Network File is used by the Department to track the composition of the CFSP's Network. The Department uses the data to build and maintain the CFSP to Provider affiliations, information that is sent to NC FAST, the State's eligibility system, as well as the EB to support beneficiaries searching for Providers. The EB sends the Member selections to NC FAST, where the CFSP and PCP assignments are tracked.

iv. The CFSP shall provide the Department with the Network Data Details Extract Report quarterly, as requested, and anytime there is significant change that impacts Network adequacy and the ability to provide services. The Department will prescribe the standardized file format. The standardized detailed file layout must include the following data elements:

1) Provider names (first, middle, last);
2) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
3) Street address(as) of service location(s);
4) County(ies) of service location(s);
5) Provider specialty;
6) Provider NPI or API;
7) NPI type (individual or organization/facility providers);
8) Taxonomy(ies);
9) Whether Provider is accepting new Members and the conditions if applicable;
10) Identification as an IHCP;
11) Identification as an Essential Provider;
12) Identification as an AMH/PCP;
13) Identification of limitations on age of Members seen by Provider;
14) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by Provider or a skilled medical interpreter at Provider's office;
15) Whether Provider has completed Cultural and Linguistic Competency training;
16) Whether Provider has completed Trauma-Informed Care training; and

17) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.

v. Ongoing Monitoring and Significant Changes in the Provider Network

1) At least once a calendar quarter, the CFSP shall monitor its Provider Network for a significant change that would affect the adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *Section VII. Attachment E. CFSP Network Adequacy Standards.*

2) The CFSP shall report the results of the monitoring for significant change performed during a calendar quarter in the quarterly submission for that calendar quarter of the Network Data Details Extract Report described in *Section VII. Attachment I. Reporting Requirements*.

3) If the CFSP determines a significant change has occurred that negatively affects adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards, the CFSP shall prepare and concurrently submit the following information to the Department when the CFSP submits the quarterly Network Data Details Extract Report that documents the significant change:

a) An updated Network Access Plan, including an updated attestation indicating compliance with or how the CFSP will come into compliance with the time/ distance and/or appointment wait time standards established by the Department; and

b) Any new or updated requests for an exception to a Network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.

vi. The CFSP shall provide the Department with a full CFSP Network File daily as described in *Section V.L. Technical Specifications*. The Department performs validation to ensure network providers are active and eligible to participate as a CFSP network provider. A daily Response file is returned to the CFSP containing the original provider data plus a status and appropriate validation messages. The CFSP is responsible for resolving all errors before the network provider is accepted by the Department. All validated active CFSP network providers will be included in NC DHHS's Medicaid Provider and Health Plan Lookup Tool to support CFSP Choice Counseling and selection. The Department will prescribe the standardized file format for the CFSP Network File and the CFSP Network Response file. The standardized CFSP Network File layout must include at minimum the following data elements:

1) Department provided data elements from the Department:

a) Department assigned CFSP identifier;
b) Provider NPI/Atypical Number;
c) Provider name;
d) Provider demographics (first, middle, and last name, gender);
e) Providers 3-digit Location Code;
f) Provider DBA Name;
g) Provider Service Location Name;
h) Provider mailing address;
i) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
j) Street address(as) of service location(s);
k) County(ies) of service location(s);
l) Telephone number(s) at each location;
m) After hours telephone number(s) at each location;
n) Provider specialty (Taxonomy Codes) by location;
o) Whether Provider is accepting new beneficiaries;

p) Provider's linguistic capabilities, i.e., languages, offered by Provider or a skilled medical interpreter at Provider's office; and
q) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.

2) Department provided data elements from the CFSP:
a) A telephone number at the CFSP where a Member can call to confirm the information in the directory;
b) CFSP assigned Managed Care Category Type Code and Effective Date;
c) Contract start/end date; and
d) Healthy Opportunities Participating Provider and dates.

2. Provider Network Management

a. The CFSP shall manage its Network to meet availability, accessibility, and quality goals and requirements.
i. In developing its Network for all services except those outlined in *Section V.E.2.a.ii.*, the Department expects the CFSP to negotiate with any willing Provider in good faith regardless of Provider or affiliation with any Standard Plan or BH I/DD Tailored Plan.
ii. The CFSP shall have the authority to maintain a closed network for the following services:
1) Intensive ~~CPS~~ In-Home Services;
2) Multi-systemic therapy;
3) Residential treatment services; and
4) PRTFs.
iii. The CFSP shall have a strong monitoring program to ensure Providers are meeting Member needs and program requirements.

b. To help recognize the Department's aim of engaging and supporting Providers, the Department is establishing a centralized Credentialing process including a standardized Provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the PDM/CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of Provider education, training, experience and competency. The period before the PDM/CVO has achieved full Implementation will be considered the "Provider Credentialing Transition Period." The Medicaid enrolled Provider information gathered by the Department or by the Department's vendors will be shared with the CFSP which will use that information for Network contracting.

c. Provider Contracting
i. The CFSP contracts with Providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses identified in *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts.*
ii. The CFSP shall develop Provider Contract Templates that comply with the requirements of this Contract and submit those to the Department for approval no later than thirty (30) Calendar Days after the Contract Award.
1) The CFSP may utilize proposed contract templates submitted to the Department prior to approval with notification to the Provider that the contract is subject to amendment based upon Department review and approval.
2) Upon approval by the Department, the CFSP shall update submitted templates 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 previously submitted contract templates once an amended version is approved.

3) The CFSP shall submit an unapproved contract template to the Department for approval at least sixty (60) Calendar Days before use with Providers, including amended previously approved templates with significant changes.

iii. The CFSP shall not include any Provider (including ordering, prescribing, or referring-only Providers) in its Medicaid Managed Care Provider Network that is not enrolled in North Carolina Medicaid. If the CFSP is made aware of Providers included in their Network file that are not actively enrolled in NC Medicaid, the CFSP shall remove the Provider from the CSFP Network File within one (1) Business Day of notification. The CFSP shall remove any Provider from the CFSP Network File and terminate its contract consistent with the effective date provided by the Department with the Provider within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a Medicaid Provider.
   1) The CFSP shall validate the enrollment status of a Provider in North Carolina Medicaid before adding a new Provider, or a new location for a contracted Provider, to an existing Provider contract.

iv. The CFSP shall not employ or contract with any Provider excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act And put forth in implementing regulations at 42 C.F.R. § 438.610(b).

v. In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the CFSP shall not exclude eligible Providers from its Network except under the following circumstances:
   1) When a Provider fails to appear in the Department's daily Provider Enrollment File, meaning the Provider has not met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled Provider; or
   2) When a Provider refuses to accept Network rates (which shall not be less than any applicable rate floors).

vi. Require that contracted facilities with the exception of the residential Provider facilities found in *Section V.E.2.c.xxii DSOHF Facilities*, implement a tobacco-free policy covering any portion of the property on which the participating Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting participating Providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve.

vii. The CFSP shall not deny a pharmacy the opportunity to participate in its Network as required by NCGS § 58-51-37(c)(2).

viii. The CFSP shall offer to contract with a Provider in writing.
   1) All offers shall include the standard provisions for Provider contracts found in *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts*, including the prescribed provisions located therein.
   2) If within thirty (30) Calendar Days the potential Network Provider rejects the request or fails to respond either verbally or in writing, the CFSP may consider the request for inclusion in the Medicaid Managed Care Network rejected by the Provider. If discussions are ongoing, or the contract is under legal review, the CFSP shall not consider the request rejected.
   3) The CFSP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the CFSP for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with

Providers or otherwise prohibit a Provider from providing services for or contracting with any other BH I/DD Tailored Plan or Standard Plan.

ix. The CFSP shall not require individual practitioners, as a condition of contracting with CFSP, to agree to participate or accept other products offered by the CFSP nor shall the CFSP automatically enroll the Provider in any other product offered by CFSP. This requirement shall not apply to facility Providers.

x. The CFSP shall give written notice to any Provider with whom it declines to contract within five (5) Business Days after the CFSP's final decision. The notice shall include the reason for the CFSP's decision, the Provider's right to appeal that decision, and how to request an appeal, consistent with 42 C.F.R. § 438.12(a)(1).

xi. The CFSP shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the Provider payment requirements herein. For Provider payment requirements that refer to Medicaid Direct rates:
   1) The CFSP shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department.
   2) The CFSP shall implement applicable rate changes within timelines prescribed by the Department. Payments made to Providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable Provider.

xii. The CFSP shall, with regard to payment to any Provider or Subcontractor that is "related to" the CFSP comply with the requirements in *Section V.A.4. CFSP Managed by Provider-Led Entities* and *Section V.J.2. Medical Loss Ratio*.

xiii. The CFSP shall include a provision regarding a Provider's right to file a grievance or appeal (as described in *Section V.E.5. Provider Grievances and Appeals*) in its contract with Providers. The CFSP shall include a notice in all Provider contracts that the internal appeal process with the CFSP must be completed before seeking other legal or administrative remedies under state or federal law.

xiv. The CFSP shall not prohibit or restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
   1) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
   2) Any information the Member needs to decide among all relevant treatment options;
   3) The risks, benefits, and consequences of treatment or non-treatment; and
   4) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, consistent with 42 C.F.R. § 438.102(a)(1)(i)-(iv).

xv. The CFSP shall include a provision in the Provider contract that requires all in-network PCPs to perform EPSDT screenings for Members less than twenty-one (21) years of age in accordance with *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*.

xvi. The CFSP shall include a provision in the Provider contract that requires Providers notify the CFSP when a Member in a high acuity clinical setting is being discharged.

xvii. The CFSP may utilize evergreen contracts, i.e. a contract that automatically renews, with Medicaid Managed Care Providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed.

xviii. The CFSP shall not include any Provider contract provisions prohibited by NCGS § 58-50-295.

xix. In contracting with Providers, the CFSP shall comply with all applicable Chapter 58 statutes in accordance with *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts*.

xx. The CFSP shall include in its Provider contracts that participating Providers shall not submit claim or encounter data for services covered by Medicaid Managed Care and the CFSP directly to the Department.

xxi. In Contract Year 1, the CFSP shall contract with all LHDs in the State that choose to provide CMHRP Women already enrolled in that program at the time of CFSP launch in accordance with *Section V.D.4.b. Local Health Departments*.

xxii. DSOHF Facilities

1) The CFSP shall contract with the DSOHF alcohol and drug treatment centers and psychiatric hospitals for inpatient and outpatient services for all levels and types of services provided or offered by the DSOHF facilities and covered by the CFSP:
   a) Julian F Keith ADATC;
   b) R.J. Blackley ADATC;
   c) WBJ Lakeside Psychiatric Hospital;
   d) WBJ Woodside Treatment Center;
   e) Cherry Hospital;
   f) Broughton Hospital;
   g) Central Regional Hospital; and
   h) Whitaker Psychiatric Residential Treatment Facility.
2) The CFSP shall consider these DSOHF facilities to have successfully completed the State's Centralized Credentialing and Re-credentialing Process (CCRP) and are enrolled as a Provider in the NC Medicaid program.
3) The CFSP shall use a Department-developed contract template to contract with these DSOHF facilities, to be delivered by the Department after award.

xxiii. The CFSP shall contract with all Department-designated facility-based crisis services for children and adolescent Providers.

xxiv. The CFSP shall contract with any new facility-based crisis services Providers for children and adolescents that operate in the State upon notification from the Department of such a new Provider. The CFSP shall contract with the new Provider within a timeframe set forth by the Department.

xxv. The CFSP shall contract with all Cross-Area Service Programs (CASPs) located throughout the state that will be listed in a forthcoming Department guidance. The CFSP shall use a Department developed standard contract, to be delivered by the Department after award for all Providers who are CASPs.

xxvi. The Department may at its discretion require the CFSP to use a Department-developed contract template of other state-owned Providers.

xxvii. For any Provider subject to a rate floor as outlined in *Section V.E.4. Provider Payments*, the CFSP may include a provision in the Provider's contract that the CFSP will pay the lesser of billed charges or the rate floor only if the Provider and the CFSP have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. The CFSP shall not consider a Provider who is subject to a rate floor to have refused to contract based upon the Provider's refusal to agree to a "lesser than" provision.

xxviii. During contract negotiations with a Provider, the CFSP may, without the Department's prior approval, make amendments to a previously approved Provider contract template.

1) Any change to a standard provision required by *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts,* is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.u., 1.v., 1.w., or 1.x., which must be prior approved by the Department.

2) Any change to a standard provision required in *Section 2.* of *Attachment F. Required Standard Provisions for CFSP and Provider Contracts*, must be prior approved by the Department.
3) Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirement of this Contract, or state or federal law.
4) The CFSP may only make changes to the provisions required in *Section 3.* of *Attachment F. Required Standard Provisions for CFSP and Provider Contracts*, when directed to do so by the Department.

xxix. Tobacco-free Policy

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

d. Provider Preventable Conditions
   i. The CSFP shall comply with 42 C.F.R. § 438.3(g) which mandates Provider identification of Provider-preventable conditions as a condition of payment, as well as the prohibition against payment for Provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. The CFSP shall submit all identified Provider Preventable Conditions in a form or frequency as described in *Section VII. Attachment I. Reporting Requirements*.
   ii. The CFSP shall include a provision in all Provider contracts that requires the Provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of Provider-preventable conditions as well as appropriate reporting as required by the CFSP.

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 that shall be submitted to the Department for review and approval ninety (90) Calendar Days after Contract Award, and annually thereafter, if applicable, to the Division.
   ii. The CFSP shall require Network Providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0600, in the NC Incident Response Improvement System.

iii. The CFSP shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of Members.
iv. The CFSP shall report information on incidents and deaths in accordance with Department procedures.
v. The CFSP shall ensure that Provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Attachment F. Required Standard Provisions for CFSP and Provider Contracts.*
vi. The CFSP shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
vii. The CFSP shall adhere to the critical event reporting requirements for Members obtaining services in DSOHF facilities as detailed in *Section VII. Attachment M. Addendum for Division of State Operated Healthcare Facilities*.

f. IHCPs
i. The CFSP shall use the Medicaid Managed Care Addendum for IHCPs when contracting with IHCPs as described in *Section VII. Attachment G. Medicaid Managed Care Addendum for Indian Health Care Providers*.
ii. The CFSP shall not include any additional special terms and conditions to the Medicaid Managed Care Addendum for IHCPs when contracting directly with IHCPs without mutual consent of both the CFSP and the IHCP. For any mutually agreed upon additional special terms and conditions, the CFSP shall:
1) Within thirty (30) Calendar Days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.
2) Recognize that the IHCP Addendum provisions supersedes any conflicting terms of the contract between the CFSP and IHCP.
iii. The CFSP must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148. IHCPs are not subject to licensure and Credentialing of the Department.
iv. The CFSP shall honor all NC Medicaid EPSDT approved services under NC Medicaid Direct or ILOS such as but not limited to the Tribal Integrated Classroom, Family Safety, Tribal Therapeutic Foster Care, and Tribal Peer Support.

g. Program Integrity
i. The CFSP shall develop policies and procedures to perform monitoring and auditing of Provider payment. The CFSP shall provide those policies and procedures to the Department upon request for review.
ii. The CFSP shall require Network Providers and Subcontractors to have a compliance program that meets the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
iii. The CFSP shall require Network Providers and out-of-Network Providers to have policies and procedures that recognize and accept Medicaid as "the payer of last resort."
iv. The CFSP shall prohibit Providers and referral Providers from billing Members for covered services any amount greater than would be owed if the Provider or referral Provider provided the service directly as provided in 42 C.F.R. § 438.106.
v. The CFSP shall not impose a monetary advantage or penalty that would affect a Member's choice of pharmacy in accordance with NCGS § 58-51-37(c)(4) or any other Provider.

h. Credentialing and Re-credentialing Process

i. The CFSP shall ~~develop a~~ follow the Department's uniform Credentialing and Re-credentialing Policy. ~~consistent with the Department requirements and its associated policies and subject to Department approval.~~

1) The CFSP shall follow documented processes and procedures for credentialing and re-credentialing Network Providers in accordance with 42 CFR § 438.214. ~~develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.~~

ii. The CFSP shall accept Provider Credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional Credentialing information from a Provider without the Department's written prior approval. The CFSP is not prohibited from collecting other information from Providers necessary for the CFSP's contracting process.

1) The CFSP shall make timely Network contracting decisions using the process outlined in the CFSP's Credentialing and Re-credentialing Policy.

iii. The CFSP shall not solicit or accept Provider Credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.E. Providers*.

iv. The CFSP is prohibited from using, disclosing or sharing Provider Credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the Provider and the Department.

v. Re-credentialing:

1) During the Provider Credentialing Transition Period, as a Provider is re-credentialed through the Provider Enrollment process, the CFSP shall evaluate a contracted Provider's continued eligibility for contracting by confirming the appearance of the Provider on the daily Provider Enrollment File. The CFSP's process shall occur no less frequently than every five (5) years consistent with the Department policy and procedure.

2) After the Provider Credentialing Transition Period, the CFSP shall evaluate a contracted Provider's continued eligibility for contracting by confirming the appearance of the Provider on the daily Provider Enrollment File. The CFSP's process shall occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.

vi. Through the uniform Credentialing process, the Department will screen and enroll, and periodically revalidate all CFSP Network Providers as Medicaid Enrolled Providers, complying with 42 C.F.R. § 438.602(b)(1).

1) The CFSP may execute Network Provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider immediately upon notification from the state that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) Calendar Days period without enrollment of the Provider, and notify affected Members, consistent with 42 C.F.R. § 438.602(b)(2).

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

viii. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section III.D.5. Availability of Funds*, DHHS shall indemnify, defend, and hold harmless the CFSP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate Credentialing information provided to the CFSP by the

Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the CFSP and relied upon by the CFSP in Credentialing a Provider for participation in the CFSP's Network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The CFSP shall have the option to participate at its own expense in the defense of such claims or actions filed and the CFSP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the CFSP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the Credentialing information provided to it by DHHS. The CFSP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the CFSP's use of and reliance on such Credentialing information.

i. Network Provider System Requirements
   i. Unless otherwise written in the contract, the CFSP shall load newly 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 health plan by the Provider:
      1) New Medicaid Enrolled Provider attached to a new contract within ten (10) Business Days after completing contract execution;
      2) New Medicaid Enrolled hospital or facility Provider attached to a new contract within fifteen (15) Business Days after completing contract execution; and
      3) Change in existing contract terms within fifteen (15) Calendar Days of the effective date after the change.
   ii. Payment should be made on the next payment cycle following the requirement outlined above.
   iii. In no case shall a Provider be used as a PCP or loaded into the Provider directory during a timeframe in which the Provider cannot receive payment on the health plan's current payment cycle.

j. Network Provider Credentialing and Re-credentialing Policy
   i. The CFSP shall establish and follow written policies and procedures for Network Provider selection and retention in accordance with 42 C.F.R. § 438.12(a)(2). The CFSP shall apply these criteria consistently to all Providers. The CFSP shall develop and maintain a Network Provider Credentialing and Re-credentialing Policy as defined in *Section VII*. *Attachment L.5. CFSP Uniform Credentialing and Re-credentialing Policy.*
   ii. The CFSP shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) Calendar Days after the Contract Award.
   iii. The CFSP shall review and update the Credentialing and Re-credentialing Policy annually, with submission due on October 1st, to reflect changes to applicable federal and state laws, rules and regulations, Department or CFSP policies, procedures, bulletins, guidelines or manuals, or CFSP business processes as necessary.
   iv. The CFSP shall make updates outside of the annual review, if there are substantive updates or revisions that impact provider or CFSP business, as determined by the Department or CFSP. Updates outside of the annual review are not counted towards the annual review. Only those specific substantive updates or revisions will be reviewed by the Department outside of the annual review. The CFSP shall submit any significant changes to the CFSP's Credentialing and Re-credentialing Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.

k. Provider Disenrollment and Termination

i. The Department manages the Provider's status from the centralized enrollment and Credentialing platform, including the reason for the status assignment. The Provider's status is then reported on the daily Provider Enrollment File for the CFSP to take appropriate action when a status changes between active, suspension, termination, or reinstatement.

ii. Payment Suspension:
   1) The CFSP shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) Business Day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit Re-credentialing documentation to the Department or otherwise fail to meet Department requirements.
   2) The CFSP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) Calendar Days of suspension, the Department will terminate the provider from Medicaid.
   3) The CFSP shall not be liable for interests or penalties for payment suspension at Re-credentialing.
   4) The CFSP shall address payment suspension in its Provider Credentialing and Re-credentialing Policy.

iii. Termination as a Medicaid Provider by the Department:
   1) The CFSP shall remove any Provider from the CFSP Network, claims payment system, and terminate the Provider's contract consistent with the effective date provided by the Department with the Provider within one (1) Business Day of receipt of a notice from the Department that the Provider is terminated as a Medicaid Provider. This applies to all Providers regardless of the Provider's Network status.
   2) If the CFSP suspended Provider payment, then upon notice by the Department that the Provider is terminated from Medicaid, the CFSP shall release applicable claims and deny payment.

iv. CFSP Provider Termination:
   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.
   2) The CFSP shall comply with the PI Provider Termination Requirements outlined in *Section V.K.2. Program Integrity*.
   3) The CFSP must provide written notice to the Provider of the decision to terminate to the Provider. The notice, at a minimum, must include:
      a) The reason for the CFSP's decision;
      b) The effective date of termination;
      c) The Provider's right to appeal the decision; and
      d) How to request an appeal.
   4) The CFSP shall report data to the Department on the number of providers terminated by provider type in a format dictated by the Department.

l. Member Notice of Provider Disenrollment/Termination

i. The CFSP shall notify each Member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated Provider, of the Provider's termination from the Network. The CFSP shall:

1) Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the Provider by the CFSP, consistent with 42 C.F.R. 438.10(f)(1);
2) Include in the notice information about selecting or being auto-assigned a new PCP*;*
3) Describe the CFSP's efforts to support transition of care for the Member to the new Provider; and
4) If the terminated Provider was a specialist, assist impacted Members with transition of care*.*

m. Provider Directory
   i. The CFSP shall develop a consumer-facing Provider directory of all Network Providers including the required information for all contracted Providers.
      1) Notwithstanding *Section V.E.2.m.i.*, the CFSP may use best practices to exclude a Network Provider from the consumer-facing directories if the CFSP includes in a Provider Directory Policy, or other policy as appropriate, an explanation of the process and rules used by the CFSP when deciding whether to include a Provider in a consumer-facing directory.
      2) The CFSP shall provide the Provider Directory Policy, or other policy as appropriate, to the Department for review at the request of the Department.
      3) As used in this section, best practices specifically include, but are not limited to:
         a) A Provider opts out of being in the directory, such as when the Provider is not open to the general public (e.g., a student health center open only to students of the educational organization).
         b) A Provider cannot traditionally be contacted directly for making appointments, such as facility-based Providers like anesthesiologists or radiologists.
         c) Provider is otherwise outside the scope of what would normally be included in a Provider Directory, such as a Value-Added Service.
   ii. The Provider directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by the Department.
   iii. The CFSP shall ensure that the Provider directory:
      1) Be in a format that is machine-readable and readily accessible;
      2) Is placed in a location on the CFSP's website that is prominent and readily accessible by Members;
      3) Includes accurate and updated Provider information consistent with Contract requirements;
      4) Is provided in an electronic form which can be electronically retained and printed; and
      5) Is available in paper form without charge upon Member request and if requested, is provided within five (5) Business Days.
   iv. In accordance with 42 C.F.R. § 438.10(h)(3):
      1) The CFSP shall update the paper directory at least quarterly, if the CFSP has a mobile-enabled, electronic Provider directory, or monthly, if the CFSP does not have a mobile-enabled, electronic Provider directory. The paper directory shall clearly identify the date of the update.
      2) The CFSP shall update the electronic version of the Provider directory no later than thirty (30) Calendar Days after the CFSP receives updated Provider information and clearly identify the date of the update.
   v. The CFSP shall provide Department with a copy of both the electronic and paper versions of the Provider directory as follows:

1) At the request of the Department during the Readiness Review;
2) Annually; and
3) Any time there has been a significant change in CFSP operations that impacts the content of the Provider directory.

vi. All consumer-facing Provider directories must comply with 42 C.F.R. § 438.10(h)(1) and shall include the following information, at a minimum:
1) Department provided data elements from the Department:
a) Provider name;
b) Provider demographics (first, middle, and last name, gender);
c) Providers 3-digit Location Code;
d) Provider DBA Name;
e) Provider Service Location Name;
f) Provider mailing address;
g) Provider type (PCP, etc.);
h) Provider type effective date;
i) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
j) Street address(as) of service location(s);
k) County(ies) of service location(s);
l) Telephone number(s) at each location;
m) After hours telephone number(s) at each location;
n) Website URL;
o) Provider specialty (Taxonomy Codes) by location;
p) Whether Provider is accepting new beneficiaries;
q) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by Provider or a skilled medical interpreter at Provider's office;
r) Whether provider has completed cultural competency training, including description of training;
s) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
t) A telephone number at the CFSP where a Member can call to confirm the information in the directory;
u) Excluded provider indicator;
v) Essential provider indicator;
w) IHCP indicator; and
x) Contract start/end date.
2) Additional Provider information collected during contracting:
a) Populations served by the Provider, including whether a BH Provider is serving children and adolescents;
b) Whether Provider has completed Trauma-Informed Care training; and
c) Treatment modalities that the Provider is certified to provide (e.g., individual therapy, group therapy).

vii. In no case shall a Provider be loaded into the Provider directory which cannot receive payment on the CFSP's current payment cycle. This provision does not apply to providers suspended by the Department. If the CFSP is made aware of Providers included in its CFSP Network File that are not actively enrolled in NC Medicaid, the CFSP shall remove the Provider from the CFSP consumer-facing electronic directory within one (1) Business Day of notification from the Department.

viii. For purposes of CFSP's consumer-facing Provider directories referenced in *Section V.E.2.m.i.*, the directories shall include, at a minimum, all of the fields listed in *Section V.E.2.m.vi.1.*

except for *subsections c., f., h., s., of Section V.e.2.m.vi.1.* For purposes of *Section V.E.2.m.vi.1.n.*, consumer-facing directories shall include the description of the respective Provider specialty by location in place of the taxonomy code.

3. Provider Relations and Engagement

a. Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to Members. The Department seeks a CFSP that will engage and support Providers through a call center and Provider web portal as well as provide training and education on the Medicaid program and their rights within the program.

b. Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
   i. The CFSP shall operate a Provider Relations function that includes a Provider Support Service Line consistent with the applicable standards found in *Section V.H. Program Operations.*
   ii. Be staffed with personnel specifically trained on the requirements, policies and procedures of the CFSP operating in North Carolina and are able to respond to all areas within the Provider Manual, including resolving claims payment inquires, in "one-touch."
   iii. The CFSP shall provide and maintain a Provider web portal that provides access to program and Provider specific information as defined by the Contract. The Provider web portal may include access to the Provider Manual.
   iv. The CFSP shall send a Provider Welcome Packet and enrollment notice to Providers within five (5) Business 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.
   v. The CFSP shall develop and maintain a Provider Support Plan as described in *Section V.F.1. Quality Management and Quality Improvement* and make it available to the Department upon request.

c. Provider Education and Training
   i. The CFSP shall provide education, specific to the Medicaid Managed Care requirements, policies, including the Department's Managed Care Provider Billing Guide, and procedures, training and technical assistance on all CFSP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network Providers.
   ii. The CFSP shall communicate with Network Providers, or include in its training and technical assistance, information as requested by the Department.
   iii. The CFSP shall provide training to network Providers within thirty (30) Calendar Days of Provider joining the Network. Additional training will be provided as determined by the CFSP and as requested by the Department.
   iv. The CFSP shall make training materials available on the Provider web portal as determined appropriate by CFSP and upon request by Network Providers or the Department.
   v. The CFSP shall develop a Provider Training Plan that outlines training topics and dates. The CFSP Provider Training Plan shall reference and acknowledge the broader role the CFSP has in supporting Department initiatives. Training must include:
      1) EPSDT, annually, where relevant to the Providers' area of practice;
      2) CFSP prevention and population health management programs;
      3) Into the Mouth of Babes (IMB) program training (required before being permitted to receive reimbursement for IMB program);
      4) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices,

particularly for Members receiving care in the home or community settings, or as Members transition across care settings;

5) Principles of Trauma-Informed Care for Members with ACEs and other unique needs of and supports for children, youth and families served by the child welfare system, including relevant DSS protocols, forms, and required comprehensive evaluations, and AAP Health Care Standards for children in Foster Care;
6) Use of dyadic therapy as a Medicaid covered service, including but not limited to models such as Child Parent Psychotherapy and Parent Child Interaction Therapy, where relevant to the Providers' area of practice;
7) SUD;
8) Needs of LGBTQ+;
9) Service accommodations for Members with co-occurring mental health and I/DD needs;
10) Principles of the SOC framework as described in *Section V.D.6. System of Care*; and
11) Any other training topics required under this Contract.

vi. The CFSP shall submit the Provider Training Plan to the Department as follows:
1) Upon award of the Contract;
2) When material changes are made to the Provider Training Plan; and
3) Annually.

vii. The Provider Training Plan must also identify how the CFSP's provider training approach, as outlined in the Provider Training Plan, will address health disparities and incorporate health equity in support of the Department's health equity goals.

d. Provider Manual

i. The CFSP shall develop, maintain, and distribute a Provider Manual that offers information and education to Providers about the CFSP and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:
1) Clinical practice standards and UM Program;
2) Covered services, additional benefits and carved-out services;
3) Provider responsibilities;
4) PCP responsibilities;
5) Network requirements, including nondiscrimination, on-call coverage, Credentialing, Re-credentialing, access requirements, no-reject requirements, notification of changes in address, and required availability;
6) Telehealth, Virtual Communications and Remote Patient Monitoring;
7) Network adequacy and access standards;
8) Billing, claim editing, SNIP editing and clearinghouse requirements;
9) Cultural and Linguistic Competency and accessibility requirements;
10) Authorization, utilization review, and Care Management requirements;
11) Care Coordination and discharge planning requirements;
12) Department-required documentation requirements;
13) Provider appeals and grievance process;
14) Complaint or Grievance investigation and resolution procedures;
15) Notification of the availability of the Department's Provider Ombudsman service where a Provider may submit a complaint about the CFSP. The manual shall include instructions on how to submit the complaint;
16) Performance improvement procedures including Member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;

17) Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
18) Interest and penalty provisions for late or under-payment by the CFSP;
19) North Carolina Medicaid payer of last resort requirements;
20) Member rights and responsibilities;
21) Member cost sharing requirements;
22) Provider PI requirements that address how to report suspected fraud, waste and abuse, and compliance other federal and state requirements; and
23) Disaster and emergency relief planning and response in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease.

ii. The CFSP shall also include in the Provider Manual Providers' obligations to:
1) Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
2) Monitor and report on Provider preventable conditions;
3) Retain patient records for the mandated period;
4) Ensure that all documentation regarding services provided is timely, accurate, and complete;
5) Ensure the CFSP is the payer of last resort; and
6) To report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment.

iii. The CFSP shall include standardized language in the Provider Manual as requested by the Department.

iv. The CFSP shall submit the Provider Manual to the Department for approval thirty (30) Calendar Days after Contract Award. The CFSP shall not use or distribute the Provider Manual prior to approval by the Department.

v. The CFSP shall review and update the Provider Manual annually, with submission due on July 1st, or upon request of the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or CFSP policies, procedures, bulletins, guidelines or manuals, or CFSP business processes as necessary. Within the Provider Manual, the CFSP shall track and maintain a list of revisions made to manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.

vi. If there are substantive updates or revisions that impact Provider or CFSP business, as determined by the Department or CFSP, the CFSP may update the Provider manual once per quarter in addition to the annual update. Unless directed by the Department, the CFSP shall not update the Provider manual more than once per quarter during the Contract Year. Submissions by the CFSP of its Provider manual during the Contract Year to the Department, as allowed in this section, shall not be construed by the CFSP to replace or eliminate the requirement to annually review and update the Provider manual in accordance with this section.

vii. When seeking review and approval of the Provider Manual, the CFSP shall submit the Provider Manual to Department for approval within fifteen (15) Calendar Days of making substantive updates. The CFSP shall not post, print or enforce the updates until the CFSP has received approval from the Department.

viii. The CFSP shall have ten (10) Calendar Days to return an updated version of the Provider manual if any revisions are requested by the Department during the review and approval process.

ix. The CFSP shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) Calendar Days of notification or request by Department. Corrections or revisions to the printed version shall be included in the next printing.

x. The CFSP shall make the Provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the Provider web portal, and in writing upon request of a contracted Provider.

xi. The CFSP shall make the redline Provider Manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the Provider web portal only.

e. Provider Survey

i. The CFSP shall conduct ongoing quality assurance of its Provider relations staff via standardized Provider surveys and internal audits of departments to ensure Provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.

1) Provider surveys shall be made available after each web, call center or in-person interaction.

2) Surveys and internal audits are intended to measure Provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness.

3) Reports, including the results of Provider surveys and CFSP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.

4. Provider Payments

a. Provider payment requirements are established to comply with State law, encourage continued Provider participation in the Medicaid program to ensure Member access, and support safety net Providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of CFSP steerage to other Providers.

b. The CFSP shall support the Department in complying with all federal laws, state laws, State Plans, waivers, program integrity or audit requirements, investigations, findings or corrective action plans related to Provider payments.

c. The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.

d. Physician and Physician Extender Payments

i. The CFSP shall reimburse all in-Network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid FFS Fee Schedule rate or bundle, as set by the Department, unless the CFSP and Provider have mutually agreed to an alternative reimbursement arrangement.

ii. The CFSP shall reimburse all in-Network physicians and physician extenders providing obstetric services no less than one hundred percent (100%) of the Medicaid FFS rate for obstetrics services, which includes an enhanced rate on all vaginal deliveries (equal to the Medicaid FFS rate for caesarian deliveries) unless the CFSP and Provider have mutually agreed to an alternative reimbursement arrangement.
    1) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.
iii. The CFSP shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as outlined below in *Section V.E.4.l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).*
iv. The CFSP shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with NCGS § 58-50-26.
v. The CFSP shall reimburse all out-of-Network primary care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid FFS Fee Schedule rate or bundle, as set by the Department, unless the CFSP and Provider have mutually agreed to an alternative reimbursement arrangement.

e. Hospital Payments (Excluding Behavioral Health Claims)
i. The CFSP shall reimburse all in-Network hospitals no less than the applicable Medicaid FFS rate specified below for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)) and utilize the applicable Medicaid FFS payment methodology, unless the CFSP and hospital have mutually agreed to an alternative reimbursement amount or methodology.
ii. The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid FFS reimbursement rate using the Medicaid FFS case weights and outlier methodology.
iii. The applicable rate floor and methodology for outpatient hospital services (excluding hospital outpatient laboratory services), including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.
    1) The applicable rate floor and methodology for in-network hospital outpatient laboratory services shall be 146.38% of the Medicaid FFS Laboratory fee schedule rate in effect on February 28, 2020, unless the CFSP and hospital have mutually agreed to an alternative reimbursement amount or methodology.
    2) The CFSP shall apply the following exceptions to the rate floor and methodology for in-network hospital outpatient laboratory services:
        a) If the services are not part of the NC Medicaid Laboratory Fee schedule, outpatient hospital reimbursement shall be one hundred percent (100%) of billed charges multiplied by the Ratio of Cost to Charges (RCC) when calculating the reimbursement rate; and
        b) COVID-19 Vaccine Administration and COVID-19 Testing reimbursement shall be based on the NC Medicaid published state-wide rate.
iv. The hospital rate floors shall apply for the following defined time periods, after which the CFSP will have flexibility to negotiate reimbursement arrangements with the hospitals:
    1) The first five (5) Contract Years for critical access hospitals and hospitals in economically depressed counties, defined as counties designated in November 2022 as Tier 1 or Tier 2 by the North Carolina Department of Commerce; and
    2) The first two (2) Contract Years for all other hospitals.

v. The CFSP shall make additional, utilization-based, directed payments to in-Network hospitals owned by UNC Health Care or Vidant Medical Center as described in *Section V.E.4.l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).*

vi. The Department shall reimburse hospitals directly for any graduate medical education payments due under the State Plan (as allowed under 42 C.F.R. § 438.60).

vii. The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments.

viii. The CFSP shall not use the Outpatient Prospective Payment System (OPPS) to reimburse institutional hospital outpatient claims including lab and drug claims.

f. Hospital Payments for BH Claims

i. The CFSP shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims to be defined by the Department.

g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments

i. The CFSP shall reimburse FQHCs and RHCs for covered services at no less than the following rates:

1) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.

2) All core services shall be based on each FQHC or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.

ii. The CFSP shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by the Department on a schedule to be defined by the Department.

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

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

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

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

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

h. IHCP Payments
   i. In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the CFSP shall reimburse IHCPs as follows:
      1) Those that are not enrolled as an FQHC, regardless of whether they participate in the CFSP's Network:
         a) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
         b) The Medicaid FFS rate for services that do not have an applicable encounter rate.
      2) Those that are enrolled as FQHCs, but do not participate in the CFSP's Network, an amount equal to the amount the CFSP would pay a network FQHC that is not an IHCP.
      3) The CFSP shall reimburse IHCPs for Pharmacy Claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan.
   ii. The CFSP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

i. Local Health Department (LHD) Payments
   i. The CFSP shall reimburse in-Network local health departments (LHDs) no lower than base rates specified in the North Carolina Medicaid Local Health Department Fee Schedule. The CFSP shall reimburse the LHDs in accordance with this schedule for EPSDT well child exams, low-risk family planning and obstetrical services or STD exams provided by enhanced role nurses.
   ii. For Contract Year 1, the CFSP shall pay in-network LHDs for CMHRP Women services an amount substantially similar to or no less than the amount paid in NC Medicaid Direct prior to the start of the CFSP contract ($4.96 PMPM for all enrolled women, ages 14 to 26).
   iii. The CFSP shall negotiate base reimbursement amounts to in-network LHDs that are no lower than rates paid to non-public Providers for similar services.
   iv. In addition to base reimbursements, the CFSP shall make additional, utilization-based, directed payments to in-Network LHDs as defined by the Department and as outlined below in *Section V.E.4.l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.
   v. The CFSP shall reimburse in-Network LHDs providing lab services, as defined by the Department's Laboratory fee schedule, at no less than one hundred percent (100%) of the Medicare fee schedule (as allowed under 42 C.F.R. § 438.6(c)), unless the CFSP and local health department have mutually agreed to an alternative reimbursement arrangement.

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

k. State Owned and Operated Facilities Payments
   i. The CFSP shall reimburse facilities that are state-owned and operated by DSOHF according to the rates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).
   ii. At such time that the CFSP is required to cover services provided by Veterans Homes operated by the Department of Military and Veterans Affairs (DMVA), the CFSP shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).

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

i. The CFSP shall make additional directed payments as prescribed by the Department and approved by CMS, to certain in-network providers described in this *Section V.E.4.l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)).*

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

iii. The CFSP shall determine a due date for Providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.

iv. The CFSP shall be financially obligated to pay the additional directed payments to the applicable Providers within five (5) Business Days of receiving the payment from the State.

v. The CFSP shall submit the data to substantiate additional directed payments to the Department and each applicable Provider quarterly in a format to be defined by the Department.

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

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

viii. Interest and Penalties

1) The CFSP shall pay interest on late directed payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid as specified in the Contract.

2) In addition to the interest on late directed payments required by this section, the CFSP shall pay the Provider a penalty equal to one percent (1%) of the directed payment for each Calendar Day following the date that the directed payment should have been paid as specified in the Contract.

ix. For Directed Payments for Local Health Departments (LHDs):

1) The Department will establish a cost-to-charge ratio for each LHD that will be used to determine a minimum fee schedule;

2) The Department will adjust each LHD's cost-to-charge ratio annually by Medicare Economic Index (MEI) and any change to the LHD's chargemaster to assure that annual per-unit payment growth rate does not exceed the MEI;

3) The Department will use LHD submitted charges and the established cost-to-charge ratio to develop the uniform dollar or percentage increase;

4) The Department will calculate the directed payment amount to the CFSP on a quarterly basis as the difference between the rate paid to the LHDs by the CFSP and the minimum fee schedule amount determined by the State multiplied by the LHD claims; and

5) The Department will perform an annual verification of the LHD directed payments based on CFSP encounter data submitted to the State to assure all claims data has been properly captured and calculated for directed payments.

x. For Directed Payment for Faculty Physicians Affiliated with the Teaching Hospitals for each University of North Carolina Medical School, and Hospitals Owned by UNC Health Care or Vidant Medical Center:

1) The Department will establish a uniform dollar increase annually at the average commercial rate for certain eligible medical professionals as defined in the Medicaid State Plan, Attachment 4.19-B, Section 5, Page 2, Subsection (c)(2);

2) The Department will calculate the directed payment amount to the CFSP on a quarterly basis as the difference between the rate paid to the eligible medical professionals and the average commercial rate determined by the Department multiplied by the actual utilization for the eligible professionals;

3) The Department will establish an annual aggregate cap for total eligible medical professional directed payments pursuant to State Law; and
4) The Department will perform an annual verification of the eligible medical professional directed payments based on CFSP encounter data submitted to the Department to assure all claims data has been properly captured and calculated for directed payments and to assure compliance with aggregate annual payment cap.

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

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

m. Nursing Facility Payments
i. The CFSP shall reimburse in-network nursing facilities (excluding those owned and operated by the State) ninety-five percent (95%) of the facilities' adjusted Medicare rate for the first twenty (20) Calendar Days of a Member's nursing facility stay and eighty percent (80%) of the facility's adjusted Medicare rate for the remainder of a Member's nursing facility stay, unless the CFSP and provider have mutually agreed to an alternative reimbursement arrangement.

n. Hospice Payments
i. The CFSP shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:
1) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year); and
2) For hospice services provided to Members residing in nursing facilities, the CFSP shall reimburse the hospice provider:
a) Hospice rate; and
b) Ninety-five percent (95%) of the Medicaid FFS nursing home room and board rate in effect at the time of service.

o. Pharmacy Payments

i. The CFSP shall adhere to the pharmacy claims payments requirements as described in *Section V.C.3. Pharmacy Benefits.*

p. Payments of Medical Home Fees to AMH
   i. In addition to the payment for services provided, the CFSP shall pay all AMH practices a Medical Home Fee. "AMH practices" means all practices participating in the AMH program for the purposes of contracting with Standard Plans, BH I/DD Tailored Plans, and the CFSP, including, but not limited to, AMH practices also certified as AMH+ practices.
   ii. The CFSP shall pay Medical Home Fees to AMH Tiers 2 – 3 practices for any month in which the CFSP Member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 2 –3 practices may be prorated for partial months and shall be no less than the $ 5 PMPM for Tier 2 and 3 practices (the enhanced PMPM relative to the Standard Plan and BH I/DD Tailored Plan Medical Home Fee is intended to compensate practices for additional medical home requirements that apply to AMHs only for CFSP Members, as described in *Section VII. Attachment L.2. CFSP Advanced Medical Home Program Policy*.
   iii. In Contract Years 1 and 2, the CFSP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:
      1) The CFSP shall design Tier 3 Performance Incentive Payments to be in addition to Medical Home Fees (i.e., the CFSP shall not place all or part of the Medical Home Fees at risk based on performance);
      2) The CFSP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMH Tier 3; and
      3) The CFSP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set, once finalized.

q. Payment Limitations
   i. Upon request by the Department, the CFSP shall submit information on payments to related Providers and Subcontractors and provide a demonstration of how payment levels for related Providers and Subcontractors are not more than equivalent payment levels for non-related Providers and Subcontractors in cases where there are Value-Based Payment arrangements in place.

r. Out-of-Network Provider Payments (Excluding Primary Care Services, Emergency Services and Post-Stabilization Care Services)
   i. With the exception of Out-of-Network primary care services, emergency services, Post-stabilization Care Services and services provided during transitions in coverage, the CFSP shall be prohibited from reimbursing an out-of-Network Provider more than ninety percent (90%) of the Medicaid FFS rate if the CFSP has made a good faith effort to contract with a Provider but the Provider has refused that contract.
   ii. The CFSP shall develop a Good Faith Provider Contracting Policy that includes a description of how the CFSP will conclude that a "good faith" contracting effort has been made and/or refused. The CFSP shall submit the policy to the Department for review ninety (90) Calendar Days after Contract Award.
      1) The CFSP shall consider all facts and circumstances surrounding a Provider's willingness to contract before determining that the Provider has refused the CFSP's "good faith" contracting effort.
      2) The CFSP shall include in its Good Faith Provider Contracting Policy a description of the outreach program to providers that the CFSP, and its subcontractors as applicable, will utilize when leveraging one of the CFSP's existing Medicaid program's Networks to build a new program's Network.

iii. The CFSP shall reimburse an Out-f-Network Provider who is providing services to a Member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid FFS rate.

iv. Unless an agreement has been negotiated, the CFSP shall reimburse an Out-of-Network Provider at one hundred percent (100%) of the Medicaid FFS rate when the CFSP has not made a "good faith" effort to contract with the Provider in accordance with the CFSP's Good Faith Provider Contracting Policy.

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

1) Are more reasonably available than can be provided by an in-state Network Provider; or
2) The care and services are provided in any one of the following situations:
   a) In response to an Emergency Medical Condition;
   b) The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or
   c) The health of the Member would be endangered if travel were undertaken to return to North Carolina.

vi. In accordance with 42 C.F.R. § 438.206(b)(5), the CFSP shall coordinate payment with the Out-of-Network Provider to ensure that the cost to the Member is no greater than it would be if services were provided within the Network.

s. Out-of-Network Emergency Services and Post-Stabilization Services Payments

i. In accordance with 42 C.F.R. § 438.114, the CFSP shall be subject to the following requirements:

1) The CFSP shall cover and pay for emergency services without regard to prior authorization or whether the Provider that furnishes the service has a contract with the CFSP;
2) The CFSP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the CFSP to seek emergency services;
3) Likewise, the CFSP shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient; and
4) The CFSP shall provide coverage and payment of services until the attending emergency physician, or the Provider actually treating the Member, determines that the Member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the Provider actually treating the Member, of when the Member is sufficiently stabilized for transfer or discharge is binding on the CFSP.

ii. In accordance with SSA 1932(b)(2)(D), the CFSP shall pay Out-of-Network Providers who provide emergency services or post-stabilization services to a Member no more than the applicable Medicaid FFS rates.

iii. The CFSP shall reimburse out-of-state hospitals that are also Out-of-Network for emergency and post-stabilization care services according to the applicable Medicaid FFS rates.

iv. In accordance with 42 C.F.R. § 422.113(c), the CFSP shall be subject to following requirements:

1) The CFSP shall be required to reimburse for Out-of-Network post-stabilization care services that are pre-approved by a CFSP representative;
2) The CFSP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain the Member's stabilized condition

within one (1) hour of a request to the CFSP for pre-approval of further post-stabilization care services;

3) Additionally, the CFSP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the Member's stabilized condition in the following instances:
   a) If the CFSP cannot be contacted;
   b) If the CFSP does not respond to request for pre-approval within one (1) hour;
   c) If the CFSP representative and the treating physician cannot reach an agreement concerning the Member's care and a CFSP physician is not available for consultation; or
   d) If the CFSP representative and treating physician cannot reach an agreement concerning the Member's care and a CFSP physician is not available for consultation, the CFSP shall give the treating physician the opportunity to consult with a CFSP physician and the treating physician may continue with the care of the Member until the CFSP physician is reached or one of the other post-stabilization care services criteria is met.
4) The CFSP shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:
   a) Once a Network physician with privileges at the treating hospital assumes responsibility for the Member's care;
   b) Once a Network physician assumes responsibility for the Member's care through transfer;
   c) Once a CFSP representative and the treating physician reach an agreement regarding the Member's care; and
   d) Once the Member is discharged.
5) The CFSP shall limit charges to Members for post-stabilization care services to an amount no greater than what the CFSP would charge the Member if he or she obtained the services through the CFSP In-Network Provider.

t. North Carolina State Laboratory of Public Health
   i. For Contract Year 1, in instances where a LHD submits a communicable disease test, as defined by the Department, to the North Carolina State Laboratory of Public Health, the CFSP shall reimburse the North Carolina State Laboratory of Public Health according to applicable North Carolina Medicaid Fee-For-Service Fee Schedule, unless the CFSP and North Carolina State Laboratory of Public Health have mutually agreed to an alternative reimbursement arrangement.

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

v. Payment for Crisis Providers
   i. The CFSP shall reimburse in-network Providers for mobile crisis services and facility based crisis services no less than the Department's Enhanced BH Fee Schedule unless the CFSP and Provider have mutually agreed to an alternative reimbursement arrangement.

w. Payments for COVID Vaccines Administration and Testing
   i. The CFSP shall reimburse Providers based on Department's NC Medicaid Direct rates for COVID-19 Vaccine Administration and COVID-19 testing.

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

y. HCBS Direct Care Worker Wage
   i. The CFSP shall increase reimbursement rates to eligible HCBS providers for eligible services by amounts no less than the amounts prescribed by the Department.
      1) Reimbursement increases for State Plan services shall be no less than the per unit reimbursement increases in the North Carolina Medicaid Fee-For-Service Fee Schedule.
      2) Reimbursement increases for approved in-lieu of services shall be no less than the per unit reimbursement increases communicated through Medicaid provider bulletins.
   ii. The Department shall maintain and share with the CFSP a list of HCBS services and codes that the rate increase will apply to through the PCDU and the NCDHHS Website.
   iii. The CFSP shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to provider eligibility for enhanced reimbursement.
   iv. The CFSP shall communicate to contracted providers that the reimbursement increase is contingent on eligibility for HCBS Direct Care Worker wage-related reimbursement increases maintained by the Department.

z. Private Duty Nursing Increase
   i. The CFSP shall reimburse eligible providers for private duty nursing services no less than the North Carolina Medicaid Fee-For-Service Fee Schedule as allowed under 42 C.F.R § 438.6(c)(1)(iii)(A).

aa. EVV System
   i. The CFSP shall increase reimbursement to Home Health Care Services (HHCS) providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate.
   ii. The CFSP shall increase reimbursement to Home Health Care Services (HHCS) providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic:
      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.

bb. Healthy Opportunities Pilot Payments
   i. General Information

1) If the CFSP covers a Healthy Opportunities Pilot region, the CFSP shall receive, separate from capitation payments, the following funds from the Department to use for the Healthy Opportunities Pilots, subject to availability of State funds:
    a) Capped allocation which includes funding for two (2) payments types:
        i) Healthy Opportunities Pilot service delivery payments; and
        ii) Healthy Opportunities Pilot administrative payments.
    b) Healthy Opportunities Pilot care management payments for "Care management Team" that are delegated from the CFSP to an entity in the community, as appropriate.
2) The CFSP shall participate in the reconciliation of actual Healthy Opportunities Pilot spending against Healthy Opportunities Pilot payments received from the Department. The CFSP shall be required to return all unused Healthy Opportunities Pilot funds to the Department at the end of the Healthy Opportunities Pilot program in accordance with the Department's forthcoming Healthy Opportunities Pilot Payment Protocol: CFSP.

ii. Capped Allocation

1) The Department will set an initial capped allocation amount for each Pilot Service Delivery Period as defined in the Department's forthcoming Healthy Opportunities Pilot Payment Protocol: CFSP.
2) The Department will notify the CFSP of its capped allocation amount, including the amounts for Healthy Opportunities Pilot service delivery payments and Healthy Opportunities Pilot administrative payments, at least thirty (30) Calendar Days prior to the start of each Pilot Service Delivery Period.
3) The Department reserves the right to adjust The CFSP's capped allocation during the Healthy Opportunities Pilot service delivery year based on actual spending on Healthy Opportunities Pilot services or due to significant changes to enrollment from that assumed in the allocation formula {e.g., if the Department determines the CFSP is at significant risk of not expending the eighty percent (80%) of its allocation within the Healthy Opportunities Pilot service delivery year}.
    a) Before adjusting the CFSP's capped allocation, the Department will inform Contractor within sixty (60) Calendar Days that it is at risk of an adjustment and allow Contractor to submit a report explaining its anticipated spending through the remainder of the Healthy Opportunities Pilot service delivery year for the Department's consideration. The Contractor shall submit this report within ten (10) Calendar Days of being informed by the Department that is at risk of an adjustment.
4) Healthy Opportunities Pilot Service Delivery Payments
    a) The Department shall distribute monthly, payments to the CFSP from the Healthy Opportunities Pilot service delivery payment component of its capped allocation.
    b) The Department shall distribute the first payment, equivalent to one-twelfth ($1/12^{th}$) of the Contractor's Capped Allocation, at least thirty (30) Calendar Days prior to the Pilot Service Delivery Period.
    c) The Department shall, monthly, distribute further Service Delivery payments to the Contractor based on fund utilization in a method and total amount to be determined by the Department, as outlined in the forthcoming Healthy Opportunities Payment Protocol: CFSP.
5) Healthy Opportunities Pilot Administrative Payments
    a) The Department shall distribute as part of CFSP's capped allocation Healthy Opportunities Pilot administrative payments for the CFSP to retain to cover administrative costs associated with Healthy Opportunities Pilot operations.

b) The Department shall determine the amount of the CFSP's Healthy Opportunities Pilot administrative payments.
c) The Department shall distribute the Healthy Opportunities Pilot administrative payment for each Pilot Service Delivery Period at a frequency as defined in the Department's forthcoming Healthy Opportunities Pilot Payment Protocol: CFSP.

iii. HSO Payments for Healthy Opportunities Pilot Service Invoices

1) The CFSP shall:

a) Authorize and reimburse for Healthy Opportunities Pilot services in all Healthy Opportunities Pilot domains (housing, food, transportation and interpersonal/toxic stress);
b) Use the Healthy Opportunities Pilot service delivery payment component of its capped allocation to make payments directly to HSOs for the delivery of authorized Healthy Opportunities Pilot services to Healthy Opportunities Pilot enrollees in accordance with the Healthy Opportunities Pilot fee schedule developed by the Department;
c) Not negotiate rates in the Healthy Opportunities Pilot Service fee schedule;
d) Not contract directly with HSOs for the purposes of Healthy Opportunities Pilot service delivery payments, unless directed by the Department to do so. The CFSP shall make payments to HSOs under the terms of the CFSP-Network Lead Model Contract developed by the Department;
e) Leverage North Carolina's Medicaid Management Information System (or future MES) and collaborate with each contracted Network Lead to ensure HSOs are set up to receive payments from the CFSP, including, at a minimum, developing guidance for HSOs explaining necessary steps to take to receive payments; and
f) At a minimum, include the following information on the Remittance Advice (RA) to the HSOs:
    i) Invoice ID: This shall be identical to the field Invoice_Short_ID from NCCARE360 and be provided for all applicable invoices included in a particular payment made to an HSO;
    ii) Actual dollar amount: This shall include the actual amount paid for each invoice processed on the payment; and
    iii) Date: This shall reflect the date the payment was made to the HSO.

2) Payment Reference Number Invoice Requirements

a) The CFSP shall ingest invoices from NCCARE360 for Healthy Opportunities Pilot services delivered by the HSO that were previously authorized by the CFSP and take one of the following actions:
    i) If the invoice is accurate and the service(s) was authorized by the CFSP:
        (1) The CFSP shall send an invoice response file to NCCARE360 to approve or deny the invoice within thirty (30) Calendar Days of receipt of the invoice from NCCARE360; and
        (2) If approved, within thirty (30) Calendar Days of the date of approval of the invoice, the CFSP shall effectuate payment, via check or direct deposit, to the HSO and send an invoice response file to NCCARE360 that includes the amount paid to the HSO.
    ii) If the invoice is inaccurate or invalid, the CFSP shall send an invoice response file to NCCARE360 with an explanation of the basis for denial within thirty (30) Calendar Days of receipt of the invoice from NCCARE360.

b) The CFSP shall process invoices from NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 837 Invoice File(s) Companion Guide.

c) The CFSP shall send invoice response file back to NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 837 Invoice File(s) Companion Guide.

d) In the event that a CFSP authorized a Healthy Opportunities Pilot service, CFSP shall not deny an invoice from an HSO on the basis of having subsequently retracted such authorization after the Healthy Opportunities Pilot service has been provided by an HSO.

e) The CFSP shall pay the HSO in the event of a payment error that requires initial, corrected or additional payment.

iv. Healthy Opportunities Pilot Care Management Payments

1) The CFSP shall use care management funds from the Department to make Healthy Opportunities Pilot care management payments to "Care Management Team", as applicable and in accordance with detailed guidance from the Department. These payments will support "Care Management Team" for Healthy Opportunities Pilot-related care management activities that are above and beyond care management activities expected for non-Healthy Opportunities Pilot enrollees.

cc. Payments under Locum Tenens Arrangements

i. The CFSP shall recognize locum tenens arrangements as provided in NCGS § 58-3-231 to the extent that the locum tenens Providers are a Medicaid enrolled Provider in accordance with 45 C.F.R. § 455.410(b).

ii. The CFSP shall establish and maintain a Locum Tenens Policy to comply with the requirements of NCGS § 58-3-231(b) and (c) and shall submit the Policy to the Department for review ninety (90) Calendar Days after Contract Award.

dd. The CFSP shall develop and maintain a Reimbursement Policy consistent with NCGS § 58-3-227(a)(5). The CFSP shall provide the Policy to the Department upon request, for review. The CFSP shall monitor the Department website and other Department communication mechanisms daily for changes to the Medicaid FFS rates to ensure compliance with the Provider payment requirements herein. For Provider payment requirements that refer to Medicaid FFS rates:

i. The CFSP shall make retroactive payment adjustments to the effective date of the Medicaid FFS rate change as prescribed by the Department; and

ii. The CFSP shall implement applicable rate changes within timelines prescribed by the Department. Payments made to Providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable Provider.

ee. Provider Hardship Payments

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

ii. The CFSP shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval by ninety (90) Calendar Days after Contract Award. The Provider Hardship Payment Policy shall include:

1) Method for Providers to submit Hardship Payment requests;

2) Description of timeline for payment for standard and urgent requests, including integration into check write schedule;

3) Criteria for requests to be reviewed and approved by the CFSP; and

4) Description of how Providers and the Department will be notified of status of the request and payment, if applicable.

iii. The CFSP shall recoup Hardship Payments by offsetting the Provider's future claim payments or through a one-time repayment by the Provider.

5. Provider Grievances and Appeals

a. The CFSP shall handle Provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The CFSP shall have in place a Provider appeals and grievance system, distinct from that offered to Members, that includes a grievance process for Providers to bring issues to the CFSP, an appeals process for Providers to challenge certain CFSP decisions, and information regarding access to a state level review through the North Carolina Office of Administrative Hearings. The CFSP shall be transparent with Providers regarding its appeals and grievance processes and procedures.

b. The CFSP shall submit the CFSP Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) Calendar Days after Contract Award. The CFSP shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.

c. The CFSP shall have a process to and staff capable of reviewing Provider Grievance and Appeal outcomes to identify trends, review existing operational or clinical opportunities to improve the Provider experience.

d. The CFSP shall not discriminate against or retaliate against any Provider based on any action taken by the Provider under Provider Grievances and Appeals Section of the Contract (*Section V.E.5.*) or under Member Grievances and Appeals Section of the Contract (*Section V.B.7*) taken on behalf of a Member.

e. Grievances

i. The CFSP shall have a process in place to receive and resolve grievances with Providers where remedial action is not requested. Grievances must be resolved in a timely manner.

ii. The CFSP shall accept and resolve Provider grievances regarding the CFSP referred from the Department.

iii. The CFSP shall have a method of allowing Providers to submit grievances through the CFSP Provider web portal.

iv. The CFSP shall provide information regarding Provider grievances in a form and frequency described in *Section VII. Attachment I. Reporting Requirements* and upon request.

f. Appeals

i. The CFSP shall offer Providers appeal rights as described in *Section VII. Attachment H. Provider Appeals*.

ii. The CFSP shall provide written notice of Provider's right to appeal with the notice of decision giving rise to the Provider's right to appeal.

iii. The CFSP shall have a method of allowing Providers to submit appeals through the CFSP Provider web portal.

iv. The CFSP shall accept a written request for an appeal from the Provider within thirty (30) Calendar Days on which:

1) Provider receives written notice from the CFSP of the decision giving rise to the right to appeal; or

2) CFSP should have taken a required action and failed to take such actions.

v. The CFSP shall acknowledge receipt of each appeal request within five (5) Calendar Days of receipt of the request.
vi. The CFSP shall extend the timeframe by thirty (30) Calendar Days for Providers to request an appeal for good-cause shown as determined by the CFSP.
1) The CFSP shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an appeal request.
2) The CFSP shall consider the voluminous nature of required evidence/supporting documentation as good-cause reasons to extend the timeframe.
vii. The CFSP shall provide information regarding Provider appeals to Department upon request.
viii. The CFSP Grievances and Appeals Policy shall provide that a Provider must exhaust the CFSP internal appeals process before seeking recourse under any other process permitted by contract or law.

g. Resolution of Appeal
i. The CFSP shall establish a committee to review and make decisions on Provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal.
ii. The CFSP shall provide written notice of decision of the appeal within thirty (30) Calendar Days of receiving a complete appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which all the evidence is submitted to the CFSP. Notice shall include information regarding further appeal rights, if any.
iii. The CFSP shall allow Providers to be represented by an attorney during the appeals process.

h. Appeals of Suspension or Withhold of Provider Payment
i. The CFSP shall limit the issue on appeal in cases of suspension or withhold or Provider payment to whether the CFSP had good-cause to commence the withhold or suspension of Provider payment. The CFSP shall not address whether the Provider has or has not committed fraud or abuse.
ii. The CFSP shall notify the Department within ten (10) Business Days of a suspension or withhold of Provider payment.
iii. The CFSP shall offer the Provider an in person or telephone hearing when Provider is appealing whether the CFSP has good cause to withhold or suspend payment to the Provider.
iv. The CFSP shall schedule the hearing and issue a written decision regarding whether the CFSP had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the Provider's appeal. Upon a finding that CFSP did not have good-cause to suspend or withhold payment, CFSP shall reinstate any payments that were withheld or suspended within five (5) Business Days.
v. The CFSP shall pay interest and penalties, as outlined in *Section V.I.1.d.iv. Interest and Penalties*, for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

i. Notice to Department
i. The CFSP shall provide notice to the Department of any Provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by the CFSP, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the appeal.
ii. The CFSP shall notify the Department if a Provider has sued the CFSP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.

j. The CFSP shall not discriminate against or retaliate against any Provider based on any action taken by the Provider as outlined in *Section V.E.5. Provider Grievances and Appeals* or based on any action taken by the Provider on behalf of a Member as outlined in *Section V.B.7. Member Grievances and Appeals*.

k. HSO Grievances related to the Healthy Opportunities Pilot
   i. The CFSP shall allow an HSO to file a grievance related to Healthy Opportunities Pilot Services with the CFSP or through the HSO's Network Lead.
   ii. Healthy Opportunities Pilot-related HSO grievances may include:
      1) HSO grievances related to Healthy Opportunities Pilot service payment, including:
         a) Payment disputes for denied Healthy Opportunities Pilot service invoices;
         b) Payment errors; and
         c) Overpayments or underpayments due to fraud, waste, or abuse.
   iii. The CFSP shall handle HSO grievances related to the Healthy Opportunities Pilot promptly, consistently, fairly, and in compliance with requirements in this section.
   iv. The CFSP shall submit a Healthy Opportunities Pilot Provider Grievance Policy to the Department for review and approval upon request.
   v. Notices
      1) The CFSP shall permit Healthy Opportunities Pilot-related HSO grievances to be filed with the CFSP or HSO's Network Lead within thirty (30) Calendar Days of the issue causing the grievance.
      2) The CFSP shall acknowledge receipt of each grievance with the HSO and Network Lead within five (5) Calendar Days of receipt of the grievance from the HSO or the HSO's Network Lead.
      3) The CFSP shall provide notice of the outcome of the grievance to the HSO and the HSO's Network Lead within thirty (30) Calendar Days of receiving a grievance.

F. Quality and Value

1. Quality Management and Quality Improvement

a. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. The Department intends to promote the highest quality of care for physical health, BH, I/DD, LTSS, and pharmacy services, and health-related resource needs and to promote integration among physical, BH, I/DD and TBI service Providers, County Child Welfare Workers, and other systems that interact with the population served by the child welfare system.

b. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. For the populations served by the CFSP, the Department emphasizes integration between care delivery for physical health needs and care delivery for BH needs, as well as care specific to the needs of individuals involved currently and formerly involved with the child welfare system.

c. The Department will work with the CFSP to develop a data-driven, outcomes-based continuous QI process. The QI process builds upon the Department's experience in NC Medicaid Direct and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes

equity through reduction or elimination of health disparities, and appropriately rewards the CFSP and, in turn, Providers for advancing quality goals and health outcomes.

d. The CFSP shall have a statewide IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures across care managers, different Provider types, and rural/urban areas. The CFSP shall engage with the Department and its designees to share quality data reported by the CFSP and receive quality data calculated by the CFSP or its designees.

e. The CFSP shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan, and comply with the quality management and quality improvement assurances and other requirements contained in North Carolina's federal Medicaid waivers (e.g., Section 1115 and other active waivers relevant to the CFSP).
   i. Quality Assessment and Performance Improvement (QAPI) Plan (42 C.F.R. § 438.330)
      1) The CFSP shall submit an annual QAPI Plan, delineating the CFSP's plans for performance improvement programs and other quality improvement efforts as part of the QAPI Plan.
      2) The CFSP shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
      3) The QAPI Plan shall include the following elements:
         a) Completion of Performance Improvement Projects (PIPs) specified by the Department;
         b) Collection and submission of all quality performance measurement data required by the Department;
         c) Mechanisms to detect underutilization, overutilization, and timely utilization of services, including but not limited to:
            i) Use of congregate care settings (both Medicaid-funded and non-Medicaid funded), including county-by-county and Member demographic-based monitoring;
            ii) Use of EDs (inclusive of lengths of stay) for behavioral (including BH) crises;
            iii) Out of home placements greater than thirty (30) miles/thirty (30) minutes (urban) or sixty (60) miles/sixty (60) minutes (rural) away from a Member's/family's home, including out of state placements;
            iv) Time to service initiation from request of service or determination of service need by a Provider;
            v) Lengths of stay in inappropriate settings while awaiting access to appropriate services;
            vi) Use of community/home-based services for youth in family foster care, Residential Treatment Services (Levels I-IV), and PRTF settings who have BH, I/DD and/or TBI diagnoses;
            vii) Use of evidence-based or best practice BH treatments, including but not limited to Trauma-Focused Cognitive Behavioral Therapy, Child Parent Psychotherapy, and Parent Child Interaction Therapy (PCIT); and
            viii) 30/60/180-day readmissions to congregate care settings and ED settings following discharge from any congregate care setting.
         d) Mechanisms to assess the quality and appropriateness of care for Members' special health care needs;
         e) Mechanisms to assess the quality, safety and appropriateness of care provided to Members in family-based (e.g., DSS-family, Level I, Level II-TFC) and congregate-

based placements (e.g., Level II-program, Level III, Level IV, PRTF), including assessment of care between settings/placements and a comparison of services and supports received with those set forth in the Member's treatment/service plan;

f) Mechanisms to assess the quality and appropriateness of care provided to Members who are Parents, Guardians, Custodians, and siblings of children/youth in Foster Care (e.g., SUD treatment services, dyadic therapy);

g) Mechanisms to assess for and a process for identifying interventions to reduce health and quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., those with physical/cognitive disabilities or those with Behavioral Health (BH) conditions), such as by leveraging findings from the disparity report that the CFSP is required to develop;

h) Mechanisms to incorporate population health programs targeted to improve outcome measures;

i) Mechanisms to assess the degree to which network Providers utilize evidence-based and other best practices;

j) Participation in efforts by the Department to prevent, detect, and remediate critical incidents including at PRTFs;

k) The CFSP's contributions to Unmet Health-Related Resource Needs that can support or align with broader improvement in particular health outcomes outlined in the Quality Strategy;

l) Mechanisms to assess and address health equity including access to CLAS and a diverse provider pool; and

m) Mechanisms to assess the level of engagement and collaboration between the CFSP and County DSS, including areas that are County DSS responsibilities and the CFSP is supporting (e.g., 7-day physical examination and 30-day comprehensive medical appointment).

4) The Quality Assessment and Improvement Program (QAPI) reporting shall also include Member Advisory Committee (MAC) activity, result summaries, and program assessments of the following:

a) Mechanisms to collect and assess feedback from the CFSP's Member Advisory Committee;

b) The CFSP's actions/initiative taken based on Member Advisory Committees feedback in alignment with improvement and appropriateness of care provided to Members;

c) Mechanisms to review member satisfaction and feedback on the member experience with CFSP responsiveness to member issues/comments/concerns; and

d) The CFSP shall submit an updated MAC roster of committee members when there are modifications made to the MAC representatives. This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUS), etc.

5) The QAPI reporting shall also include Statewide Consumer and Family Advisory Committee (CFAC) activity, result summaries, and program assessments of the following:

a) Mechanisms to collect and assess feedback from the CFSP's participation in the Statewide CFAC;

b) The CFSP's actions/initiative taken based on CFAC feedback in alignment with improvement and appropriateness of care provided to Members;

c) Mechanisms to review member satisfaction and feedback on the member experience with CFSP responsiveness to member issues/comments/concerns; and

d) The CFSP shall submit an updated Statewide CFAC roster of committee members when there are modifications made to the CFAC representatives. This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUD), etc.

f. The QAPI reporting shall also include North Carolina Association of County Directors of Social Services (NCACDSS) activity, result summaries, and program assessments of the following:
   i. Mechanisms to collect and assess feedback from the CFSP's engagement with NCACDSS; and
   ii. The CFSP's actions/initiative taken based on NCACDSS feedback in alignment with improvement and appropriateness of care provided to Members.

g. The CFSP Quality Director shall participate in monthly meetings with the Department.

h. The CFSP shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of the CFSP's overall QAPI program design as directed by the Department.

i. Quality Measures
   i. The CFSP will be held accountable for performance on all measures listed in *Section VII. Attachment D. Required CFSP Quality Metrics* that are meant to provide the Department with a complete picture of the CFSP's processes and performance. The CFSP's accountability may include:
      1) Public reporting of measure performance by the Department;
      2) Requirements to engage with Department staff around measure performance; and
      3) Beginning no earlier than Contract Year 2, financial accountability for a select set of measures to be specified by the Department.
   ii. The CFSP shall calculate and report on those measures that require claims or encounter data or clinical data. Measures are indicated in *Section VII. Attachment D. Required CFSP Quality Metrics*. The Department reserves the right to add and remove measures from the measure set.
   iii. Detailed specifications around measure reporting, stratification, and data submission will be supplied to the CFSP prior to launch and annually thereafter.
   iv. The CFSP shall incorporate elements of the Department-identified measures into the CFSP's QAPI and quality improvement activities.
   v. Beginning in or after Contract Year 2, the Department will implement a quality withhold/incentive program based on quality measures used to administer the CFSP. The performance measures subject to withholds will align with the State's Quality Strategy. Additional details on the Department's withhold program are provided in *Section VI.L. Withholds*.
   vi. The Department intends to monitor CMS's development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.

j. Measurement of Outcomes
   i. The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas that may include quality of life, functional status and Member satisfaction. This measurement may involve the use of surveys that may be administered by Providers or third-party Contractors, and may involve the development and piloting of novel survey instruments.

ii. The CFSP shall support the administration of surveys as requested by the Department. This support may include conducting outreach to Members and Providers, incorporating in Provider contracting requirements related to survey administration, providing guidance to facilitate survey completion, and conducting analysis of internal data to support survey piloting.

iii. The CFSP shall ensure administration of the NC-TOPPS interview tool to Members in a form and manner specified by the Department.

k. Disparities Reporting and Tracking

i. The CFSP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, age, and gender where appropriate and feasible for many of the Quality Measures.

1) Detailed specifications around measure reporting, stratification, and data submission will be supplied to the CFSP after Contract Award and annually thereafter.

ii. The CFSP shall address inequalities as determined by the Department during review of the CFSP's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.

1) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.

l. Public Health Reporting and Tracking

i. The CFSP shall work with the Department to target areas of collaboration and develop programs as part of QI efforts that can:

1) Remove barriers (e.g., benefit coverage, implementation challenges, Member and family education);

2) Align incentives by targeting withholds for measures that will affect public health priorities; and

3) Require select quality initiatives to be embedded in QAPIs, including EPSDTs and contributions to health-related resources.

ii. The CFSP shall be an active partner in Healthy NC 2030 (https://nciom.org/healthy-north-carolina-2030/) goals planning by participating at a minimum as follows:

1) Joining planning meetings (to be convened by the State);

2) Designating a senior level clinical staff person to engage in public health issue discussions; and

3) Aligning QI activities to support Healthy NC 2030 goals.

m. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)

i. The CFSP shall include no less than four (4) PIPs as part of the annual QAPI program, with a minimum of one (1) PIP in the non-clinical category, two (2) PIPs in the clinical category, and one (1) PIP in the transitions and continuity of care category. The CFSP's PIPs must be approved by the Department annually as part of the CFSP's QAPI program. The CFSP may be required to develop additional PIPs for specific focus areas and/or clinical measures as directed by the Department.

ii. The CFSP shall develop PIPs that are:

1) Designed to achieve significant improvement in health outcomes as part of the annual CFSP QAPI program review; and

2) Include measurement of performance using quality indicators as part of the annual CFSP QAPI program review.

iii. Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.

iv. The CFSP shall conduct PIPs that are aligned with the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy. The CFSP should align PIPs with those that are being conducted for other Medicaid populations that the vendor is serving in North Carolina, as applicable.

1) The CFSP shall be required to develop and execute at least one (1) non-clinical PIP annually that must be related to one or more of the following areas:
   a) Improving timeliness of health assessment completion (including DSS initial and follow-up health screenings) and Care Plan development (e.g., implementation of data sharing and other coordination best practices);
   b) Improving supports to promote diversion, in-reach and/or transition for populations in or at risk of entrance into residential treatment centers, ACHs, or other congregate care (including non-Medicaid funded congregate care) settings;
   c) Improving the adequacy of the BH network with regards to geographic and virtual accessibility to Members, as applicable, and representation of historically underrepresented groups among providers in the network; or
   d) Improving educational outcomes and addressing underlying health needs/learning disabilities that contribute to poor school performance (e.g., ADHD screening and treatment; collaboration with Department of Public Instruction to track educational outcomes such as grade-appropriate reading level and kindergarten readiness).
2) The CFSP shall be required to develop and execute at least two (2) clinical PIPs annually.
3) The first of the two (2) PIPs must describe the Plan's efforts to implement a comprehensive program to reduce overutilization of psychotropic medications and underutilization of evidence-based psychotherapies for children and youth involved in the child welfare system, including but not limited to Members in Foster Care. At a minimum, the program shall:
   a) Adopt and utilize clinical guidelines defining potentially harmful or inappropriate psychotropic prescribing, including inappropriate use of antipsychotic medications and inappropriate psychiatric polypharmacy;
   b) Adopt and utilize clinical guidelines outlining when psychosocial or psychotherapeutic treatments should be used first line or in conjunction with psychotropic medications for Behavioral Health (BH) conditions;
   c) Use these guidelines and available data, including UM and care management data and referrals, to:
      i) Identify Members who are not receiving or have not received appropriate evidence-based psychosocial or psychotherapeutic treatments;
      ii) Identify Members with potentially harmful or inappropriate psychotropic medication regimens; and
      iii) Identify prescribers/providers with patterns of potentially harmful or inappropriate psychotropic medication prescribing.
   d) Educate and monitor care management and UM staff on when to refer individual Members for review of their psychotropic medication regimen by CFSP medical and pharmacy staff;
   e) Track and address the needs and treatment gaps of identified individual Members in collaboration with their providers and care manager;

f) Promote appropriate utilization of psychotropic medications and psychosocial/psychotherapeutic treatments with relevant BH and Primary Care Providers;
g) Promote appropriate metabolic and neurologic monitoring for children and youth on antipsychotic medications;
h) Increase access to evidence-based psychotherapies for children and families; and
i) Be developed and overseen in collaboration with the CFSP CMO, Deputy CMO, Pharmacist, Quality Director and Director of Population Health and Care Management.

4) The second of the two (2) PIPs must be related to one or more of the following areas, and the CFSP must consider how innovative use of Care Management can contribute to clinical performance improvement in the selected area(s):
   a) Improving prevention and management of acute and chronic conditions; focus area(s) may include but are not limited to the following:
      i) Asthma;
      ii) Early childhood health and development including well visits, immunizations, and developmental screenings;
      iii) Tobacco screening and cessation;
      iv) Behavioral-physical health integration;
      v) Birth outcomes;
      vi) Wellness visits;
      vii) Immunizations; and
      viii) Maternal health;
   b) Improving identification of and treatment for primary diagnoses of Trauma- and Stressor-Related Disorders, including PTSD, and underlying diagnoses;
   c) Improving identification of and care for Children with Special Health Care Needs; and
   d) Enhancing incorporation of trauma-informed competence and services into physical and BH care delivery, particularly for children/young adults who have a history of abuse/neglect and children/young adults who are at risk for juvenile justice involvement.
5) The CFSP shall be required to develop and execute at least one (1) PIP annually that is related to care and continuity across Foster Care placements and institutional settings (e.g., PRTFs, juvenile justice system, from one Foster Care placement to another, and out-of-state placements) for this population.
   a) The Plan must focus on care while the Member is in a placement, is transitioning between placements, or is transitioning out of Foster Care (e.g., Member Aging Out of County DSS Custody, Member Exiting County DSS Custody and is reunified with family):
      i) In Placements
         (1) Measures taken to conduct regular clinical team care conferences, particularly before and after new placements occur, that engage all appropriate representatives for the Member (e.g., care manager, County Child Welfare Worker, PCP, BH Provider, and/or I/DD Provider);
         (2) Coordination with DSS to provide all necessary supports required to enable a Member to remain in a placement, provided the placement is safe and suitable; and
         (3) Measures taken to mitigate law enforcement involvement in behavioral crises (e.g., specialized trauma-informed training for group home staff and

Guardians, coordination with local Emergency Medical Services to promote dispatching trained mobile crisis units, rather than law enforcement, as a best practice).

ii) Between Placements

(1) Development of transitional Care Plans to ensure continuity across placements and institutional settings (e.g., PRTFs, juvenile justice system, out-of-state placements);

(2) Processes implemented to conduct regular monitoring and timely in-person interactions with Members who are temporarily in out-of-county or out-of-state placements; and

(3) Mechanisms to involve family (biological and Foster Care) and County Child Welfare Worker in Care Plan development and transitional care (e.g., engaging a family partner to support transitions from institutional settings).

iii) Transitions out of Foster Care

(1) Measures taken prior to Member Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody to reduce risk of adverse outcomes, (e.g., connection to primary care physician, screenings for depression and anxiety; diagnosis and treatment of SUD; social supports including housing assistance); and

(2) Measures taken prior to Member Aging Out of County DSS Custody or Otherwise Exiting County DSS Custody to ensure successful community integration (e.g., Life Skills Inventory/Independent Living Skills Assessment, supports to ensure community inclusion, community living skills; coordination with member and County Child Welfare Worker to facilitate transition into adulthood).

v. The Department reserves the right to mandate specific PIPs and/or prescribe additional PIPs under each of three categories that are not listed in the Contract based on Member experience and outcomes.

n. External Quality Review (42 C.F.R. § 438.3(s)(1))

i. The CFSP shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO.

ii. The CFSP shall participate in the annual Consumer Assessment of Healthcare Providers and Systems Plan Survey® (CAHPS®) and Provider Survey conducted by the EQRO, and other surveys as required by the Department.

iii. The CFSP shall comply with validation and research activities related to surveys, including survey instruments under development, that are required by the Department.

o. Quality Improvement - Provider Supports

i. The CFSP shall provide support to providers tailored to advance State priorities and ensure providers' ability to achieve the goals outlined in the Quality Strategy.

ii. The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.

iii. The CFSP shall develop and maintain a CFSP Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the CFSP Provider Support Plan.

iv. The Provider Support Plan shall be developed as a component part of the QAPI and provider support activities should relate to improvement in specific health outcomes.

v. The CFSP Provider Support Plan shall include:

1) All planned technical support activities;
2) Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy, including addressing health disparities and incorporating health equity in support of the Department's health equity goals; and
3) An overview of which metrics the CFSP will use to evaluate its provider engagement progress over time.

vi. CFSP's continuous improvement approach to update the Provider Support Plan. In addition to implementing QI activities required to execute PIPs, the CFSP shall provide broader practice training to Network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
1) The Opioid Misuse Prevention and Treatment Program;
2) Healthy Opportunities interventions, including but not limited to interventions delivered through the Healthy Opportunities Pilots;
3) BH integration;
4) VBP;
5) Pregnancy management/PMP;
6) Tobacco Cessation Plan;
7) Activities to support at-risk children; and
8) Support for other activities such as response to or recovery from COVID-19, or future epidemic or pandemic preparedness and response, as indicated by the Department.

2. Value-Based Payments/Alternative Payment Models

a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, integration of physical and BH, appropriateness of care and other measures related to value included in the CFSP Quality Strategy, the Department is requiring adoption of VBP arrangements between the CFSP and providers. The Department will issue additional guidance and details on VBP requirements for the CFSP.

b. The Department defines VBP arrangements as payment arrangements between the CFSP and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at https://hcp-lan.org/workproducts/apm-figure-1-final.pdf. The Department reserves the right to narrow the definition of VBP and the range of acceptable CFSP VBP arrangements with providers in the future. All VBP arrangements must be aligned with the CFSP Quality Strategy and related measures.

c. The Department may set minimum targets for VBP contracting starting in Contract Year 2, and implement withholds associated with these targets. Targets will be published at least six (6) months prior to the Contract Year in which they take effect.

d. The CFSP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward VBP, including having systems that can support alternative payment arrangement models which require data-sharing across different provider types, care settings and locations shared savings. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.

e. The CFSP shall complete a VBP assessment based on the categories developed by HCP-LAN. The Department will provide specifications on the assessment methodology upon Contract Award.
   i. The Department shall use the VBP assessment to demonstrate the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the amount of total medical expenditures and covered lives under these VBP payment arrangements, and compare documented progress to the CFSP's final VBP Strategy on an annual basis.
   ii. The CFSP shall report the results of its VBP assessment focused on VBP contracts in place to date within six (6) months of Contract Award, in a format to be determined by the Department.
   iii. The CFSP shall update the VBP Assessment on an annual basis, within ninety (90) Calendar Days of the end of each Contract Year.

f. To ensure the CFSP's response aligns with the Department's strategy and goals, the CFSP shall develop a CFSP VBP Strategy for Contract Years 1-3, in alignment with the Department's short- and long-term goals to shift from a fee for service system to VBP.
   i. The CFSP VBP Strategy must be submitted to the Department within six (6) months of notice by the Department it is due, in a format to be determined by the Department.
   ii. All sections of the CFSP VBP Strategy must be updated on an annual basis, within ninety (90) Calendar Days of the end of each Contract Year.
   iii. After initial approval, the CFSP shall submit any material modifications, additions, or deletions of all policies to the Department at least thirty (30) Calendar Days prior to implementation.
   iv. The VBP Strategy shall contain the following elements:
      1) A narrative description addressing:
         a) The results of the HCP-LAN APM assessment;
         b) The CFSP's goals, strategies and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the CFSP will involve BH providers in its VBP arrangements;
         c) The CFSP's strategy to align Medicaid Managed Care payment models with the CFSP's other payor contracts;
         d) The CFSP's projections and plans to meet the Department's VBP targets for amount of funding in VBP/APM arrangements by year, including a description of the payment model(s), their HCP-LAN classification, and targets across different models and provider types;
         e) An explanation of how the CFSP will ensure that physical and BH are integrated under its VBP arrangements;
         f) The CFSP's plan for measurement of outcomes and results related to VBP/APM by year;
         g) The CFSP's approach to address Unmet Health-Related Resource Needs as part of its VBP Strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes;
         h) The CFSP's approach to address health disparities and incorporate health equity in support of the Department's health equity goals;
         i) Specific program(s) that will be offered to AMH Tier 3 practices, which must align to HCP-LAN Categories 2 through 4 and meet any other criteria specified within AMH program requirements;
         j) Specific program(s) that will be offered to other AMH providers and/or specialties; and

k) A description of the CFSP's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the CFSP's VBP/APM program. Specific functionalities to address include:
   i) Risk adjustment;
   ii) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
   iii) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
   iv) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
   v) Reporting capabilities; and
   vi) Payment functions.

2) The CFSP's projected annual targets for the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the percent of total medical expenditures flowing to providers through shared savings and covered lives under these VBP payment arrangements, in a format to be determined by the Department.

v. The CFSP shall submit an updated VBP Strategy to the Department on an annual basis that includes the following updates:
   1) Updates to the HCP-LAN APM assessment;
   2) Progress towards the CFSP goals, strategies and interventions for moving providers through higher levels of the LAN framework;
   3) The CFSP's progression over time, if applicable, in advancing providers through higher levels of the LAN framework;
   4) Progress toward the CFSP's projections and plans to meet the Department's VBP targets for amount of funding in VBP/APM arrangement;
   5) Updates against all Physician Incentive Plans (as applicable);
   6) Results of the CFSP's outcome measurements and analysis of the outcomes and results by year and to-date; and
   7) Changes or improvements in the CFSP's IT capabilities necessary for the successful implementation of the targeted VBP/APM arrangements.

g. Physician Incentive Plans
   i. The CFSP is permitted to develop Physician Incentive Plans outside of the VBP and Pregnancy Management Program requirements put forth by the Department, provided that any such Physician Incentive Plans are related to the aims and goals set forth in the Quality Strategy.
   ii. The CFSP shall submit all Physician Incentive Plans as part of the CFSP VBP Strategy to the Department for review and approval prior to CFSP implementation of such incentives.
   iii. Any Physician Incentive Plans developed by the CFSP shall be in compliance with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, in which references to 'MA organization', 'CMS', and 'Medicare beneficiaries' must be read as references to 'the CFSP, 'the Department', and 'Medicaid beneficiaries', respectively.
   iv. The CFSP shall submit to the Department annual reports as part of the annual update to the VBP Strategy containing a detailed overview of any implemented (and previously approved) Physician Incentive Plans, or, if no such arrangement is in place, attest to that fact. Annual Physician Incentive Plan reports must provide assurance satisfactory to the Department that the requirements of 42 C.F.R. § 422.208 are met.
   v. The CFSP shall provide the following information to any Medicaid Member who requests it:
      1) Whether the CFSP uses a Physician Incentive Plan that affects the use of referral services;
      2) The type of incentive arrangement; and

3) Whether stop-loss protection is provided.

G. Stakeholder Engagement

1. Engagement with Federally Recognized Tribes

a. The CFSP must have a strong understanding of and capability to meet the needs of federally recognized tribal members, including North Carolina's federally recognized tribe, EBCI.

b. In accordance with Chapter 108D-40 of the North Carolina General Statute, individuals who meet the definition of Indian under 42 C.F.R. § 438.14(a) are exempt from mandatory enrollment in Medicaid Managed Care enabling them to choose enrollment in NC Medicaid Direct or Medicaid Managed Care at any time.

c. The Department collaborated with the EBCI to develop a Tribal Option that considers and addresses the unique cultural, BH and medical needs of federally recognized tribal populations.

d. The CFSP shall establish an ongoing partnership with the EBCI and other tribal populations that supports Members who are tribal members.

e. For individuals who meet the definition of Indian under 42 C.F.R. § 438.14(a) that enroll in the CFSP, the CFSP will implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health care for the individual, family, or community members of federally recognized tribes. The Strategy should adapt individual engagement interventions, programs, and policies, demonstrate cultural humility, cultural awareness, respect and honor and fit the historical and cultural context of the individual, family, or community members of federally recognized tribes.

f. The Tribal Engagement Strategy shall include:
   i. A proposal of an administrative, clinical and operating model intended to meet the needs of federally recognized tribes and specifically in western NC;
   ii. Culturally and linguistically sensitive, proactive, innovative methods for engaging and communicating with EBCI tribal members and EBCI leadership;
   iii. A proposal and strategy to improve communication through the utilization of a health information exchange in order to improve coordination of care and health outcomes for tribal members;
   iv. A description of how the CFSP's Care Management and quality strategies take into consideration the needs of tribal members;
   v. Seamless integration with the EBCI, its local Public Health and Human Services (PHHS) staff, members of other federally recognized tribes residing in NC and other tribal populations native to North Carolina;
   vi. Medicaid Managed Care education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may create barriers to health care, provider access and service delivery; and
   vii. Approaches the CFSP will take to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities.

g. The Tribal Engagement Strategy shall be developed in consultation with the Tribe at initial development and submitted to the Department for review and approval within ninety (90) Calendar Days of Contract Award. The Strategy shall be updated annually, in consultation with the Tribe, and resubmitted to the Department for review.

h. The CFSP shall consult with the Indian Tribes and Tribal Organizations quarterly regarding Medicaid Managed Care initiatives impacting tribal populations.

i. The CFSP shall collaborate with the EBCI to facilitate, at least semi-annually, meetings and forums with EBCI and IHCPs that serve tribal members.

j. When requested, the CFSP shall make Member education and training material available to licensed and unlicensed physical and BH personnel who work with federally recognized tribal members or their families.

k. The CFSP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.
   i. The CFSP shall provide and maintain a point of contact for IHCP billing issues to the Department.

l. The CFSP shall ensure its staff, materials, and resources adhere to the requirements described in *Section V.B.4. Member Engagement.*

m. Annually, the CFSP shall train its staff regarding the CFSP's Tribal Engagement Strategy and in providing culturally and linguistically sensitive and consumer-specific supports to the tribal population as referenced in *Section V.H.2. Staff Training*.

2. Engagement with Community and County Organizations

a. The CFSP must have a strong understanding of and capability to meet the needs of North Carolina's local communities, including county agencies (e.g., LHDs, County DSS, Area Agency on Aging, Local Education Agencies, children's developmental services agencies, local System of Care Collaboratives, law enforcement, justice and judicial agencies such as sheriff departments, police departments, pre and post-trial release programs, reentry councils, county magistrates, housing authorities, county commissioners, county managers, etc.) and county and community based organizations (CBOs) (e.g., faith-based organizations, food pantries, domestic violence agencies) to help guide and support the delivery of services to Members and their families statewide.

b. The CFSP shall engage with County Agencies and CBOs across the State to understand the potentially unique resources and needs of each community and to integrate its model of care with the local communities it serves.

c. The CFSP shall establish an ongoing partnership with North Carolina county agencies and CBOs that support North Carolina Medicaid Members statewide.

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

e. The Local Community Collaboration Strategy shall address how the CFSP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, Member engagement, and local continuums of care.
   i. The Strategy shall include:
      1) Approach to understand the unique needs of the communities the CFSP is serving;
      2) Methods of collaborative outreach with county agencies, CBOs, and community partners;
      3) Measures of successful engagement and collaboration across county lines;
      4) Reporting of outcomes to county agencies, CBOs, and other community partners; and

5) Information on how the CFSP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.

ii. The Local Community Collaboration Strategy shall be submitted to the Department for review and approval no later than ninety (90) Calendar Days after Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.

f. The CFSP shall consult with the county agencies, county executives and/or the county commissioners' association quarterly regarding Medicaid Managed Care initiatives impacting counties and community organizations.

g. The CFSP shall collaborate with county agencies, county executives, and/or the county associations to facilitate, at least semi-annually, meetings and forums with the county agencies, county executives and/or the county associations.

h. The CFSP shall support local collaboratives that are focused on addressing the unique needs of the populations it serves.

i. The CFSP shall participate in city or county System of Care Community Collaboratives, and work with the Collaboratives to address service barriers, identify system gaps, and develop cross system training plans for Members who received BH services as referenced in *Section V.D.6. System of Care*; and

ii. The CFSP shall participate in local crisis collaboratives as detailed in *Section V.G.4. Community Crisis Services Plan.*

i. The CFSP is encouraged to organize and participate in other local and regional collaboratives, including those focused on the adult and juvenile justice-involved populations.

3. Integration with Other Department Partners

a. The Department seeks a CFSP with the ability to seamlessly integrate with key Medicaid partners, including the EB, Ombudsman Program and County DSS to support beneficiaries through the transition to and on-going implementation of Medicaid Managed Care. To achieve this goal, the CFSP shall be required to do the following:

i. Engage in joint community-based education events and activities with the staff of the EB and Ombudsman Program as requested by the Department, including but not limited to health fairs and community events;

ii. Provide information to the EB such that those interested in enrolling have adequate, written descriptions of the CFSP's rules, procedures, benefits, services, and other information necessary for Members to make an informed decision about enrollment;

iii. Provide educational materials described in *Section V.B.4. Member Engagement* in hard copy and electronic format for distribution to County DSS and to Members who may utilize the Ombudsman Program for assistance;

iv. Collaborate with the Ombudsman Program to facilitate issue resolution for Members navigating the Medicaid Managed Care delivery system;

v. Engage in on-going coordination and communication with County DSS to support Members with their family preservation and permanency planning goals;

vi. Coordinate efforts with the Department, the EB and the Ombudsman Program to improve the Member experience by incorporating Member feedback into the CFSP education campaign strategy by modifying, updating, removing, changing, or adding materials, call center scripts, website content, education materials, presentations, or other administrative or operational processes;

vii. Collaborate with County DSS, PHHS offices, community based and family support, youth support and advocacy organizations and the Ombudsman Program to understand and incorporate the needs of Members into the CFSP's Members education strategy; and
viii. Engage in innovative pilot initiatives with DMH/DD/SUS, as available and at the direction of the Department.

b. The CFSP shall collaborate with other Department and Division partners to ensure that Members' unique needs are met, including DSS, Department of Public Instruction, the Department of Public Safety, the North Carolina Housing Financing Agency, DHSR, DMH/DD/SUS, DCFW, Office of Minority Health and Health Disparities, NC Olmstead, and the Department of Public Health.
c. The CFSP shall collaborate with the DSS and County DSS on efforts to implement the Family First Prevention Services Act (FFPSA) to be further specified in guidance.

4. Community Crisis Services Plan

a. As defined in NCGS § 122C-202.2(b), the CFSP shall participate in the development and implementation of BH community crisis services plans, including:
   i. Actively participate in the development of all local area crisis services plans across the State;
   ii. Mutually agree in writing to all local area crisis services plans across the State;
   iii. Contract for the relevant BH crisis services with the provider(s) identified in each local area crisis plan; and
   iv. Coordinate with BH I/DD Tailored Plans and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BBH crisis management as defined in each local area crisis plan.

b. The CFSP shall develop Comprehensive Local Crisis Management Plan that outlines the following:
   i. Contracting status with each provider identified in each local area crisis services plan and other key crisis providers identified by the Department within their regions;
   ii. Approach to integrate with each BH I/DD Tailored Plan and local communities in the development and implementation of each local area crisis service plan;
   iii. Planned activities for the upcoming year to support the development, implementation and ongoing operations of all plans statewide;
   iv. Progress on planned activities for the prior year to support the development, implementation and ongoing operations of all plans statewide; and
   v. Barriers to accomplishing the planned activities for the prior year.

c. The CFSP shall submit the Comprehensive Local Crisis Management Plan annually within sixty (60) Calendar Days of the end of each Contract Year, when significant changes (including agreement on new Local Area Crisis Service Plan) are made or as requested by the Department.
   i. The first Comprehensive Local Crisis Management Plan is due within sixty (60) Calendar Days of the CFSP's agreement of any Local Area Crisis Service Plan.

d. The CFSP shall coordinate with BH I/DD Tailored Plans and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each community crisis services plan and alternatives to involving law enforcement in BH crisis response.

e. The CFSP shall participate in local or regional crisis collaboratives with local magistrates, law enforcement, county commissioners, crisis providers, and hospitals, to meet and regularly share information on improvements to the crisis continuum.

H. Program Operations

1. Service Lines

a. All service lines shall be staffed with personnel specifically trained on the requirements, policies and procedures of the North Carolina market and can resolve an inquiry or issue in "one-touch."

b. The CFSP shall establish the following service lines as part of its call center:

i. **Member Service Line**: To enable Members to conveniently access information about benefits or claims, referral assistance and access to treatment or services.

ii. **Provider Support Service Line**: To assist providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries and complaints.

iii. **Pharmacy Service Line**: To assist pharmacies and prescribers with point of sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.

iv. **Nurse Line**: To provide Members with around-the-clock access to medical information and advice on where to access case.

v. **Behavioral Health Crisis Line**: To provide Members with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year through confidential, toll free access, and emergency referral with immediate access to trained, skilled, licensed BH professionals who provide assistance for any type of BH issue the Member may be experiencing, and offers assistance in linking Members to supportive available community resources. In addition to accessing call recordings in real time, the CFSP shall maintain a record of telephonic crisis line encounters, including date of the call, type of call, and disposition and make it available to the Department upon request.

vi. **Non-Emergency Medical Transportation (NEMT) Member and Provider Service Line**: To assist callers in scheduling coordinated, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid enrolled Providers.

c. The CFSP shall adhere to the Department's hours of operations, location, staffing, Member ID requirements and service line activation date for each service line as described in accordance with *Section V.H.1. Table 1: Member and Provider Support Call Center Operations*.

Section V.H.1. Table 1: Member and Provider Support Call Center Operations

Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
i. Member Service Line	1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g., CFSP launch) 2. Emergency Member issues: open twenty-four (24) hours per day/seven (7) days per week 3. Open all State holidays	Yes	Yes	At least forty-five (45) Calendar Days prior to Auto-Enrollment

ii. Provider Support Service Line	1. Monday – Saturday: 7 a.m. – 6 p.m. ET 2. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to Auto-Enrollment
iii. Pharmacy Service Line	1. Monday – Saturday: 7:00 a.m. – 6:00 p.m. ET 2. Prescriber prior authorization services available to meet 24-hour review requirements as defined in *Section V.C.3. Pharmacy Benefits* 3. Open all State holidays	Yes	Yes	At least thirty (30) Calendar Days prior to CFSP launch
iv. Nurse Line	1. Twenty-four (24) hours per day/seven (7) days per week / three hundred sixty-five (365) days per year	No	Yes	At least thirty (30) Calendar Days prior to CFSP launch
v. Behavioral Health Crisis Line	1. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	Yes	Yes	At least thirty (30) Calendar Days prior to CFSP launch
vi. NEMT Member Service Line	1. Monday-Saturday: 7:00 a.m. – 6:00 p.m. ET 2. Open all State holidays	No	No	At least sixty (60) Calendar Days prior to CFSP launch
vii. NEMT Provider Service Line	1. Twenty-four (24) hours per day / seven (7) days per week/ three hundred sixty-five (365) days per year	No	No	At least sixty (60) Calendar Days prior to CFSP launch

d. The CFSP service lines shall be accessible via a toll-free telephone line. The CFSP shall establish and maintain a direct inward dialing (DID) number for each required service line to allow for Warm Transfers between the CFSP, the Department and other Department vendors.

e. The CFSP services lines shall have capacity to handle:
   i. All inbound and outbound telephone calls during the hours of operation as defined in this section;
   ii. Calls from Members and providers with limited English proficiency, as well as Members and providers with communications impairments, including individuals with hearing and/or speech disabilities;
   iii. Technology needed to receive calls from deaf, hard of hearing and Deaf-Blind callers to include TTY, captioned phones and amplified phones;
   iv. After-hours, including:
      1) Accepting, recording or providing instruction in response to incoming calls during non-business hours;
      2) Allowing option to leave a message and request for call back;

3) If a request for a call back is made, the return phone call shall be made the following Business Day during normal hours of operations; and
4) Department approval of the after-hours message;

v. An Automated Voice Response System (AVRS) which:
1) Interacts with the Member through voice and/or numeric prompts and allows Members to perform self-service activities and resolve simple inquiries without the need to interact with a live person; and
2) May prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the Member prior to the call being distributed to a call center representative.
a) The AVRS must have the capability of allowing non-enrolled individuals and providers to access service line staff.
3) Offers user-friendly options that are easily understood by Members and Authorized Representatives (including a decision tree illustrating AVRS system);
4) Works in conjunction with an Automated Call Distribution System (ACD) which intelligently routes and effectively manages all calls to appropriate and available staff:
a) When a Member desires to speak with a live person; and
b) Based on unique Member needs (i.e. caller language needs).

vi. Ensure adequate staffing and capacity to meet the service line performance standards defined in the Contract.

f. The CFSP shall be permitted to use overflow or secondary call centers to meet capacity requirements as defined in this section. All call centers shall be held to the same service line performance standards as defined within the Contract, unless the Department has approved an exception as provided in this section.

g. The CFSP shall be permitted to provide educational messages or other messages that improve the customer experience (e.g., announcement of new program changes or reminders) while callers are on hold, as directed or approved by the Department. Callers to the Behavioral Crisis Line shall not be placed on hold.

h. All CFSP services lines, with the exception of the NEMT Member and Provider Service Lines, shall be able to transfer calls via Warm Transfer to the Department's FFS Provider and Medicaid call centers, EB, Ombudsman, County DSS, EBCI Public Health & Human Service (PHHS) offices, and all participating Standard Plans and BH I/DD Tailored Plans when appropriate and without impacting the capacity to handle in-bound calls simultaneously.
i. The Warm Transfer is required only during the operational hours of the entities listed above in *Section V.H.1. Table 1: Member and Provider Support Call Center Operations*.
ii. If the service line is attempting to connect a Member to another entity that is closed, the CFSP shall provide the information on how the caller may contact the entity directly during their operating hours.

i. All CFSP services lines shall be able to transfer calls via Warm Transfer to all other CFSP service lines, when appropriate.

j. The CFSP shall digitally record and store one hundred percent (100%) of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months.

k. The CFSP shall allow the Department real-time remote access via secure internet connection to all call recordings, including video and audio, with the Department having ownership and control of these recordings.

l. The CFSP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge, as defined in *Section V.H.2. Staff Training,* on North Carolina Medicaid as defined within this Contract.

m. The CFSP shall acquire the necessary phone number(s) to support the requirements of this section within sixty (60) Calendar Days of Contract Award.
   i. The CFSP shall relinquish ownership of the toll-free number(s), with the exception of the NEMT Member and Provider Service Line numbers, upon contract termination or expiration, at which time the Department shall take title of these telephone numbers.
   ii. All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the CFSP and shall be paid prior to the Department taking title.

n. The CFSP shall develop service line scripts for use by CFSP staff when talking with Members, Authorized Representatives, and providers.
   i. All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies and procedures of the North Carolina market.
   ii. The CFSP shall submit to the Department for approval a listing of topics which scripts will address, and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
      1) Member Medicaid Managed Care resources, education and assistance to understand Medicaid benefits;
      2) Provider Contracting;
      3) AMH certification;
      4) Provider claim submission and adjudication issues;
      5) Service prior authorization process and status;
      6) Member pharmacy lock-in program;
      7) Information to contact the EB;
      8) Member grievances and appeal process, including information on Member supports available;
      9) Healthy Opportunities Pilot services, including information on Healthy Opportunities Pilot program eligibility criteria, counties included in Healthy Opportunities Pilot regions, Healthy Opportunities Pilot services offered, and connecting the Member to a Care Management Team to assess the member for Healthy Opportunities Pilot eligibility; and
      10) Other topics as identified by the Department.
   iii. All service line scripts shall be made available to the Department upon request, and all Member Service Line, Nurse Line, NEMT Member Service Line, and Behavioral Health Crisis Line scripts shall be approved by the Department prior to use or when Significant Changes are made.

o. The CFSP shall document all call center interactions with Members, Authorized Representative and providers. The record of contact must include:
   i. Current or Potential Member's name;
   ii. Medicaid identification number (preferred);
   iii. Channel of interaction/Service Line;
   iv. Demographics, including, but not limited to
      1) Phone number; and
      2) Emergency or alternative number, if needed.
   v. Notes summary of current or Potential Member interaction (e.g., summary of issue, if issue was resolved or addressed, what information was provided by the CFSP's representative);

vi. Record of the time and date of interaction;
vii. Contact agent;
viii. Resolution and/or if additional follow-up is or was required; and
ix. Interpreter requests and the language requested.

p. The CFSP shall develop and maintain a Call Center and Service Line Policy that defines how the CFSP will meet and maintain the requirements of the Contract. The Policy shall be made available to the Department, upon request.
   i. The Policy shall include at a minimum:
      1) Service line process flows and call-tree routing options;
      2) Service line script topics;
      3) Staffing and licensure requirements;
      4) Quality assurance and monitoring approach;
      5) Provider and Member issue tracking and resolution process; and
      6) Incorporation of Member and provider issues into broader CFSP quality improvement.

q. Member Service Line:
   i. Emergency Member issues shall be defined as a Member having an Emergency Medical Condition or in need of emergency services.
   ii. The Member Service line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined in *Section V.B.4. Member Engagement*.

r. The CFSP Member Service Line must be able to connect to the CFSP Behavioral Health Crisis Line via a Warm Transfer twenty-four (24) hours per day, seven (7) days per week. The Nurse Line shall integrate with the CFSP's overall Care Management program.
   i. Within forty-eight (48) hours of a Member call, the Nurse Line shall follow up with the Member's care manager to share relevant clinical and follow up information.

s. Pharmacy Service line:
   i. The Service Line Policy shall include standards to meet twenty-four (24) hour prior authorization requirement as defined in *Section V.C.3. Pharmacy Benefits*.

t. Behavioral Health Crisis Line:
   i. The CFSP Behavioral Health Crisis Line must be staffed with licensed Behavioral Health professionals trained in Trauma-Informed Care.
   ii. The CFSP Behavioral Health Crisis Line must be able to address mental health, SUD, and I/DD related crisis events.
   iii. The CFSP Behavioral Health Crisis Line must immediately connect to the crisis response systems.
   iv. The CFSP Behavioral Health Crisis Line must have patch capabilities to 911 emergency services. In instances where there is immediate danger to self or others, the CFSP shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
   v. The Behavioral Health Crisis Line must follow up with the Member's care manager within twenty-four (24) hours to share relevant clinical and follow up information.
   vi. The CFSP Behavioral Health Crisis Line must not:
      1) Allow Members to receive a busy signal in order to meet the minimum performance requirements;
      2) Allow Member calls to be answered by an automated response;

3) Allow Members to leave messages and receive a call back;
4) Shift calls to an overflow system during high volume call times; or
5) Allow maximum call duration limits.

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

u. NEMT Member and Provider Service Lines:
i. The NEMT Member and Provider Service Lines shall adhere to logistical, informational, and accessibility requirements as defined in *Section V.C.4. Non-Emergency Medical Transportation.*

v. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers. The CFSP is required to submit a request to the Department for review and approval for a call center used by the CFSP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or contract requirement standards defined by the Contract. The CFSP shall not be allowed to request, for Department review and approval, any exceptions for overflow call centers.
i. Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the five (5) service lines specified by the Contract.

w. Gross Customer Abuse
i. The CFSP shall prohibit gross customer abuse by call center agents across its service lines. Gross customer abuse includes any of the following actions performed by a call center agent, as determined by the Department:
1) Use of profanity or vulgar language;
2) Yelling or screaming at callers;
3) Intentional disconnection with the caller; and
4) Negligent or willful misconduct.
ii. As part of its call center quality assurance and monitoring approach, the CFSP shall monitor its service lines for gross customer abuse and report any identified incidents to the Department. Any complaints received by the CFSP from a caller claiming gross customer abuse shall be reported to the Department. The CFSP shall report incidents of gross customer abuse to the Department within two (2) Business Days after the incident is reported to or discovered by the CFSP, in a format and manner defined by the Department.
iii. The Department will monitor service lines for gross customer abuse during call center quality assurance procedures such as call listening observations or investigating external complaints.

2. Staff Training

a. The CFSP shall meet the Department's goals and objectives of providing support and services to meet Member and provider needs by training and educating CFSP staff members and Contractors on the requirements, policies and procedures of Medicaid Managed Care and the unique needs of Medicaid Managed Care Members served by this Contract.

b. The CFSP shall participate in Department initiatives to educate Members and providers about implementation activities, including but not limited to:
   i. Assistance with the development of call center scripts;
   ii. Participation in Department-sponsored educational activities; and
   iii. Integration of Department developed implementation-related content into Member-facing and provider-facing educational materials.

c. The CFSP shall ensure that staff and Contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under the Contract. Staff Members having contact with Members or providers, or with the Department or County DSS staff shall receive training regarding the appropriate identification and handling of questions and concerns.

d. The CFSP shall begin training new staff to the North Carolina Medicaid Program within seven (7) Calendar Days of their start date and complete within sixty (60) Calendar Days, unless otherwise approved by the Department.

e. The CFSP shall conduct due process training at least annually for all relevant staff.

f. The training program shall include distinct training for:
   i. Member services staff and Contractors;
   ii. Provider relations staff and Contractors;
   iii. Staff and Contractors whose work integrates with the County DSS, eligibility workers and social work program administrators;
   iv. Staff and Contractors whose work integrates with the Department; and
   v. Key personnel as identified in *Section V.A.9.: Table 1. CFSP Key Personnel Requirements.*

g. The CFSP must seek feedback from DSS and County DSS subject matter experts on relevant training materials, including but not limited to:
   i. Feedback from DSS subject matter experts on training materials relevant to child welfare policy and practice; and
   ii. Feedback from County DSS subject matter experts on training materials relevant to coordination with local County DSS.

h. The CFSP shall be responsible for ensuring training directed toward Member services staff and Contractors include, but are not limited to:
   i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
   ii. Services which the CFSP is required to make available to all Members;
   iii. Overall understanding of the unique needs of Members served by the CFSP, including the impact of ACEs and the importance of providing Trauma-Informed Care;
   iv. Services which the CFSP is required to make available to all Members;
   v. Awareness of all supports and services that enhance the Member experience;
   vi. Awareness of the unique needs of the Member populations, including physical, behavioral, social, educational, and legal needs;

vii. Awareness of the importance of supporting County DSS in its permanency planning for Members served by the CFSP, including making all reasonable efforts to support family preservation, minimize disruptions in placement and support long-term permanency;
viii. Awareness of stakeholders who may interact with Members (e.g., County DSS, Department of Public Instruction, Division of Juvenile Justice and Delinquency Prevention);
ix. Awareness of other Medicaid Managed Care and Medicaid FFS programs and services for distinct populations, including individuals with military service or who are pregnant;
x. Awareness for the role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to Members' health and health care needs;
xi. Awareness of the increased risk of psychotropic medication usage and appropriate Medication Reconciliation and management programs;
xii. Awareness of the impacts of potential frequent placement changes, including, but not limited to, home to Foster Care, Foster Care to independent living, return of child in Foster Care to Parent, change in legal status from Foster Care to adoption, and transition from one level of care to another; and potential change in legal custody status and/or change in legal status as a Parent, Guardian, or Custodian, including potential removal of parental rights;
xiii. Knowledge of the unique health care, education, financial and other support needs for Members Aging Out of County DSS Custody or otherwise Exiting County DSS Custody.
xiv. Awareness of and sensitivity to low-income families;
xv. individuals with disabilities, people who do not fluently speak or read English, individuals with varying levels of reading comprehension or illiteracy, health disparities for Historically Marginalized Populations, individuals with trauma and ACEs, including those served by the child welfare system;
xvi. Ability to communicate appropriately with bilingual individuals or those with special needs. Use of bilingual interpreters, sign language interpreters both in-person and through video remote interpreting, Relay Video Conferencing Captioning, video relay services, 711 relay services, TTY machines, or assertive communication devices;
xvii. Awareness of benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI;
xviii. Sensitivity to different cultures and beliefs;
xix. Member rights and responsibilities;
xx. Member Grievances and Appeals processes, including State Fair Hearing Process;
xxi. The CFSP's provider networks;
xxii. Overcoming barriers to accessing medical care;
xxiii. Linking Members to other state and local programs or assistance, including but not limited to social services, state-funded Behavioral Health services, law enforcement and the juvenile justice/criminal justice systems;
xxiv. Fraud, waste, and abuse detection, investigation, and prevention;
xxv. Process for offering suggestions to improve the Member or provider experience;
xxvi. Unique needs and experiences of Members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:
    1) The significance of extended families including an understanding that the definition of extended families is different than non-native families;
    2) The different service eligibility for non-enrolled family members of enrolled members in EBCI or other federally recognized tribes;
    3) The potential services available for family members of enrolled Members in EBCI or other federally recognized tribes;
    4) The role of the EBCI Family Safety Program, including how it operates separately from County DSS;

5) Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish); and
6) Respect for traditions where gender and age may play an important role;
   a) Elders have a highly respected status due to their life experiences;
   b) Elders tend to be non-verbal; and
   c) Veterans.

xxvii. The different service types and benefit plans available through the Tribal Option;
xxviii. HIPAA and the Department's privacy and security requirements;
xxix. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention; and
xxx. The Healthy Opportunities Pilot, including ensuring the following:
1) That call center supervisors are trained to have an in-depth knowledge of the Healthy Opportunities Pilot to allow them to act as a point of contact for escalations related to the Healthy Opportunities Pilot; and
2) That call center supervisors attend refresher training hosted by the Department at least quarterly.

i. The CFSP shall be responsible for training care manager and supervising care managers as described in *Section V.D.2.s. Staffing and Training Requirements*.

j. The CFSP shall be responsible for ensuring training directed towards provider relations staff and Contractors include, but are not limited to:
i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, utilization management and clinical practice guidelines, cost sharing, network adequacy, key initiatives and priorities, and program goals;
ii. Unique needs of Members served by the CFSP;
iii. The critical importance of closely coordinating with County DSS;
iv. Awareness of all supports and services that enhance the provider experience and help to ensure permanency planning for children served by the child welfare system;
v. Awareness of stakeholders who may interact with providers;
vi. Awareness of other Medicaid Managed Care and Medicaid FFS services for distinct populations;
vii. Awareness of multi-system/cross-agency involvement;
viii. Awareness and sensitivity to different cultural health beliefs and practices and individuals with trauma and Trauma-Informed Care;
ix. Covered services, including EPSDT;
x. Provider rights and responsibilities;
xi. Fraud, waste, and abuse detection, investigation, and prevention;
xii. Importance of Medication Reconciliation and management for Member population;
xiii. Use of bilingual interpreters, sign language interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, or assistive communication devices;
xiv. Sensitivity to different cultures and beliefs;
xv. Understanding of generational, experiential and other preferences to receiving information;
xvi. Unique needs and requirements of IHCPs;
xvii. HIPAA and the Department's privacy and security requirements; and
xviii. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious

disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.

k. The CFSP shall be responsible for ensuring training directed towards staff and Contractors whose work integrates with the County DSS, including County Child Welfare Workers, eligibility workers and social work program administrators include, but are not limited to:
   i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, cost sharing, key initiatives and priorities, and program goals;
   ii. Overall understanding of the unique needs of Members served by the CFSP, including physical, behavioral, social, educational, and legal needs;
   iii. Overall understanding of the critical importance of closely coordinating with County DSS;
   iv. Awareness of Member supports and services including those that help to support family preservation and promote permanency planning for Members served by the CFSP;
   v. Awareness of multi-system/cross-agency involvement;
   vi. Member rights and responsibilities;
   vii. Member Grievances and Appeals processes;
   viii. Awareness of other Medicaid Managed Care and Medicaid FFS services for distinct populations;
   ix. Fraud, waste, and abuse detection, investigation, and prevention;
   x. HIPAA and the Department's privacy and security requirements; and
   xi. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.

l. The CFSP shall be responsible for ensuring training directed towards staff and Contractors whose work integrates with the Department includes topics identified for all other training programs.

m. The FC Plan shall be responsible for ensuring training directed towards key personnel as identified in *Section V.A.9.: Table 1. CFSP Key Personnel Requirements* include but are not limited to:
   i. Overall understanding of:
      1) The unique and complex needs of Members served by the CFSP, including the impact of trauma and ACEs; and
      2) Overall understanding of the critical importance of closely coordinating with County DSS to support permanency planning for Members served by the CFSP.

n. Submission and Approval
   i. No later than ninety (90) Calendar Days after Contract Award, the CFSP shall submit a training and evaluation program to the Department.
      1) The training program shall comply with all state and federal provisions, and should utilize Department resources where available.
      2) Each training program shall be approved by the Department before use with CFSP staff and Contractors.
      3) The CFSP shall initiate training within five (5) Calendar Days of approval by the Department.
   ii. Training materials shall include, but are not limited to:
      1) Training policies and procedures;
      2) Training plan;
      3) Training curriculum; and
      4) Evaluation methodology.

iii. The CFSP shall update the training materials and conduct training of its staff and Contractors annually, as changes are made to Medicaid Managed Care, in response to improving the Member experience, improving the provider experience, improving staff and Contractor performance, and/or as requested by the Department.
    1) The CFSP shall submit all updates and changes to the Department for review and approval before use with CFSP staff and Contractors.

o. The CFSP must collaborate with the Department on providing training to Department, County DSS staff, the EBCI, the Ombudsman program, EB, Department of Public Instruction, and the Division of Juvenile Justice and Delinquency Prevention.
    i. Training must:
        1) Be completed at least ninety (90) Calendar Days prior to CFSP launch;
        2) Be hosted at multiple locations as defined by the Department;
        3) Contain information on the role of the CFSP;
        4) Describe the relationship and integration of the CFSP with the Department, EB, County DSS staff, the EBCI PHHS, and the Ombudsman program; and
        5) Describe how to navigate the public facing websites.
    ii. Materials for the training must be provided to the Department no later than thirty (30) Calendar Days prior to scheduled events for review.

p. The CFSP shall require all staff to complete implicit bias training, inclusive of race, ethnicity and religion in health care, gender and class bias.

3. Reporting

a. The CFSP shall comply with all the reporting requirements established by the Contract.

b. The Department shall provide the CFSP with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in *Section VII. Attachment I. Reporting Requirements*.

c. The Department may, at its discretion, change the content, format or frequency of reports or require CFSP to submit additional reports both ad hoc and recurring.
    i. If the Department requests any revisions to the reports already submitted, the CFSP shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.

d. The CFSP shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.

e. The CFSP shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.

f. The CFSP shall provide all necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements including in the administration of North Carolina's 1115 waiver and to maximize federal match of state funds.

g. Upon request, the CFSP shall provide the Department with all underlying data required to produce reports required under the Contract.

4. CFSP Policies

a. The CFSP shall develop policy documents outlining key business process, procedures and staffing requirements as required in this Contract.

b. Each policy document shall include:
   i. Outline processes and procedures;
   ii. Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
   iii. Define required CFSP and Department systems;
   iv. Role of Subcontractors; and
   v. Describe CFSP's continuous improvement approach to update policies.

c. All required CFSP policies are outlined in the Contract. The CFSP shall submit policy documents to the Department for review and approval as defined in the Contract.

d. After initial approval, the CFSP shall submit any material modifications, additions, or deletions of all policies to the Department at least thirty (30) Calendar Days prior to implementation, unless another time frame has been specified in the Contract.

5. Business Continuity

a. The CFSP shall develop and maintain a Business Continuity Plan that is acceptable to the Department and demonstrate the adequacy of the Plan at the Department's request. The CFSP shall adhere to all applicable published Department privacy and security policies, and all other requirements set forth in the Contract.

b. Within thirty (30) Calendar Days of Contract Award, the CFSP shall submit a detailed description of its Business Continuity Plan for all requirements specified in the Contract. The CFSP shall update the Business Continuity Plan every six (6) months. The CFSP shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following a natural or manmade disaster or state of emergency. The CFSP shall meet recognized industry standards for security and disaster recovery requirements. The CFSP shall identify disaster or emergency situations that can result in a major failure or disruption in care (e.g., fire, flood, terrorist event, hurricanes/tornadoes, terrorist event, epidemic or pandemic), which could result in a major failure or disruption of care. As part of the CFSP's business continuity planning, the CFSP shall identify and review all federal or state disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Award to inform future disaster or emergency planning. For each identified disaster or emergency situation, the CFSP shall explain in detail:
   i. The preventive measures that would be instituted to minimize impact;
   ii. The back-up, off-site storage, and other pre-disaster safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
      1) Descriptions of the controls for back-up processing, including how frequently back-ups occur;
      2) Documented back-up procedures;
      3) The location of data that has been backed up (off-site and on-site, as applicable);
      4) Identification and description of what is being backed up as part of the back-up plan;
      5) Any change in back-up procedures in relation to the CFSP's technology changes; and
      6) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; The tasks that would be involved, and identify by job description of title the CFSP's staff and the Department's staff involvement.
   iii. The tasks that would be involved, and identify by job description or title the CFSP's staff and the Department's staff involvement;
   iv. Current contact information for all critical staff and relevant personnel and notification procedures (i.e. call tree);

v. Approach for providing Care Coordination activities to high-risk Medicaid members;
vi. Approach for supporting the Department's priorities for statewide and local disaster or emergency planning;
vii. Process to provide information and resources to Medicaid Members on how to protect themselves during a disaster or emergency and assist members with understanding how and when to access Medicaid benefits;
viii. Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a Member;
ix. Processes to ensure that providers deliver all necessary care to members during a disaster or emergency;
x. Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
xi. Approach to supporting providers in the event of provider revenue disruptions;
xii. Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
xiii. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternative worksite locations;
xiv. The time-frame required to accomplish full recovery from the point of interruption;
xv. A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
xvi. The procedures for coordinating with the Department in the event of a disaster;
xvii. Employee training and awareness detailing activation process;
xviii. Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results;
xix. The procedures for notifying the Department, EBr, Members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans;
xx. The CFSP shall comply with any additional requirements released by the Department to ensure continuity of care during a public health emergency, epidemic or pandemic, including those related to Care Coordination, Care Management, and supports to address their Unmet Health-Related Resource Needs;
xxi. The CFSP shall provide disaster or emergency-related Care Coordination for high-risk Medicaid Members (e.g., high risk pregnant women, dialysis patients, hemophiliacs) who are obtaining Care Management during three (3) emergency timeframes as applicable:
    1) Pre-Emergency:
        a) Incorporate disaster or emergency planning in the care planning process.
    2) During an Emergency:
        a) Continue to check-in on high-risk Members to ensure safety, and access to supports to address their Unmet Health-Related Resource Needs;
        b) Arrange for NEMT to evacuate if needed;
        c) Offer extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries; and
        d) Ensure continuity of care, as directed by the Department, to:
            i) Remove and/or reduce required prior authorizations and concurrent review;
            ii) Ensure all Members have access to out-of-network and telehealth providers; and

iii) Increase member access to medications by removing maximum dosage limits for required medication including medication assisted treatment (MAT), anti-psychotics, and insulin.

3) Post-Emergency:
   a) Follow up with high-risk members to ensure safety and identify additional behavioral or medical needs, or Unmet Health-Related Resource Needs; and
   b) Offer extended service line hours with available and trained to answer and triage calls, including disaster or emergency-related queries.

c. The CFSP shall comply with any additional guidance released by the Department during any type of disaster or emergency, including guidance on provider payments.

d. The CFSP shall support the Department's priorities for state-wide and local disaster or emergency planning and response, including:
   i. Participation in the development of community disaster emergency response plans;
   ii. Collaboration with the other Department vendors to align efforts, as needed;
   iii. Appointment of at least one representative to the statewide disaster or emergency response panel;
   iv. Recruitment and training for in-network Behavioral Health providers to staff local disaster shelters; and
   v. Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.

e. Participation in the development of community disaster or emergency response plans as needed;

f. As part of the Business Continuity Plan, the CFSP shall submit Business Continuity Plan(s) for any/all call centers for the Department's review and approval within (30) Calendar Days of the Contract Award and be updated at least every six (6) months thereafter.

g. The CFSP shall notify the Department each time the Business Continuity Plan is activated within two (2) hours of an event.

h. The Plan shall, at a minimum, include an overflow telephone system to operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.
   i. The overflow system must interface with the call tracking and recording standards and technology required in the Contract.
   ii. All quality and performance standards required in this Contract shall apply to the overflow call center.

I. Claims and Encounter Management

1. Claims

a. In order to incentivize successful Medicaid Managed Care and increase provider participation, the CFSP shall pay all providers on a timely basis upon receipt of any clean medical and pharmacy claims for covered services rendered to covered Members who are enrolled with the CFSP in accordance with state and federal statutes. To maximize federal match and ensure accurate reporting, the CFSP shall comply with the Department's Managed Care Provider Billing Guide or as otherwise directed by the Department.
   i. When the Department releases revisions to the Managed Care Billing Guide, the CFSP shall update their systems to process new claims received within forty-five (45) Calendar days of the Managed Care Billing Guide publish date, and reprocess impacted claims within seventy-five (75) Calendar Days of publication of this new guidance. If the CFSP is unable to update

their system and reprocess claims within the seventy-five (75) Calendar Day timeline, interest and penalties shall be paid on those claims according to requirements in *Section V.I.1.d.iv. Interest and Penalties*.

b. Incorrect claim payment or inappropriate claim denial result in increased administrative costs to both the provider and the CFSP and by extension, increase the program costs of Medicaid Managed Care. Therefore, the CFSP shall develop, maintain and operate a claims payment, review and program integrity process which minimizes incorrect claim payments and inappropriate claim denials.

c. Claims Processing and Reprocessing Standards

i. The CFSP shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when the Department decisions are made that would warrant reprocessing (i.e. Member retrospective eligibility determinations or plan enrollment changes).

ii. In addition to processing claims for all Medicaid Managed Care covered services, the CFSP shall have the operational and administrative capability to process ILOS, Value-Added Services, and qualifying EPSDT services which may be otherwise non-covered.

iii. The CFSP shall process and reimburse providers in accordance with the Department's prompt payment standards, regardless of Provider contracting status.

1) Prior to paying a claim, the CFSP shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of Provider contracting status.

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

iv. The CFSP shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:

1) The CFSP shall process claims in accordance with requirements set forth by the NCGS § 58-3-225 and within the Contract.

2) The CFSP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes.

3) The CFSP shall capture and retain the IP address/location and the user login/username for all claims submitted via an on-line portal.

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

v. In instances where a provider submits an adjustment to a previously adjudicated claim, the CFSP shall adjudicate the adjusted claim within the same timeframes as required for the initial Clean Claim.

vi. Remittance Advice

1) The CFSP shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.

2) The CFSP shall provide a remittance advice to every Local Health Department each month explaining their CMHRP payments including number of members, rates, and total payment for each program individually.
3) The CFSP shall provide a remittance advice to every AMH Tier 3 or its payment delegate each month explaining their medical home and care management fees, number of members, rates, and total payment for each component (medical home and care management payment) individually.

vii. The CFSP shall process and pay claims based on the codes submitted by the provider. The CFSP shall not change any data elements submitted by the provider on a claim.

viii. Claims Processing for Child Medical Evaluation (CME)
1) When a Member is referred for an exam for suspected maltreatment by Child Welfare Services or DSS, the CFSP shall require the rostered CMEP providers to follow the Child Medical Evaluation and Medical Team Conference for Child Maltreatment Policy (Clinical Coverage Policy 1A-5) and bill according to Clinical Coverage Policy 1A-5 Attachment A, requiring the CME claim to be submitted with the Child Medical Evaluation Checklist (Attachment B).
2) When processing CME claims referred through law enforcement, the CFSP shall process these claims as any other claim for services rendered and not follow Clinical Coverage Policy 1A-5.

ix. Claims Provider Validation
1) The CFSP shall validate the taxonomy code submitted on the claim against the Taxonomy Code field(s) sent for the provider on the provider enrollment file. The additional taxonomy level information provided for information purposes only on the provider enrollment file should not be used during the claim submission process.
2) The CFSP shall validate the claim's date of service against the enrolled provider's taxonomy effective dates. In the case of inpatient stays, if a provider's taxonomy status changes during a Member's stay, taxonomy effective date validation should be based on the date of discharge for DRG based claims and should be based on the date of service for per diem claims.
3) Once validated, the CFSP shall price claims based on the taxonomy code submitted on the claim.

x. The CFSP shall use the same grouper version as the Department. Grouper updates at the Department occur annually in October, and the CFSP shall use the CFSP Billing Guide to identify the current grouper version number.

d. Prompt Payment Standards

i. The CFSP shall promptly pay Clean Claims, regardless of provider contracting status. The CFSP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean Medical Claim or Pharmacy Claim is received.
1) Medical Claims
a) The CSFP shall, within eighteen (18) Calendar Days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim. The CFSP shall have the capability to receive additional information request via ASC X12, 275 Request for Additional Information EDI transaction, electronic means (including through a portal or email), and by mail. The CFSP shall pay or deny a clean Medical Claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

b) A pended Medical Claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

2) Pharmacy Claims

a) The CFSP shall within fourteen (14) Calendar Days of receiving a Pharmacy Claim pay or deny a clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim. The CFSP shall have the capability to receive additional information request via ASC X12, 275 Request for Additional Information EDI transaction, electronic means (including through a portal or email), and by mail.

b) A pended Pharmacy Claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.

3) If the requested additional information on a Medical Claim or pended Pharmacy Claim is not submitted within ninety (90) Calendar Days of the notice requesting the required additional information, the CFSP may deny the claim in accordance with NCGS § 58-3-225(d).

4) The CFSP shall pay medical home fees and care management fees, that includes AMH, CMHRP 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.

ii. The CFSP shall reprocess medical and pharmacy claims, including resubmitted and corrected claims, in a timely and accurate manner as described in this section (including interest and penalties if applicable).

iii. Pursuant to NCGS § 58-3-225(f), the CFSP may require that claims be submitted within three hundred and sixty-five (365) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within three hundred and sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. However, the CFSP may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365). Unless otherwise agreed to by the CFSP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

iv. Interest and Penalties

1) The CFSP shall pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.

2) In addition to the interest on late payments required by this section, the CFSP shall pay the provider a penalty equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid as specified in the Contract.

3) The CFSP shall not be subject to interest or penalty payments under circumstances specified in NCGS § 58-3-225(k).

v. The CFSP shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website.

1) The fee schedule changes communicated within ninety (90) Calendar Days of the effective date, the CFSP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates, including sending notification of overpayments, within an additional thirty (30) Calendar Days of implementing fee schedule changes.

2) For fee schedule changes communicated more than ninety (90) Calendar Days after the effective date, the CFSP shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates, including sending notification of overpayments, within an additional forty-five (45) Calendar Days of implementing fee schedule changes.
3) This standard is only applicable for NC DHB rate floor programs.
4) Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this section.

vi. The CFSP shall maintain written or electronic records of its activities under this section in accordance with NCGS § 58-3-225(i).

vii. For purposes of actions which must be taken by a CFSP as found in *Section V.I.1.d. Prompt Payment Standards*, if the referenced Calendar Day falls on a weekend or a holiday, the first Business Day following that day will be considered the date the required action must be taken.

viii. The Date of Receipt for medical and pharmacy claims shall be the date the CFSP receives the claim, as indicated by its date stamp on the claim, and the Date of Payment for a claim is the date of the check or other form of payment from the CFSP to the provider, consistent with 42 C.F.R. § 447.45(d)(5) and (d)(6).

ix. CFSP is presumed to have received a written claim in accordance with NCGS § 58-3-225(b).

e. The CFSP shall comply with the Department's Tribal Payment Policy, to be provided by the Department upon Contract Award.

f. Overpayment or Underpayment Recovery

i. The CFSP, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the CFSP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state, consistent with 42 C.F.R. § 438.608(a)(2).

ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with NCGS § 58-3-225(h).

iii. The CFSP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.

g. System Standards

i. The CFSP shall have a Claims Processing and Management Information System (MIS) capable of meeting Medicaid Managed Care requirements and maintaining compliance throughout the term of the Contract.

ii. The CFSP shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a Member.

iii. 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 or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must, at a minimum, allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard HIPAA transaction (ASC X12, 275 claim attachment format or attachment indication in an 837 with the attachment sent separately).

h. Mass Adjustment
   i. The CFSP shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
   ii. The CFSP shall comply with the Department's policies and procedures on mass adjustment.

i. National Correct Coding Initiative (NCCI)
   i. The Department has opted to use the Compatible Medicaid NCCI Methodologies in the Medicaid Managed Care program and share the Non-public Medicaid NCCI Edit Files with the CFSP for processing claims that are paid by the CFSP on a FFS basis.
   ii. The CFSP shall follow Medicaid NCCI policies to control improper coding that may lead to inappropriate payments to providers by the CFSP.
      1) The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with the CFSP on a quarterly basis, when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
      2) The CFSP shall incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the CFSP pays on a FFS basis. The NCCI editing shall occur prior to current procedure code review and any other editing by the CFSP's claims payment systems.
      3) The CFSP shall load the Non-public Medicaid NCCI Edit Files into its claims payment systems upon receipt of the edit files from the Department.
         a) The edit files shall be loaded and ready for use by the CFSP by no later than 12:00 a.m. on the first day of the calendar quarter in which the edit files are effective.
         b) If the CFSP experiences issues loading the edit files into its claims payment systems or any other issues with the edit files that prevents the CFSP from properly loading the files into its systems, the CFSP shall notify the Department within twenty-four (24) hours of identifying the issue.
         c) The CFSP shall submit the NCCI File Certification form by the fifteenth (15th) Calendar Day of the next month following the receipt of the Non-Public Medicaid NCCI Edit Files from the Department confirming the following:
            i) The CFSP has received and downloaded the Non-Public Medicaid NCCI Edit Files from the Department; and
            ii) The CFSP has loaded the Non-Public Medicaid NCCI Edit Files, as provided to the CFSP by the Department, and are ready for use by CFSP by no later than 12:00 a.m. on the first day of the calendar quarter in which the edit files apply.
         d) If the edit files are not properly loaded and ready for use by 12:00 a.m. on the first day of the calendar quarter, the CFSP shall reprocess any claim processed without using the Non-public Medicaid NCCI Edits in effect for that quarter. All reprocessed claims are subject to the prompt pay standards, including interest and penalties, specified in the Contract.
         e) The CFSP shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
   iii. The CFSP and its Subcontractors are subject to the terms and conditions of *Section IX.K. National Correct Coding Initiative Confidentiality Agreement*.
   iv. The CFSP shall only apply Outpatient Hospital NCCI edits to outpatient lab, drugs, and radiology claims.

j. Known System Issues
   i. The CFSP shall develop, maintain, and share a Known System Issues Tracker with providers through newsletters, provider portal, and/or health plan website on a weekly basis to keep providers informed on all known health plan system issues with provider impact.
   ii. The Known System Issues tracker shall include the following information, at a minimum:
      1) Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);
      2) Number of Impacted Providers: number of known providers impacted by the system issue;
      3) Category: type of system issue (e.g., claims, eligibility, provider, prior approval);
      4) Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;
      5) Date Issue Found: month, day, and year the CFSP identified the system issue;
      6) Number of Days Outstanding: number of days this issue has been open;
      7) Estimated Fix Date: month, day, and year the CFSP plans to have this system issue resolved;
      8) Status: status of the issue (open, ongoing, or closed);
      9) Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;
      10) Interest/Penalties Owed: whether interest and penalties will be applied (Yes or No); and
      11) Date Resolved: month, day, and year the CFSP resolved this system issue.
   iii. The CFSP shall maintain each item on the Known Issues Tracker for at least ninety (90) Calendar Days after resolution of the issue.
   iv. The CFSP shall include the link to the Known Issues Tracker in the Provider Manual.

k. Payer Initiated Claim Adjustment
   i. The CFSP shall have the capability to complete payer-initiated claim adjustments of adjudicated claims by provider types, claim types, and time-period.
   ii. The CFSP shall comply with the Departments policies and procedures on claim adjustments/reprocessing.
   iii. The CFSP shall have the capability to complete a report of adjudicated claims and provide all relevant claim data including claim number, Member Medicaid number, provider NPI, and date of service.
   iv. The CFSP shall complete the adjustment report as requested by the Department when a previously processed claim by the CFPS has been adjusted/reprocessed. There is no minimum number of claims required for the report. If an issue has been identified, all claims impacted should be corrected and included in the report.

2. Encounters

a. The Department collects and uses medical, Behavioral Health, and pharmacy service encounter data for many purposes including, but not limited to, Federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.

b. The Department and its vendors, Subcontractors, Providers and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations,

Care Management, administrative policies, and financial responsibilities and objectives associated with Medicaid Managed Care.

c. Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, penalties paid or recovered, incentive payments paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated services, third party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the CFSP, its delegees or Subcontractors.

d. Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPAA rejection and not a Denied Claim or claim line.

e. Submission Standards and Frequency
   i. The CFSP shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Encounter Companion Guides -837I, 873P and NCPDP developed by the Department or its vendor(s) to be provided at Contract Award.
   ii. The CFSP shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
   iii. The CFSP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Data Submission Guide and Encounter Companion Guides -837I, 873P and NCPDP.
   iv. Encounter data submissions must contain adjustments made by CFSP due to payment errors and/or provider adjusted claims.
   v. The CFSP shall submit a monthly certification from the CFSP CEO, CFO, or other designee that the complete encounter data set has been submitted for a designated month.
   vi. The CFSP is responsible to ensure that all encounters are identified with an active NPI for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
   vii. Specifications
      1) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Data Submission Guide and Encounter Companion Guides -837I, 837P, and NCPDP.
      2) The CFSP shall follow the detailed process outlined in the Encounter Data Submission Guide. Encounters are defined in two (2) groups:
         a) Medical, including ILOS, value added services, and Healthy Opportunities Pilot services. In addition, medical includes pharmacy claims billed as professional or institutional claims; and
         b) Pharmacy includes outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.
      3) The CFSP shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
         a) The CFSP shall have the capability to submit to the Department encounter data from:
            i) Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
            ii) Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.

4) The CFSP shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.
5) The CFSP, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.
6) The CFSP shall reference the same edit codes as the Department's system, which are defined in the Department Encounter Data Submission Guide and Encounter Companion Guides - 837I, 837P, and NCPDP.

viii. The CFSP shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the CFSP submitted an encounter data file.

ix. The CFSP shall submit all claims processed as encounters, as defined in this section. Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
1) Timeliness
a) Encounter data for Medical Claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract and monthly medical home and care management fees, shall be submitted no later than thirty (30) Calendar Days from the Claim Adjudication date.
b) Encounter data for Medical Claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract and monthly medical home and care management fees, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.
c) Encounter data for all Pharmacy Claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the payment date.
d) The CFSP encounter data submissions shall meet or exceed a timely submission standard of ninety-eight percent (98%) within thirty (30) Calendar Days after payment whether paid or denied for Medical Claims and within seven (7) Calendar Days after payment whether paid or denied for Pharmacy Claims.
i) Medical: for purposes of determining if the 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. 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, as applicable.
ii) Pharmacy: for purposes of determining if the CFSP has met the timeliness encounter submission standards, 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters will be counted by the Department as Pharmacy Encounters.
e) Encounter data timeliness shall be defined as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
2) Accuracy

a) CFSP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
   i) Medical: for purposes of determining if the 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 CMHRP and Healthy Opportunities per member per month payments.
   ii) Pharmacy: for purposes of determining if the CFSP has met the accuracy encounter submission standards, only NCPDP encounters will be counted by the Department as Pharmacy Encounters.
b) Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.

x. Initial Encounter Data at Medicaid Managed Care Launch
   1) The CFSP shall include encounter data for Medical Claims which have a date of service on or after the Medicaid Managed Care Launch date on which the CFSP becomes responsible for the administration of services.
   2) The CFSP shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the CFSP becomes responsible for the administration of services.

xi. To support the Department achieving efficient encounter data processing, the CFSP shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.

xii. In the event the CFSP enters into a sub-capitated or other Value Based Payment reimbursement arrangement with a provider, the CFSP shall be responsible for submitting all encounters to the Department, containing all the required data fields.

xiii. The CFSP shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.

f. Encounter Data Resubmission Standards
   i. Following the Department's validation and processing of encounter data submissions, the CFSP shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.
   ii. The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial Date of Service.
      1) The CFSP shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
      2) The Department will work with a CFSP for any retroactive encounter denial longer than three (3) years after the initial Date of Service.
   iii. Timeliness
      1) The CFSP will receive notification of medical encounter data errors requiring correction and resubmission within thirty (30) Calendar Days of the CFSP's initial medical encounter data submission date.

a) CFSP shall, where the CFSP submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.

b) CFSP shall, where CFSP submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.

2) Within thirty (30) Calendar Days after a Pharmacy Encounter fails NCPDP edits, X12 (EDI) edits or NC MMIS system edits, the CFSP or its Subcontractor shall correct and resubmit each Pharmacy Encounter for which errors can be remedied.

iv. Completeness and Accuracy. Unless otherwise directed by the Department, the CFSP shall correct and successfully resubmit:

1) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) Calendar Days from the date the 277 was generated;

2) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) Calendar Days from the date the 277 was generated; and

3) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) Calendar Days from the date the 277 was generated.

v. The CFSP or its Subcontractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP Pharmacy Encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) Calendar Days of the respective action.

g. Data Validation and Processing

i. The CFSP shall have the capability to access sufficient enrollment information to perform Member and service provider matching on all claim and/or encounter transactions, if necessary.

ii. The Department shall utilize data validation protocols on encounter data files to assess CFSP encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).

iii. The CFSP shall perform testing with the Department prior to system changes when medical or pharmacy clinical policy changes that may impact operational transactions (i.e. encounter submissions) are identified by CFSP or by Department. The CFSP shall not implement any system changes until testing is approved by the Department.

iv. The CFSP shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.

v. The CFSP shall, in instances where the CFSP is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) Calendar Days prior to the date the modified file will be submitted to the Department production environment.

vi. The CFSP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.

vii. At the discretion of the Department, the CFSP may be prohibited from submitting a specific encounter type to the Department's Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the CFSP. In addition, if the CFSP's access to the Production Encounter Processing System is revoked, the CFSP must actively test with the Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any penalties incurred by the CFSP because of the loss of production access are the responsibility of the CFSP.

h. Denied Claims Submitted as Encounters
   i. The CFSP shall submit Denied Claims as encounters to support denial trend analysis.
   ii. CFSP submissions of Denied Claims as encounters must adhere to data quality editing and limited program editing.
   iii. On Denied Claims submitted as encounters, the CFSP shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
   iv. Denied Claims submitted as encounters must also include the same data content, including provider, Member and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
   v. The CFSP shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction or the Department designated Pharmacy Encounter format.

i. Communication and Oversight
   i. If the CFSP experiences a technical issue preventing encounter data submission, the CFSP shall notify the Department via the approved communication method within the predefined timeline.
   ii. The CFSP shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the CFSP's system(s) or process(es) that prevents the CFSP from submitting encounter data files as scheduled.
   iii. The CFSP shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
   iv. The CFSP shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.

j. Testing
   i. The CFSP will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the CFSP to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The CFSP shall pass the testing phase for all encounter claim type submissions at a time specified by the Department.
   ii. The CFSP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Data Submission Guide and Encounter Companion Guides– 837I, 837P, and NCPDP.

k. In the event of Contract Termination or Non-renewal, the CFSP shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) Calendar Days following

the Contract Termination Effective Date for adjudicated claims with the DOS on or before the Contract Termination or Non-renewal effective date.

l. In instances where the Contract has been terminated for greater than ninety (90) Calendar Days from the contract termination effective date, the CFSP shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

J. Financial Requirements

1. Capitation Payments

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 and payments for additional directed payments to certain providers as required under the Contract.

b. The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates.

c. The Department shall set CFSP capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.

d. The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.

e. The CFSP shall supply, certify, and validate data to support rate setting and qualified directed payments based on schedules to be provided by the Department after Contract Award.

f. The Department has established a separate maternity event payment. This payment will be made to the CFSP after the CFSP submits required documentation of a successful delivery event, defined as a qualifying birth, to the Department.
   i. The CFSP shall follow with the Department's Maternity Event Payment Billing Guide.
   ii. The CFSP shall void the claim within thirty (30) Calendar Days after notice from the Department that valid documentation is not found during the Maternity Event Reconciliation with Encounters as part of the Maternity Event Payment Billing Guidance.

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)). The CFSP is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The CFSP shall provide the necessary data to support this process in a format and frequency to be defined by the Department.

h. The Department will make capitation payments in accordance with the Payment and Reimbursement term in *Section III. D. 39. Payment and Reimbursement*.

2. Medical Loss Ratio

a. The Medical Loss Ratio 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).
   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) Meet standards established in the Department's Quality Strategy that such contributions 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) Meet standards established in the Department's Quality Strategy that the expenditures 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 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), that are reimbursed by the Department separate from the prospective PMPM capitation 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 payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

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, including contributions to health-related resources 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 exceeds the minimum MLR threshold for a prior year;
4) Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the CFSP exceeds the minimum MLR threshold for a prior year; and
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.

iii. The CFSP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
iv. The CFSP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), if there are fewer than 380,000 Member months in a MLR reporting year.
v. Payments related to the Healthy Opportunities Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
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 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. Contribute to initiatives that advance public health and health equity in alignment with the Department's Quality Strategy, subject to approval by the Department; 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 and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

e. The minimum MLR threshold in aggregate across the CFSP shall be exactly eighty-eight percent (88%) as codified in NCGS § 108D-65.

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, consistent 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, consistent 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, consistent with 42 C.F.R. § 438.8(m).

3. Financial Management

a. The Department's financial management requirements were developed to monitor and promote program sustainability. The Department expects, and will rely upon, the CFSP to be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve Member health. The Department will pay the CFSP a capitation payment that is set in an actuarially sound manner. The CFSP is expected to manage CFSP expenditures within the capitation payments and have access to sufficient capital to cover any losses the CFSP experiences.

b. The CFSP shall closely track and report their expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor CFSP expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.

c. Managing and Monitoring Cost Growth
   i. The CFSP shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
   ii. As codified in NCGS § 108D-65, risk-adjusted cost growth for the CFSP's Members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."
   iii. The Department shall monitor annual cost growth of CFSP expenditures by region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
   iv. The CFSP shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.

d. Pharmacy Savings
   i. Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, requires that CFSP spending for prescribed drugs, net of rebates, ensures the Department realizes a net savings for the spending on prescription drugs. To ensure net savings, the Department shall monitor CFSP compliance with the Department's Preferred Drug List and compliance with pharmacy claims encounter reporting.
   ii. The CFSP shall provide reports as requested, and in a format prescribed, by the Department to demonstrate net pharmacy savings.

e. Reinsurance
   i. The CFSP shall have and maintain at all times an adequate plan for protection against insolvency as follows:
      1) A CFSP that also operates a Behavioral Health I/DD Tailored Plan or a CFSP that meets the definition of a consortium established under NCGS § 122C-116 shall maintain at all

times an adequate plan for protection against insolvency that meets the terms of this contract and NCGS § 122C.

a) A CFSP that meets the definition of a consortium must define how costs and risk will be shared amongst the entities engaged in the consortium as part of the plan for protection against insolvency.

b) Any arrangement proposed by the CFSP is subject to review and approval by the Department due upon request and no later than one hundred (180) Calendar Days after Contract Award. The CFSP must notify the Department no less than sixty (60) Calendar Days prior to the cancellation or reduction of coverage.

2) A CFSP that is licensed by the NC DOI as a PHP must maintain at all times an adequate plan for protection against insolvency pursuant to NCGS § 58-93-70. Any arrangement proposed by the CFSP is subject to review and approval by NC DOI. The CFSP shall provide the Department with the most currently approved plan, including amendments, upon request. The CFSP shall inform the Department when a previously approved plan is revised.

ii. The CFSP shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify CFSP of any required changes to the proposed reinsurance arrangement or alternative mechanism. The CFSP shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.

iii. The CFSP shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. For a CFSP that is licensed by the DOI as a PHP, this requirement may be met by providing copies of documentation submitted to the Commissioner of Insurance pursuant to NCGS § 58-93-70 and NCGS § 58-93-75. The Department may require additional protections and documentation at any time.

iv. The Department reserves the right to revisit reinsurance requirements annually and to modify the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that such a change in the threshold is deemed warranted by the Department.

v. The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a CFSP or its reinsurer within forty-five (45) Calendar Days of the request by the CFSP.

vi. The CFSP shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the CFSP or the reinsurance carrier, the CFSP shall be fully responsible for all pending and unpaid claims.

vii. Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include Medicaid Managed Care Members as a covered class.

viii. The CFSP shall notify the Department when the CFSP incurs a claim against the reinsurance policy.

f. Financial Viability

i. The CFSP shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. A significant penalty is a penalty greater than twenty percent (20%).

1) For a CFSP that also operates a BH I/DD Tailored Plan or a consortium established under NCGS § 122C-116, if the CFSP's Current Ratio falls below 1.0 at any point in time, the CFSP must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.

ii. The CFSP shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as Cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period measured in days.

1) For a CFSP that also operates a BH I/DD Tailored Plan or a consortium established under NCGS § 122C-116, if the CFSP's Defense Interval Ratio falls below thirty (30) Calendar Days at any point in time, the CFSP must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.

iii. The CFSP shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.

iv. The Department reserves the right to impose enrollment caps on the CFSP based on the CFSP's financial position.

v. A CFSP that also operates a BH I/DD Tailored Plan or a consortium established under NCGS § 122C-116 shall also comply with the following financial viability requirements:

1) The CFSP must, by Day 1 of CFSP launch, fully fund its capital reserves at twelve and a half percent (12.5%)[26] of total expected annual combined BH I/DD Tailored Plan and CFSP Medicaid capitation.

a) If the CFSP fails to meet the Medicaid twelve and a half percent (12.5%) reserve requirement outlined in *Section V.J.3.f. Financial Viability* by Day 1 of CFSP launch, the CFSP must submit a viable plan outlining how the CFSP will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section V.A.6. Readiness Requirements*.

b) For a CFSP to be considered viable at the time of readiness review and subsequently have their solvency plan evaluated, a CFSP must document capital reserves of at least nine percent (9.0%) of total expected annual combined BH I/DD Tailored Plan and CFSP Medicaid capitation by Day 1 of CFSP launch.

2) The CFSP shall maintain capital reserves of at least nine percent (9.0%) of total expected annual combined CFSP and BH I/DD Tailored Plan Medicaid capitation as determined from the monthly, quarterly, and annual financial reporting schedules.

a) If a CFSP's capital reserves fall below nine percent (9.0%) of total expected annual combined BH I/DD Tailored Plan and CFSP Medicaid capitation in any quarterly statement, the CFSP must submit a report the Department that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves, and projections of the impact of the corrective actions on the capital reserve levels.

b) If a CFSP's capital reserves fall below six and a quarter percent (6.25%) of total expected annual combined BH I/DD Tailored Plan and CFSP Medicaid capitation in any quarterly statement, the CFSP must submit a report to the Department as

[26] 12.5% of expected annual BH I/DD Tailored Plan capitation is used as a proxy for appropriate Risk Based Capital (RBC) solvency standards. 300% RBC is approximately equal to 1.5 months of claims, or approximately 12.5%.

described in *Section V.J.3.f.v.2.b.* for Department review. The Department reserves the right to stipulate required corrective action for the CFSP.

c) If CFSP Tailored Plan capital reserves fall below four percent (4.0%) of total expected annual combined BH I/DD Tailored Plan and CFSP Medicaid capitation in any quarterly statement, the Department reserves the right to place the CFSP under the control of the regulator or initiate actions outlined in *Section V.J.3.f.v.2.c.*

3) The Department will provide expected annual combined BH I/DD Tailored Plan and CFSP Medicaid Capitation revenue for use in these calculations. Medicaid capitation revenue will include monthly PMPM capitation payments, but exclude all other managed care payments defined in the Terms and Conditions (i.e., additional directed payments to certain providers, and any Healthy Opportunities Pilot program payments).

4) For purposes of the capital requirements, capital reserves are defined as unobligated assets net of liabilities.

5) The CFSP must, at least ninety (90) Calendar Days before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the North Carolina Department of Insurance (DOI), as outlined in NCGS § 58-93-70, contingent upon legislative authority.

vi. The Department may, at its discretion, implement a risk corridor program to provide additional protection to the CFSP and the Department to address any uncertainty associated with pricing or enrollment. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.

g. Financial accounting and audit

i. The CFSP's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with AR, Generally Accepted Accounting Principles (GAAP), and this Contract. The Department will not recognize or pay services that cannot be properly substantiated by the CFSP and verified by The Department. The CFSP shall:

1) Maintain accounting records for this Contract separate and apart from other corporate accounting records;

2) Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;

3) Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the CFSP. The CFSP must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the CFSP;

4) Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts;

5) Provide copies of the most recent annual audit within thirty (30) Calendar Days of certification, to verify the CFSP's financial status, solvency, and viability; and

6) Provide copies of the CFSP's annual cost allocation plan for the Department's review at least sixty (60) Calendar Days prior to the start of the state fiscal year.

a) The annual financial audit and cost allocation plans shall be subject to annual independent verification and audit by the Department or a firm(s) of the Department's choosing, in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A-87. All such audits shall be arranged to occur at dates and times that are mutually agreeable, and the CFSP shall be provided

with reasonable notice of the Department's intent to perform, or cause to be performed, any such audits. The costs for such audits shall be the responsibility of the Department.

ii. The CFSP shall reimburse the Department, if reimbursement is sought, for reasonable costs incurred by the Department to perform examinations, investigations, audits, or other types of attestations the Department reasonably determines are necessary to ensure CFSP compliance with this Contract. The use of and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are also at the Department's sole discretion.

iii. If, as a result of an audit or review of payments made to the CFSP, the Department discovers a payment error or overcharge, the Department will notify the CFSP of such error or overcharge. The Department will be entitled to recover such funds as an offset to future payments to the CFSP, or to collect such funds directly from the CFSP.

1) The CFSP must return funds owed to the Department within thirty (30) Calendar Days after receiving notice of the error or overcharge, or interest will accrue on the amount due.

2) The Department will calculate interest at twelve percent (12%) per annum, compounded daily. In the event that an audit reveals that errors in reporting by the CFSP have resulted in errors in payments to the CFSP, the CFSP will indemnify the Department for any losses resulting from such errors, including the cost of audit.

K. Compliance

1. Compliance Program

a. The CFSP shall implement a comprehensive Compliance Program focused on ensuring the CFSP is in compliance with all applicable federal and state laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.

b. The CFSP's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include:

i. Written policies, procedures, and standards of conduct that articulate the CFSP's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:

1) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Medicaid Managed Care program, including termination of the provider agreement with the CFSP, consistent with 42 C.F.R. § 438.608(a)(4);

2) Retention policies for the treatment of recoveries of all overpayments from the CFSP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse, consistent with 42 C.F.R. § 438.608(d)(1)(i);

3) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the CFSP is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii);

4) Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. 42 C.F.R. § 438.608(c)(3);

5) Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5);
6) Process for providers to report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2); and
7) Process for monitoring internal business processes to ensure that the CFSP does not engage in inappropriate activities that would be out of compliance with 42 C.F.R. § 438.608.

ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the CEO and the Board of Directors;
iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the CFSP's Compliance Program and its compliance with the requirements under the Contract;
iv. A system for training and education for the Compliance Officer, the CFSP's senior management, and the CFSP's employees on the federal and state standards and requirements under the Contract;
v. Effective lines of communication between the Compliance Officer and the CFSP's employees;
vi. Enforcement of standards through well-publicized disciplinary guidelines;
vii. Identification of potential and actual compliance risks; and
viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

c. The CFSP shall develop a Compliance Plan which defines the CFSP's Compliance Program.
i. The CFSP shall provide the Compliance Plan to the Department:
1) As part of the Implementation Plan, during Readiness Review;
2) Annually thereafter; and
3) Upon request by the Department.
ii. The CFSP shall revise the CFSP's Compliance Plan as requested by the Department.
iii. The CFSP shall submit any requested document within five (5) Calendar Days of the Department's request to review the CFSP's Compliance Plan, and any other policy or procedures governing the CFSP's compliance activities.

d. The CFSP shall develop annual monitoring and auditing work plan(s) for the upcoming year.
i. The CFSP shall submit a Compliance Program report describing the workplans for the upcoming year.
ii. In Contract Year 1, the report shall be submitted ninety (90) Calendar Days prior to CFSP launch.
iii. Following Contract Year 1, the Compliance Program report shall include proposed workplan(s) for the upcoming year and summarize of the status of the previous year's work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.

e. Healthy Opportunities Pilot Compliance Program

i. If the CFSP identifies a significant performance issue or program integrity issue with an HSO, the CFSP shall notify the Network Lead within three (3) Business Days to enable the Network Lead to conduct HSO performance improvement activities consistent with the CFSP Network Lead and Network Lead-HSO model contracts.
   1) For the purposes of this section, a significant performance issue is defined as three (3) or more incidents within three (3) months of failures to comply with material Healthy Opportunities Pilot program requirements.
   2) For the purposes of this section, a program integrity issue is defined as one incident that would likely affect the health or safety of a Healthy Opportunities Pilot enrollee or inappropriate management of Healthy Opportunities Pilot funding.

ii. In the event that the CFSP identifies a significant performance issue or program integrity issue with an HSO, the CFSP shall notify the Network Lead within three (3) Business Days to enable the Network Lead to conduct an investigation.

iii. In the event of verified performance issue or program integrity issue identified by the Network Lead during the investigation results in suspension or termination of the HSO from its network, the CFSP shall:
   1) Stop payment to the HSO within one (1) Business Day of notification of suspension or termination by the Network Lead or Department; and
   2) Begin payment, as owed, to the HSO within three (3) Business Days if suspension is lifted at the direction of the Network Lead or Department.

iv. The CFSP's contracted Network Lead shall make best efforts to facilitate resolution of overpayments consistent with the Department-Network Lead Contract, the CFSP- Network Lead model contract, and the Network Lead-HSO Contract. In the event of an overpayment identified by the Network Lead or Department to an HSO, the HSO shall return payment to the CFSP or Department, at the Department's sole discretion, as facilitated by the Network Lead.

v. The CFSP shall have the right, to inspect, during normal business hours, Network Lead's records related to Healthy Opportunities Pilot service provision by HSOs, or Network Lead's obligations under the CFSP-Network Lead contract. The CFSP shall provide at least thirty (30) Calendar Days advance notice to the Network Lead and shall limit the inspection to purposes related specifically to obligations of the Network Lead to the CFSP and as applicable to CFSP-Network Lead contract.

2. Program Integrity

a. To ensure the effective use and management of public resources in the delivery of services to Medicaid Managed Care Members, the CFSP shall also increase awareness within its organization and across its provider network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the CFSP shall comply with all applicable federal and state laws and regulations including, but not limited to Article 51 of Chapter 1 of the NCGS, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.

b. To promote PI, the CFSP shall adhere to the following program standards, at a minimum:
   i. Validation of Exclusion List Status
      1) The CFSP shall, prior to contracting, check the exclusion status of all contracted providers against the following lists (collectively, these lists are referred to as the "Exclusion Lists") to ensure that the CFSP does not pay federal funds to Excluded Persons or entities:
         a) State Exclusion List;
         b) U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);

c) The System of Award Management (SAM);
d) The Social Security Administration Death Master File (SSADMF);
e) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
f) Office of Foreign Assets Control (OFAC).

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

3) The CFSP shall take appropriate action upon identification that a person, agent, Managing Employee, delegated entities or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.

4) The CFSP shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
a) The name(s) of the Excluded Person(s); and
b) The amounts paid to the Excluded Person(s) over the previous twelve (12) months;

ii. Prohibited Relationships

1) In accordance with 42 C.F.R. § 438.610, the CFSP shall not knowingly have a relationship with any of the following:
a) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549;
b) An individual or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person;
c) An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act; and
d) For the purposes of this section, a "relationship" means any of the following:
i) A director, officer, or partner of the CFSP;
ii) A Subcontractor of the CFSP, as governed by 42 C.F.R. § 438.230;
iii) A person with beneficial ownership of five percent (5%) or more of the CFSP's equity; or
iv) A network provider or person with an employment, consulting or other arrangement with the CFSP for the provision of items and services that are significant and material to the CFSP's obligations under this Contract.

2) If the Department learns that the CFSP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the CFSP has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the CFSP unless the Secretary of HHS directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the CFSP unless the Secretary of HHS provides to the Department and to Congress a written

statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

iii. Deficit Reduction Act Reporting

1) The CFSP shall have a policy and procedure which complies with the requirements of the Deficit Reduction Act (DRA) of 2005, which requires entities that make or receive annual Medicaid payments of five million dollars ($5,000,000) or more to provide detailed information in written policies applicable to employees, Contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
2) The CFSP shall submit annually to the Department, in the format prescribed by the Department, policies and procedures in accordance with the Deficit Reduction Act.
3) Providers and Subcontractors
   a) The CFSP shall require network providers and Subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the Deficit Reduction Act of 2005 requirements.
   b) The CFSP shall provide its network providers and Subcontractors with training materials regarding fraud, waste, and abuse prevention.
   c) The CFSP shall annually certify that no payments are made for services or items provided to a provider, Subcontractor, or financial institution located outside of the United States.
   d) In accordance with federal regulations, the CFSP shall require network providers and non-contract providers to have and implement a policy recognizing Medicaid as the payer of last resort.

iv. Suspensions and Withholds for Payments to Providers for Program Integrity

1) The CFSP shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold.
2) The CFSP shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold.
3) When the Department notifies the CFSP that payments to a provider have been suspended or are being withheld, the CFSP shall suspend payments to or withhold payments from the provider in accordance with the Department's instructions within one (1) Business Day of receipt of the notice or as otherwise instructed. The CFSP shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
4) The CFSP shall commence a payment suspension or withhold in accordance with the Department's instructions and such suspension or withhold shall continue until the CFSP receives notice from the Department to lift the suspension or withhold.
5) The CFSP shall lift the suspension or withhold within three (3) Business Days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
6) The CFSP shall obtain the Department's written approval of the suspension prior to suspending payments to any provider due to suspected fraud. The CFSP shall initiate such suspension within two (2) Business Days of receipt of the approval if the Department approve the suspension of payment.
7) The CFSP shall provide the following information to the Department to request a suspension or withhold of payment to a network provider or non-contract provider:
   a) Name of the network provider or non-contract provider and NPI;

b) The nature of the suspected fraud;
c) Basis for the suspension/withhold;
d) Desired date for the suspension/withhold to begin;
e) Proposed length of the suspension/withhold;
f) Proposed percentage of the withhold, if applicable; and
g) If applicable, the good cause rationale for imposing a partial payment suspension.

8) The CFSP shall be permitted to immediately stop payment to providers after the Department has determined credible fraud.

v. Prohibited Payments

1) The CFSP shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
a) Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;
b) Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
c) Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
d) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997; and
e) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.

vi. The CFSP shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services (U.S. DHHS), the Inspector General of the US DHHS, the Comptroller General, and Members a description of transactions between the CFSP and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
1) Any sale or exchange, or leasing of any property between the CFSP and such a party;
2) Any furnishing for consideration of goods, services (including management services), or facilities between the CFSP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
3) Any lending of money or other extension of credit between the CFSP and such a party. Section 1903(m)(4)(A) of the Social Security Act.

c. Coordination of Provider Monitoring and Auditing

i. The CFSP may conduct an audit of a provider or accept a self-disclosure from a provider even when the Department or MID conducted an audit of the same provider or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period with prior permission from the Department.
ii. The CFSP shall comply with any Department directive not to conduct an audit of a provider.

3. Fraud, Waste, and Abuse Prevention

a. To promote integrity in all CFSP activities and combat fraud, waste, and abuse, the CFSP shall:
   i. Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (Members, providers, Subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid Managed Care;
   ii. Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits;
   iii. Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
   iv. Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
   v. Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
   vi. Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;
   vii. Refer all suspected allegations of fraud to the Department within the timeframes and in the formats specified by the Department; and
   viii. Identify, upon request to the Department the individual(s) most qualified and familiar with the potential financial loss due to fraud, waste, and abuse.

b. Fraud, Waste, and Abuse Investigation Staffing
   i. The CFSP shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the CFSP in preventing and detecting fraud and abuse.
   ii. The CFSP shall establish a Special Investigations Unit (SIU) sixty (60) Calendar Days prior to Medicaid Managed Care, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan. The CFSP shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.
      1) The SIU will consist of at least one (1) dedicated staff Member who is located in North Carolina.
      2) The CFSP's CCO may not serve as a Member of the SIU, although he or she may oversee the SIU.
      3) The CFSP shall ensure that SIU Members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each Member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management, criminal justice or pre-law, or have at least three (3) years of relevant experience.
      4) The CFSP shall require that the Members of its SIU, as well as its CCOr, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training.

c. Investigation Coordination
   i. The CFSP shall refer credible allegations of fraud, including instances involving the CFSP's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) Calendar Days of making the credibility determination.

ii. Once a credible allegation of fraud has been referred to the Department, until further written notice by the Department, the CFSP shall not take any further action including the following:
    1) Contacting the subject of the investigation about any matters related to the investigation;
    2) Continuing the investigation into the matter;
    3) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
    4) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
iii. The CFSP shall cooperate with all appropriate state and federal agencies, including but not limited to, MID and/or federal OIG, in investigating fraud and abuse.
iv. The CFSP shall provide data or information requested by the Department or MID in the standardized form within five (5) Calendar Days of receiving the request.
v. The CFSP shall cooperate with the Department and MID to mitigate any suspected financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.
vi. If the CFSP is directed to complete the investigation into suspected instances of fraud, then the CFSP shall report to the Department and MID, in a specified format, its finding within ten (10) Calendar Days of the conclusion of the investigation.
vii. The CFSP shall report new information related to a previously referred suspected instance of fraud where PI and MID did not intervene in the investigation to the Department. The CFSP shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) Calendar Days of receiving or identifying the new information.
viii. The CFSP cannot take action, such as termination of a provider, suspension of payment, or withhold of payment, related to potential findings of fraud without approval of the Department. Any such action taken after CFSP has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.
ix. Action by the CFSP shall not preclude the Department or MID from conducting an audit or accepting a self-disclosure from a provider even if the CFSP has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.
x. The CFSP must participate in:
    1) Monthly calls with the Department regarding fraud, waste, and abuse;
    2) Quarterly in person meetings with the Department and MID regarding fraud and abuse; and
    3) Ad hoc calls or meetings as requested by the Department and MID.

d. Whistleblower Protections
    i. The CFSP shall develop and maintain a Whistleblower Policy related to whistleblower protections and submit to the Department for review ninety (90) Calendar Days after Contract Award.
    ii. The CFSP shall include fraud, waste, and abuse policies and procedure information in the CFSP's employee handbook with reference to and description of the applicable federal and state fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the CFSP's compliance policies and how to access those policies.

e. Healthy Opportunities Pilot Fraud and Abuse, Waste and Abuse Prevention
    i. The CFSP's contracted Network Lead shall make best efforts to facilitate resolution of overpayments or underpayments due to fraud, waste and abuse between the CFSP and HSOs

consistent with Department-Network Lead Contract, the CFSP-Network Lead model contract and Network Lead-HSO Contract.

ii. In the event of an underpayment identified by the Network Lead to an HSO due to fraud, waste or abuse, the CFSP shall make a payment to the HSO in the amount it is owed.

iii. In the event of an overpayment identified by the Network Lead to an HSO due to a finding of fraud, waste, or abuse, the HSO shall return payment to the CFSP or Department, at the Department's sole discretion, as facilitated by the Network Lead.

f. Fraud Prevention Plan

i. The CFSP shall develop and maintain a Fraud Prevention Plan subject to Department review and approval. The CFSP shall submit the Plan to the Department:

1) Ninety (90) Calendar Days after Contract Award;
2) Annually thereafter; and
3) Upon request by the Department.

ii. The CFSP shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the CFSP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the CFSP's Fraud Prevention Plan.

iii. The Fraud Prevention Plan shall include the following:

1) The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2;
2) Name of the CCO;
   a) The CCO shall be responsible for ensuring suspected fraud, waste, or abuse cases are referred to the Department.
3) Description of the Special Investigations Unit (SIU), the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care;
4) Description of other staff assigned to fraud, waste, and abuse functions;
5) Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
6) Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
7) Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
8) Processes and procedures for in-network provider and CFSP staff terminations related to suspected or confirmed fraud and abuse;
9) Processes and procedures by which the CFSP avoids fraud, waste and abuse engaged in by out-of-network providers;
10) Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by Members;
11) Training procedures for directors, officers, employee, delegated entities, and Subcontractor education on federal and state laws, as well as CFSP practices for detection, identification, reporting and prevention of fraud, waste and abuse;
12) Processes and procedures for ensuring in and out-of-network providers and Members know and understand fraud, waste and abuse obligations;
13) Processes and procedures for putting a provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate. The Policy shall be included in the CFSP's Provider Manual;

14) Description of the CFSP's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
    a) A list of automated pre-payment claims edits;
    b) A list of automated post-payment claims edits;
    c) A list of desk audits on post-processing review of claims planned;
    d) A list of reports on network provider and non-contract provider profiling used to aid program and payment integrity review;
    e) The methods the CFSP will use to identify high-risk claims and the CFSP's definition of "high-risk claims";
    f) Visit verification procedures and practices, including sample sizes and targeted providers types or locations;
    g) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
    h) Policies and procedures used by the CFSP designed to prevent, detect, and report known or suspected fraud, waste and abuse;
    i) A list of references in provider and Member material regarding fraud and abuse referrals (e.g. on Member EOB);
    j) Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly;
    k) The process by which the Special Investigations Unit (SIU) shall monitor the CFSP's marketing representative activities to ensure that the CFSP does not engage in inappropriate activities, such as provision of inducements; and
    l) Description of roles and responsibilities for each key role within the SIU.
15) Assurance that the identities of individuals reporting violations by the CFSP are protected and that there is no retaliation against such persons;
16) Description of criminal background and exclusion screening processes for its owners, agents, delegated entities, employees, network providers and Subcontractors; and
17) Process and procedures for working and coordinating with the Department, including its state and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.

4. Third Party Liability (TPL)

a. The CFSP shall be responsible for actively seeking and identifying third party resources for the purposes of the following:
    i. Cost avoidance;
    ii. Credit balance;
    iii. Commercial health insurance;
    iv. Medicare disallowance[27];
    v. Casualty insurance; and
    vi. Liability insurance.

b. Cost Avoidance
    i. The CFSP shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
        1) Policy number;
        2) Policyholder's name;

[27] Unlikely to be applicable to the CFSP population.

3) Group Policy number;
4) Group Policy name;
5) Identification of whether the policyholder is the non-custodial parent;
6) Member Medicaid ID;
7) Member relationship to policy holder;
8) The begin date of insurance coverage; and
9) The end date of insurance coverage.

c. The CFSP shall engage in third party resource recovery and cost avoidance for all other types of recovery.

d. The CFSP shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the CFSP.

e. The CFSP shall report cost recovery and cost adjustments through the encounter process, including denials.

f. The CFSP shall make every reasonable effort to determine the liability of third parties to pay for services rendered to Members and to cost avoid and/or cost recover such liability from the third party.

g. The CFSP shall treat all funds recovered by the CFSP from third party resources as income to the CFSP.

h. TPL Recovery
   i. The CFSP shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
   ii. The CFSP shall open a new case upon receipt of a Third-Party Liability Accident Information Report form from the Member's attorney or other reliable leads that indicate third party recovery might be possible.
   iii. The CFSP shall be responsible for attorneys retained for tort action, through contact with the Members, participating providers, and the Department for seeking and identifying third party resources.
   iv. The Department shall review the effectiveness of the CFSP's TPL recovery programs annually and may revoke TPL activities from an CFSP if the CFSP's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the CFSP's TPL Recovery programs may include:
      1) A comparison to annual FFS recovery averages to CFSP recovery averages per Beneficiary;
      2) The percentage of recoveries over total spend;
      3) The percentage of cost avoidance over total spend;
      4) The average turnaround time from the remittance to recovery;
      5) The average number of policy adds in comparison to historical FFS Policy adds on a monthly basis; and
      6) Quarterly audits on CFSP encounter data.
   v. The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.

i. Identification of Other Forms of Insurance
   i. The CFSP shall notify the Department within five (5) Calendar Days if it has identified that a Member has another form of insurance.

ii. The CFSP shall load and submit to the Department updates and additions on other forms of insurance into its system within five (5) Business Days of matching and verification and the CFSP shall review State TPL data prior to denying any claim for TPL or other insurance.
iii. The CFSP shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been updated in the CFSP's system or submitted by the CFSP to the Department for Medicaid Managed Care Members.
iv. The CFSP shall ensure that the information on other forms of insurance is accurately tracked and maintained within the Member record. The CFSP must correct all errors made in its submission of other forms of insurance to the Department within five (5) Business Days of notification by the Department and must provide proof of such corrections upon request from the Department.
v. The CFSP shall review paid claims to determine which paid claims should have been paid by the Member's other forms of insurance instead of by the CFSP.
vi. The CFSP shall notify the Department of overpayments paid to the CFSP from an insurance carrier for recovery claims billed by the CFSP for Members with other forms of coverage.
vii. The CFSP shall bill the applicable insurance carriers for Medicaid Managed Care Members' major medical, prescription drug and dental claims within thirty (30) Calendar Days of matching the claims to TPL segments pertaining to Members' active insurance policies for commercial insurance direct billing.
    1) The CFSP shall adhere to the billing requirements of each commercial insurance carrier.
    2) In instances where the carrier will not accept the claim without supporting medical records, the CFSP shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) Calendar Days of becoming aware of the need for medical records for commercial insurance direct billing.
viii. Within ten (10) Business Days after receipt of a direct claim billing denial or other types of denials, the CFSP shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the CFSP's IT system; and resubmit the claim to the appropriate insurance carrier.
ix. The CFSP shall ensure providers have the capability to verify other insurance information through the CFSP's provider portal and Real-Time Eligibility EDI transactions 270/271.

j. Subrogation Cases
i. Pursuant to 42 C.F.R. § 438.608, the CFSP agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
ii. The CFSP lien in each subrogation case shall be equal to the payments made by the CFSP.
iii. The CFSP shall identify the CFSP paid Medical Claims amounts for each subrogation case using data from the paid claims file.
iv. Relevant information in the subrogation case at the time of closure shall include:
    1) Settlement sheet listing all providers with medical subrogation rights;
    2) Original lien amount of each entity with subrogation right;
    3) The CFSP recovered amount; and
    4) The amount disbursed to each entity involved.
v. The CFSP shall review the diagnosis code and Member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
vi. A subrogation case shall be closed with recovery after the CFSP lien has been satisfied to the statutory limits, as referenced in NCGS § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery

only after the CFSP provides relevant and adequate documentation supporting the reason for case closure without recovery. The CFSP shall obtain and record all relevant information in the subrogation case at the time of closure.

vii. In accordance with NCGS § 108A-57(a1), the CFSP shall collect the amount of the CFSP lien or up to one-third (1/3) of the amount of the Member's gross recovery in the personal injury or wrongful death case, whichever is less.

viii. The CFSP shall coordinate collection of the settlement amount with the Member or the Member's attorney.

ix. The CFSP shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the CFSP's claim to any part of the proceeds of any settlement.

x. The CFSP shall not compromise, waive or reduce the CFSP's lien without written authorization from the Department or its designated legal counsel.

xi. The CFSP shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.

xii. The CFSP shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.

k. The CFSP shall develop and maintain a TPL Policy for review and approval by the Department.

i. The TPL Policy shall include the following:

1) Cost avoidance activities;
2) Payment recovery activities;
3) Identification of other forms of insurance processes and procedures; and
4) Subrogation, including:

a) Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'

ii. The CFSP shall submit the TPL Policy:

1) Ninety (90) Calendar Days after Contract Award;
2) Annually thereafter; and
3) Upon request by the Department.

l. The CFSP shall pay and then chase for the following services:

i. Medical Support Enforcement: The CFSP shall pay and chase if the claim is for a service provided to a Member on whose behalf child support enforcement is being carried out if:

1) The third-party coverage is through an absent parent; and
2) The provider certifies that, if the provider has billed a third party, the provider has waited one hundred (100) Calendar Days from the date of service without receiving payment before billing the CFSP.

ii. Preventive Pediatric Services: The CFSP shall pay and chase for claims for preventive pediatric services, including EPSDT.

iii. In addition to medical support enforcement and preventative pediatric services, *Section V.K. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits* lists programs and services that are an exception to the general rule that NC Medicaid is the payer of last resort. As applicable, when a Member of the CFSP is entitled to one or more of the following programs or services covered by the CFSP, the CFSP shall pay and chase the claim.

Section V.K. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program or Service	**Federal**	**State**
1. Crime Victims Compensation Fund	X	
2. Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
3. Ryan White Program	X	
4. Indian Health Services	X	
5. Veteran's Benefits for state nursing home per diem payments	X	
6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	
7. Women, Infants and Children Program	X	
8. Older American Act Programs	X	
9. World Trade Center Health Program	X	
10. Grantees under the Title V of the Social Security Act	X	
11. Division of Service for the Blind		X
12. Division of Public Health "Purchase of Care" Program		X
13. Vocational Rehabilitation Services		X
14. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

m. Bypass Third Party Liability Rules
   i. The CFSP shall adjudicate claims as the primary payer and bypass Third Party Liability edits for Medicaid covered services that commercial insurance does not typically cover based on criteria in the Managed Care Billing Guide.

5. Recipient Explanation of Medical Benefit (REOMB)

a. The CFSP shall create the REOMB using the previous month's claims for North Carolina Medicaid and the previous month's paid claims (i.e. February claims comprise March REOMB sample).

b. The CFSP shall include the following in the REOMB:
   i. List of services provided and billed to the CFSP;
   ii. The name of the provider administering the service;
   iii. The date on which the service was administered;
   iv. The paid and unpaid services; and
   v. The reason a service was not paid.

c. The CFSP shall exclude those claims that include sensitive procedure information, claims that have been adjusted, and Medicare Cross-over Population claims when creating the REOMB as defined by the Department. Sensitive procedure information shall be defined as any procedures for

allergies, newborn treatment and care, and any treatment for a Member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, and sterilization.

d. The CFSP shall exclude sensitive procedure information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with NC Chapter 48A.

e. The CFSP shall send a REOMB for at least ten percent (10%) of all claims or five hundred (500) claims for the month, whichever is less. (Excluded claims include those referenced in this section).

f. The CFSP shall send the REOMB via US mail to randomly selected Members that have been approved by the Department. The CFSP shall collect responses from the REOMB mailing.

g. The CFSP shall use a Department approved sampling method to determine population for the REOMB and include it in the CFSP's annual Fraud Prevention Plan.

h. The CFSP shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.

i. The CFSP shall provide ad hoc REOMB to a Member upon request.

L. Technical Specifications

1. Data Exchange Model

a. The matrix below provides a point in time, high-level view of the primary data exchanges associated with the CFSP, the Department, and Department vendors. This is not the complete list of data that will need to be exchanged between the CFSP, the Department, and the Department vendors. As the program evolves and technical designs are finalized the data exchanges included below will change. The CFSP will be responsible for implementing the data exchanges as defined by the Department.

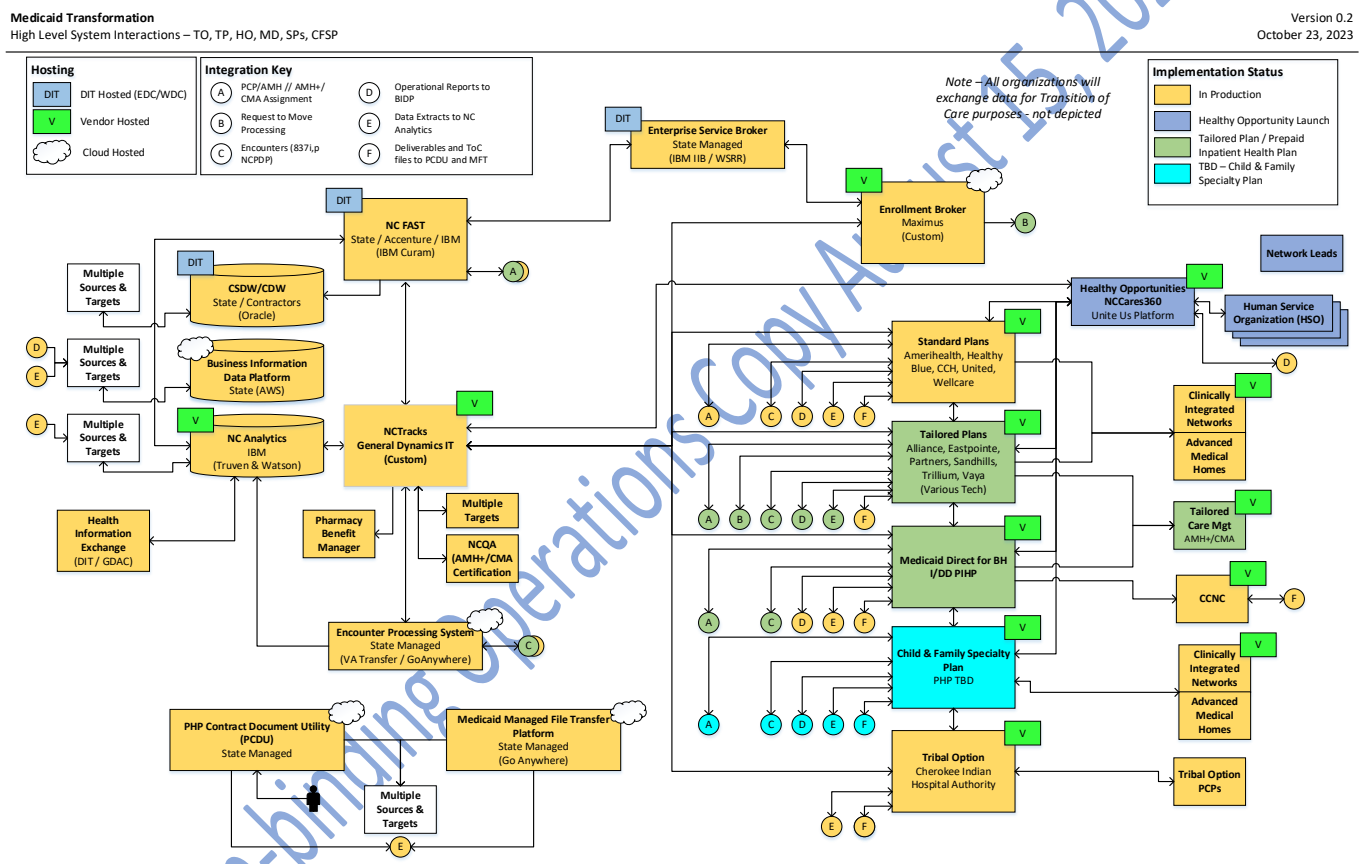
b. The Department anticipates changes to its Information Technology Systems. The CFSP will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file). The Department will provide test environments to allow adequate testing time.

c. MES – The Department is in the process of aligning its Medicaid systems with CMS direction for modularity. As part of this multi-year program the Department anticipates that its technology partners, including the CFSP will need to change in several ways:
   i. Implementation of new interfaces that may includes changes to existing interfaces, updates to how interfaces are routed to partners, and migrations from file-based interfaces to APIs.
   ii. Changes in the format and standards used to exchange data. Examples of these changes include modifications to data formats such as the use of the implementation of the Fast Healthcare Interoperability Resources (FHIR) or other open or proprietary canonical models.
   iii. The implementation of the System Integration Platform (SIP) which will centralize the routing of all interfaces through a standards based platform.

d. The Department anticipates that the SIP will be implemented at the time the CFSP is being developed and all interfaces can be routed through the SIP at go live, however as additional MES changes are implemented in support of the overall MES program the CFSP will make the necessary technical modifications to CFSP systems to remain in compliance with the overall MES program

and technology. The Department will provide technical designs and test environments to allow adequate development and testing time.

e. The Department will require reporting on interfaces based on the priority of the interface (which is determined by the business units). This reporting will be in a standard format and facilitated through Tech Ops. The Department may require the reporting to be automated as part of the execution of the interface and delivered to the Department via Managed File Transfer (MFT)or email, in a CSV or other pipe delimited format. The CFSP will comply with the requirements as defined by the Department.



No.	Data Exchange Description – For Informational Purposes
1.	The Department will send the CFSP the following data: a. Member Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records. This file will be provided daily and weekly (for reconciliation purposes) b. Provider enrollment data including all Medicaid providers c. Managed Care Payments d. Member claims history including prior authorizations, claims, encounters, pharmacy, and other information as needed to support the enrollment and care of the member by the CFSP

No.	Data Exchange Description – For Informational Purposes
	e. Managed Care Payments including an 820 and monthly 834 for payment reconciliation purposes f. Specialized data as needed for member care g. CFSP Network Response File – the Department will send a response file upon validation of the CFSP Network File reporting the status of each network provider into the Departments' consolidated provider system.
2.	The CFSP will send to the Department or its Vendors the following data: a. Encounter Data – Medical and Pharmacy Encounter data b. AMH/PCP Assignment – The CFSP will submit to the Department the Member's assigned AMH/PCP c. Lock-in Data – Member lock-in data (including pharmacy and prescriber) d. CFSP Network File including All Contracted Medicaid Managed Care providers – The CFSP will send its network of Medicaid Managed Care providers to the Department for validation and inclusion into the Department's centralized provider system. e. Member Enrollment – On a monthly basis (or at the request of the Department the CFSP will send a complete roster of its Medicaid Managed Care members in the format dictated by the Department f. Member claims history including prior authorizations, claims, encounters, pharmacy, and other information as needed to support the enrollment and care of the member by the CFSP as member transition from the CFSP to other the Department vendors, or to the Department. g. Member Risk Stratification Data h. Other member data as directed by the Department, either on a one time, ad-hoc, or scheduled basis. i. Member Insurance Data j. Operational Data Extracts and Reports as dictated by the Department
3.	The CFSP will send the following data to the AMHs: a. Member Assignments b. Transition of care data as needed
4.	The CFSP and the Provider will exchange the following data: a. Claims Data – The contracted Providers will send claims data for payment to the CFSP. b. Payment Data – The CFSP will send payments to the provider.

2. Electronic Data Submission

a. EDI and Other Integrations

i. Integrations between the CFSP, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.

ii. The CFSP shall not transmit Protected Health Information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 C.F.R. § 142.308(d).

iii. If the CFSP stores, transmits, or maintains data or information in an encrypted format, the CFSP will, at the Department's request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.

iv. The CFSP will work with the Department or its designated Vendor to establish and manage all integration.

v. The CFSP will comply with all NC DHHS Technical Operations team processes and procedures. The following is a high-level overview of the Tech Ops processes and procedures. Upon award and prior to implementation, the Tech Ops team will provide an onboarding process which will detail all specific process and procedures the CFSP will need to follow:

1) Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the CFSP's ability to deliver Member services, it must be reported immediately. NC DHHS provides a 24x7 number for incidents that require immediate response.

2) The CFSP will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure in a format defined by NC DHHS. The Department may require additional information if the initial RCA does not include adequate information.

3) The Department at its discretion will track issues reported by the CFSP and may require a more comprehensive corrective action plan if the Department identifies trends in the CFSP's performance.

b. Retransmissions

i. If the CFSP receives an unintelligible transmission from the Department or Department vendor, the CFSP will immediately notify the Department via the Tech Ops team and the Department shall retransmit as soon as the errors are remediated.

ii. If the CFSP is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the CFSP shall retransmit as soon as the errors are remediated.

iii. For the purposes of this section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.

c. Test Data Transmission

i. The CFSP will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for Member enrollment prior to initial Enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the CFSP, or between the CFSP and other Department vendors such as the EB or PHPs. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.

3. Enrollment and Reconciliation

a. Member Enrollment and Reconciliation

i. Enrollment:

1) The CFSP shall accept an 834 eligibility file daily from the Department with new, modified, and terminated Member records.

2) The CFSP shall add, modify, or terminate Members daily based on 834 eligibility file within any defined SLA periods.

3) The CFSP shall send a daily Pharmacy lock-in file to the Department, or entity designated by the Department.

ii. Reconciliation:

1) The Department will provide to the CFSP a weekly 834 eligibility file, including all Members that were added, modified, and terminated for the period.
2) The Department will collect on a monthly basis the full roster of members for reconciliation purposes across all partners.
3) The CFSP at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
4) At the Department's request, the CFSP shall provide a full roster of Members currently enrolled in their CFSP in the Department's preferred format within seventy-two (72) hours.
5) The CFSP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
6) The Department shall determine if corrections are needed to the enrollment data to address discrepancies by the CFSP identified during reconciliation.
7) The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the CFSP.
8) The CFSP shall add, modify, or terminate Members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
9) The CFSP shall reconcile the monthly 820 payment file with the monthly 834 eligibility file.
10) The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
11) In addition to the reconciliation process defined above, the CFSP shall be able to identify duplicate Members and report those findings to the Department in a format defined by the Department.

b. AMH/Primary Care Physician Assignment and Reconciliation

i. All AMH/PCP choices made by the Member at application will be transmitted to the CFSP by the Department via an 834 transaction.
ii. If no choice is made by the Member, the CFSP shall assign an AMH/PCP and transmit to the Department on a daily basis. The file format and layout will be defined by the Department, and it was anticipated to be a daily batch transaction.
iii. The CFSP shall reconcile AMH/PCP data with the Department at least monthly using the monthly 834 file described above.
iv. The CFSP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
v. The Department shall determine if corrections are needed to the AMH/PCP data to address discrepancies identified by the CFSP during reconciliation.
vi. The CFSP will provide to the Department any AMHs that the CFSP moves to a Tier other than that attested to by the Provider and sent to the CFSP by the Department.

c. Provider Enrollment and Credentialing

i. The Department or a designated vendor will provide to the CFSP a daily, full file including all North Carolina Medicaid enrolled providers, including relevant enrollment and Credentialing information.
1) During the Provider Credentialing Transition Period, the information will be provided on a daily basis, in a format and transmission protocol to be defined by the Department.

2) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the CFSP a notice of change to the frequency and format within one hundred- twenty (120) Calendar Days of CFSP implementation.

ii. The CFSP shall reconcile provider data with the Department, or designated vendor, at least daily.

iii. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address discrepancies identified by the CFSP during reconciliation.

4. Provider Identification Numbers (NPIs, Atypical Number)

a. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the CFSP must use the registered NPI that the provider used to enroll with NC DHHS or the Department-assigned Atypical number for those providers who do not qualify for an NPI. The CFSP must require that providers use these identifiers when submitting data to the CFSP.

b. The Department produces a daily provider enrollment file that includes all active Medicaid providers, Medicaid providers terminated within the last year, and suspended Medicaid providers. The CFSP is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.

5. Enrollment and Reconciliation

a. Provider Enrollment and Credentialing

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

1) During the Provider Credentialing Transition Period, the information will be provided on a daily basis, in a format and transmission protocol to be defined by the Department.

2) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the CFSP a notice of change to the frequency and format not less than one-hundred and twenty (120) Calendar Days prior to implementation.

ii. The CFSP shall reconcile provider data with the Department, or designated vendor, at least daily.

iii. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address CFSP discrepancies identified during reconciliation.

6. Provider Identification Numbers (NPIs, APIs)

a. Provider Directory

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

1) The CFSP should use the NPI issued by NPPES plus the Department's specified key as the as the unique provider identifier. For those providers who do not qualify for NPI's, the Atypical Provider ID issued by the Department designated vendor system should be used. The CFSP shall reconcile provider data with the Department, or designated vendor, at least daily.

b. Consolidated Provider Directory Data Transmissions

i. The Department has appointed the Department's designated vendor with the creation of a Consolidated Provider Directory which will include all Managed Care and Medicaid Fee for Service providers.

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

iii. The final file format will be determined by the Department's designated vendor; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).

iv. The transport will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).

v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the selected Department's designated vendors.

7. Technology Documents

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

~~b.~~ Security Documentation: The CFSP must comply with all State and DHHS security policy as outlined in the State and DHHS Security manuals. These manuals are available here: ~~https://it.nc.gov/documents/statewide-information-security-manual and https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals.~~
https://it.nc.gov/documents/statewide-information-security-manual and https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals.
In compliance with this policy, the DHHS Privacy and Security Office and the Department of Information Technology require, at a minimum, three (3) documents to be submitted by the CFSP. Two of the three documents as detailed below must be submitted using the State's templates.

i. Vendor Readiness Assessment Report (VRAR) - The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the information system. The template for the VRAR can be accessed here: https://it.nc.gov/documents/vendor-readiness-assessment-report.

ii. System Security Plan (SSP): The CFSP shall provide a SSP that details how the CFSP will comply with all of the Departments' Confidentiality, Privacy and Security Protection requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above. After approval by the Department, the SSP shall be updated annually and resubmitted to the Department for review. The template which must be used to submit the SSP can be accessed here:~~https://it.nc.gov/documents/system-security-plan-template.~~
https://files.nc.gov/ncdit/documents/files/NC%20DIT%20SSP%20Template.20180112.docx
The SSP must be updated and submitted annually. The SSP must include at a minimum:

1) Approach to customer and Member data protection including internal programs and policies;
2) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
3) Approach to complying with HITECH and HIPAA;
4) Approach to risk analysis and assessment associate with NIST;
5) Processes for monitoring for security vulnerabilities including the use of external organization such as US CERT;
6) Processes and plans for vulnerability and breach management including response processes; and
7) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).

iii. SOC 2 Type 2 Report – The CFSP must submit a completed Soc 2 Type 2 report. If the technology platform used to deliver the services under this contract has not been used in a production setting prior to the go live of the CFSP, a Self-Assessment must be performed on the technology platform and submitted in lieu of the Soc 2 Type 2. After a minimum of one hundred eighty (180) Calendars Days of production activity, a Soc 2 Type 2 assessment must be performed, and the resulting report submitted to the State. The Soc 2 Type 2 must be updated and submitted annually. If a Self-Assessment is required, it must be completed on the template provided by the DHHS Privacy and Security Office.

c. Encounter Implementation Approach. The CFSP shall provide a plan that shows how the CFSP will implement their encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
   i. Approach to meeting performance, accuracy, and timeliness requirements;
   ii. Operating model including staffing and technology to process and submit encounters;
   iii. Reference data management process including how NC DHHS's reference data (if applicable) will be integrated into the encounter management process;
   iv. Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
   v. QA and Process improvement processes including how errors detected by NC DHHS's Encounter Processing System are addressed by the CFSP, as well as how continuous improvement is integrated into the overall process. This section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Offeror's processes; and
   vi. The plan should include distinctions for medical and Pharmacy Encounter management.

d. System Interface Design. The CFSP shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
   i. Detailed design by interface showing the Offeror's approach to meeting the requirements defined by the State;
   ii. Approach to managing EDI transactions including technology;
   iii. Technical integration architecture including the Offerors technical approach to integrating multiple internal systems with external partners;
   iv. Operating model around interface and batch management including staffing and technical architecture. This section should include the processes for managing failures in transmissions; and

v. Software and platform testing processes for new interfaces including the data management approach.

8. Testing

a. System Test Plan. The CFSP shall develop and maintain a System Test Plan inclusive of the CFSP's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. The Test Plan shall be submitted to the Department ninety (90) Calendar Days after Contract Award and otherwise upon request by the Department and shall include:
   i. High level description of the scope of each testing phase;
   ii. Applications or Systems that are part of the testing;
   iii. Integrations that are part of the testing;
   iv. Testing techniques or tools that will be used for testing;
   v. Test Environment; and
   vi. Test Metrics and Reporting of Defects.

b. The CFSP shall complete internal testing and report status throughout the duration of the project.

c. The CFSP shall facilitate User Acceptance Testing with key state identified personnel as requested.

d. The CFSP will participate in all End-to-End testing with other Department partners as directed by the Department. This will include End to End testing prior to launch and may include periodic End to End testing as other technical processes and systems are modified or brought online.

e. The CFSP will maintain dedicated test environments adequate to support multiple testing workstreams concurrently, for example multiple concurrent cycles of internal testing and End to End Testing. In addition, for the End-to-End environment and testing specifically, the Contractor will maintain a test environment provisioned with the same security controls that are required by the Department's Privacy and Security Office for production environments. This may include, but is not limited to encryption of data at rest, production like authentication and authorization processes (e.g. dedicated user IDs, password policies, etc.), and appropriate scanning and intrusion detection. The parties will use best efforts to use synthetic data as part of End-to-End Testing. As part of End-to-End testing, this environment may need to support and secure production data including production volumes.

f. The CFSP will leverage the Department's test management platform (currently Microfocus ALM) as the test management system to document test procedures as part of End-to-End testing. This requirement does not preclude the CFSP from using their own test management platform in addition to the Department platform for all phases of testing.

9. CFSP Data Management and Health Information Systems

a. The following section contains high-level information on Health Information System and Member Data that will be established, maintained, analyzed, and reported by the CFSP. Specific details on the data, analysis, and reporting will be provided upon Contract Award.
   i. The CFSP shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the CFSP's operations as well as satisfying the reporting requirements detailed in this RFP which may include but are not limited to utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

ii. The CFSP shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act.
iii. The CFSP shall collect and maintain data on Member and Provider characteristics and interactions as specified by the state and on all services furnished to Members through a claims processing system or other methods as specified by the state.
iv. All data, reports, and information submitted by the CFSP on behalf of the Providers (including Providers within or outside of its networks) shall be validated by the CFSP as accurate and complete prior to submission.
v. The CFSP shall collect data from Providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
vi. The CFSP shall make all collected data available to the Department and upon request to CMS.

b. North Carolina's Health Information Exchange
i. The CFSP shall submit encounters and claims to North Carolina's Health Information Exchange, known as NC HealthConnex, as required by Article 29B of Chapter 90 of the NC General Statutes, the Statewide Health Information Exchange Act.

10. Healthy Opportunities Pilot

a. The CFSP shall make modifications as needed to its technology systems and data exchange processes to account for Healthy Opportunities Pilot requirements including, but not limited to:
i. Changes to the CFSP systems to allow for the ingestion of the provider enrollment file from North Carolina's Medicaid Management Information System (or future MES) to account for and incorporate changes associated with enrollment of Network Leads and HSOs as Medicaid providers and provider affiliations.
ii. Changes to the CFSP systems to allow for sending the CFSP Network File to North Carolina's Medicaid Management Information System (or future MES) with an indicator noting that the CFSP has contracted with a "Care Management Team" to perform Healthy Opportunities Pilot care management according to the Healthy Opportunities Pilot Updated Network File Companion Guide, as applicable.
iii. Changes to the CFSP systems to allow for the ingestion of member data from NCCARE360 including, but not limited to, Healthy Opportunities Pilot member enrollment rosters, and Healthy Opportunities Pilot member consents.
iv. Changes to the CFSP systems to allow for the ingestion of data from NCCARE360 associated with the approval and payment of invoices for Healthy Opportunities Pilot service delivered to the CFSP's members including outbound interfaces to allow the CFSPs to update the NCCARES360 platform with payment status.
v. Changes to CFSP systems and processes to allow for the transition of Healthy Opportunities Pilot-enrolled members and associated data to and from other health plans. This may include systematic transfers between health plan systems, changes on the NCCARE360 platform, or manual processes between the sending and receiving care management providers.
vi. Changes as needed to CFSP systems to pay HSOs for authorized Healthy Opportunities Pilot services delivered.
vii. Changes as needed to CFSP systems to pay "Care Management Team" ties, as applicable.