STATE OF NORTH CAROLINA

Primary Care Case Management Entity Contract

#30-2021-061-DHB

between the

North Carolina Department of Health and Human Services, Division of Health Benefits

and

North Carolina Community Care Networks, Inc

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This Primary Care Case Management Entity Contract ("Contract") is between the Department of Health and Human Services, Division of Health Benefits ("Department") and North Carolina Community Care Networks, Inc ("Contractor"), a primary care case management (PCCM) entity as defined by 42 C.F.R. § 438.2.

I. Background

In the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the State Plan for Medical Assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs.

The Department's goal is to improve the health of all North Carolinians through an innovative, whole person centered, and well-coordinated system of care, which purchases health while addressing both medical and non-medical drivers of health. N3CN has decades of experience in North Carolina providing care management services to Medicaid enrollees on behalf of the Department.

The goals of the PCCM program include:

- Supporting the Department's overall vision of creating a healthier North Carolina;
- Delivering whole-person care through the coordination of physical health, behavioral health, addressing unmet health-related resource needs and care models with the goal of improved health outcomes and more efficient and effective use of resources;
- Utilizing cost-effective resources and uniting community resources and health care providers to address the full set of factors that affect health; and
- Performing localized care management at the site of care, in the home, or in the community to build on the strengths of the current Carolina Access primary care and care management infrastructure.

North Carolina's State Plan under Title XIX of the Social Security Act Medial Assistance Program, as amended, calls for federal and state funds for Medical Assistance Programs and the State Children's Health Insurance Program to be managed through a Primary Care Case Management program, entitled the Community Care of North Carolina Program.

This agreement values the collective effort and the desire to build a genuine partnership, which reiterates the commitment that exists between the State of North Carolina and N3CN.

II. Definitions, Abbreviations and Acronyms

A. Definitions

1. **Adverse Determination:** Has the same meaning as Adverse Determination as defined in N.C. Gen. Stat. 108A-70.9A. Adverse Determinations relate to decisions made by the Department, or the Department's designated contractor, for services provided under Medicaid Direct.
2. **Applicable Law**: All State and federal statutes and regulations governing the conduct of all entities covered under this Agreement, including without limitation governing the use and protection of individually identifiable health information, protected health information, and personally identifiable information.
3. **Authorized Representative:** An individual, provider, or organization designated by a beneficiary, or authorized by law or court order, to act on their behalf in assisting with the individual's participation in NC Medicaid Direct. With written consent of the enrollee, or as otherwise legally authorized, an Authorized Representative may consent on behalf of an enrollee and may access information the same as the enrollee.
4. **Authorized User**: Means Contractor's employees, workforce members, Subcontractors, and other entities such as Carolina Access practices who have executed the Contractor's participation agreement, to use the Data Platform for a permitted purpose and who have been assigned a user name and password to access the Data Platform.
5. **Behavioral Health Intellectual / Developmental Disability Tailored Plan (Behavioral Health I/DD Tailored Plan or Tailored Plan):** A managed care plan specifically designed to provide targeted care for individuals with severe mental health disorders, substance use disorders, and intellectual and/or developmental disabilities as described in Section 4. (10) of Session Law 2015-245, as amended by Session Law 2018-48.
6. **Beneficiary:** An individual eligible to receive North Carolina Medicaid or NC Health Choice benefits.
7. **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals: with HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving 1915(b)(3), Innovations or TBI Waiver services.
8. **Benefit:** Fee for service services and supports provided to enrollees through participation in the NC Medicaid Direct program.
9. **Business Associate Agreement (BAA):** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the contract between a HIPAA-covered entity and business associate that sets forth the safeguards required for protected health information (PHI).
10. **Calendar Day:** A Calendar Day includes the time from midnight to midnight each day. It includes all days in a month, including weekends and holidays. Unless otherwise specified within the Contract, days are tracked as Calendar Days.
11. **Care Coordination:** Defined as organizing patient care activities and sharing information among all the participants concerned with a Member's care to achieve safer and more

effective care. Through organized care coordination, Members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

12. **Care Management:** Defined as a team-based, person centered approach to effectively managing patients' medical, social and behavioral conditions. Care Management shall include, at a minimum, the following:
    a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
    b. Care Needs Screening;
    c. Identification of Members in need of care management;
    d. Development of Care Plans (across priority populations);
    e. Development of comprehensive assessments (across priority populations);
    f. Transitional Care Management: Management of Member needs during transitions of care and care transitions (e.g. from hospital to home);
    g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
    h. Chronic care management (e.g., management of multiple chronic conditions);
    i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
    j. Management of unmet health-related resource needs and high-risk social environments;
    k. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
    l. Development and deployment of population health programs.
13. **Children with Special Health Care Needs:** Those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.
14. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
15. **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement.
16. **Contractor:** North Carolina Community Care Networks, Inc.

17. **Comprehensive Assessment:** A person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive Care Management and will inform the Member's ongoing care plan and treatment.
18. **CMS:** The Centers for Medicare and Medicaid Services.
19. **Data Breach**: Refers to the improper access to, use of, or disclosure of protected health information that does or is likely to compromise the security or privacy of the protected health information. To be deemed compromising or likely to comprise the privacy or security of the protected health information, the unauthorized use or disclosure must be determined to meet the following criteria: (i) The data is identifiable to specific individuals; (ii) The person accessing or using the data is outside the control of either Party and is likely to use the data for an unpermitted purpose; (iii) The data was actually acquired or viewed; and (iv) The risk of an unpermitted use has not been or cannot be mitigated.
20. **Data Platform**: Means collectively the software, hardware, applications, systems, and other code and devices controlled, leased, or used by the Contractor to acquire, use, maintain, store, and transfer data required under this Contract.
21. **DHHS:** The North Carolina Department of Health and Human Services.
22. **Department or Division of Health Benefits (DHB):** The North Carolina Department of Health and Human Services, Division of Health Benefits, formerly the Division of Medical Assistance, responsible for operating the State Medicaid and Health Choice programs.
23. **Emergency medical condition:** Has the meaning defined in 42 C.F.R. § 438.114(a).
24. **Enrollment:** The process through which a beneficiary selects or is auto-assigned to the PCCM entity.
25. **Enrollment Broker:** Has the meaning defined in 42 C.F.R. § 438.810(a).
26. **Fee-for-Service (FFS):** A payment model in which providers are paid for each service provided. The Department's Medicaid Fee-for-Service program is also known as NC Medicaid Direct.
27. **Fiscal Agent:** A contractor that processes or pays vendor claims on behalf of the Medicaid agency.
28. **Foster Care:** Has the meaning defined in N.C. Gen. Stat. § 131D-10.2.
29. **Grievance:** A formal complaint filed by an enrollee or their Authorized Representative, or a PCP, with the Contractor or the Department regarding any aspect of the services to be provided to the enrollee.
30. **Health Choice**: A comprehensive health care program for children at no or reduced cost to the recipient established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*.
31. **HIPAA:** The Health Insurance Portability and Accountability Act of 1996.
32. **HITECH:** The Health Information Technology for Economic and Clinical Health Act.
33. **Key PCCM Roles:** The positions identified in this Contract as critical to the management of the Contract.
34. **Limited English Proficient (LEP):** Has the meaning defined in 42 C.F.R. § 438.10(a).

35. **Local Management Entity/Managed Care Organization (LME/MCO):** Has the meaning defined in N.C. Gen. Stat. § 122C-3(20c).

36. **Long Term Service and Supports (LTSS):** LTSS shall include:

    a. Care provided in community-based settings, private homes (including apartments), facilities, nursing homes, group homes, and adult care homes, etc.;

    b. Care for older adults, children with medical conditions and people with disabilities who need support because of age, physical cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves;

    c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as eating; taking baths; managing medications; grooming; walking; getting up and down from a seated position; using the toilet; cooking; driving; getting dressed; or managing money; and/or

    d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.

37. **Managed Care Entity:** Vendors that the Department contracts with to provide MCO or PCCMe services as defined in 42 C.F.R. § 438.2.

38. **Managing Employee:** Means the individual(s) who exercise(s) operational or managerial control over the Contractor, or who directly or indirectly conducts the day-to-day operations of the Contractor.

39. **Marketing:** Has the meaning defined in 42 C.F.R. § 438.104(a).

40. **Marketing Materials:** Has the meaning defined in 42 C.F.R. § 438.104(a).

41. **Medicaid Managed Care:** The name of the North Carolina managed care program for North Carolina Medicaid and NC Health Choice benefits (including Prepaid Health Plans, both Standard Plans and Behavioral Health/Intellectual Developmental Disability Tailored Plans).

42. **Medical Home:** An approach to providing comprehensive primary care that facilitates partnerships between individual Members, their providers, and, where appropriate, the Member's family. The primary care practice selected by or for a Member, through which Members receive continuous, comprehensive, and coordinated care within the PCCM Program.

43. **Enrollee**: Beneficiaries enrolled in NC Medicaid Direct and receiving care management services through the PCCM Entity.

44. **Medical Home Fees:** Per-member per-month (PMPM) payments to Network PCPs made in addition to fee for service payments, providing stable funding for care coordination support, and quality improvement at the practice level.

45. **NC Medicaid Direct**: Refers to the Medicaid Fee-For-Service program serving enrollees who are not enrolled in a prepaid health plan or the EBCI Tribal Option.

46. **NCCARE360**: The statewide coordinated care application used to electronically connect enrollees to community resources and allow for a feedback loop on the outcome of that connection.
47. **Primary Care Provider (PCP)**: A licensed medical professional selected by or assigned to the enrollee to provide healthcare services to that enrollee.
48. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department's integrated case management system that provides eligibility and enrollment information for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
49. **North Carolina Health Choice (NC Health Choice):** The Health Insurance Program for Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
50. **Ombudsman Program:** A new Department program to be established to provide education, advocacy, and issue resolution for Medicaid beneficiaries whether they are in the Medicaid Managed Care program or the Medicaid Fee-for-Service program. This program is separate and distinct from the Long-Term Care Ombudsman Program.
51. **Ownership or Control Interest:** Means an individual or entity that: has an ownership interest totaling five percent (5%) or more; has an Indirect Ownership Interest equal to five percent (5%) or more; has a combination of direct and Indirect Ownership Interests equal to five percent (5%) or more; owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent (5%) of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.
52. **Potential Enrollee:** A beneficiary enrolled in Medicaid or NC Health Choice and eligible for enrollment in the PCCM entity.
53. **Prevalent Language:** Means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient, as defined in 42 C.F.R. § 438.10(a).
54. **Protected Health Information (PHI):** Has the meaning defined by 45 C.F.R. § 160.103.
55. **Prepaid Health Plan (PHP)**: Has the meaning defined in N.C. Gen. Stat. § 108D-1.
56. **Primary Care Case Management Entity** (PCCM Entity): Has the meaning defined in 42 C.F.R. § 438.2.
57. **Readily accessible:** Has the meaning defined in 42 C.F.R. § 438.10(a).
58. **Rising Risk:** Population group that has not yet become high-risk but who may become high-risk if certain risk factors and behaviors are not addressed.
59. **Security Breach:** As defined in 45 CFR 164.400-414, generally defined as an impermissible use of disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of PHI is presumed to be a

breach unless the covered entity as applicable, demonstrates that there is low probability that the PHI has been compromised based on a risk assessment as defined in rule.

60. **Cybers Security Incident:** has the meaning defined at NCGS 143B-1320(a)(4a).
61. **State:** The State of North Carolina, which according to context could include the NC Department of Health and Human Services.
62. **State Business Day or Business Day:** Monday through Friday 8:00 a.m. through 5:00 p.m., Eastern Time, excluding North Carolina State holidays as defined by the Office of State Human Resources at https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays.
63. **State-owned data**: The Medicaid and Health Choice Claims Data and Medicaid and Health Choice enrollment data, for which the State of North Carolina is a covered entity for HIPAA purposes.
64. **Subcontractor**: The entities specifically identified in this Contract, and who have executed the Contractor's Subcontractor agreement, who will take on the care management obligations of the Contractor for populations covered by practices affiliated with these entities.
65. **Telelanguage:** Refers to the non-English language telephonic or video services provided to enrollees with Limited English proficiency by the entity Telelanguage, Inc.
66. **Tribal Option:** The program defined in the State Plan of North Carolina, administered by the North Carolina Department of Health and Human Services, Division of Health Benefits, and operated by Cherokee Indian Hospital Authority under the Indian Managed Care Entity Contract, for providing care management support to Medicaid and Health Choice populations using a medical home model.
67. **Vendor:** A company, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.

B. Abbreviations and Acronyms

1. ADT: Admission, Discharge, Transfer
2. AVRS: Automated Voice Response System
3. BAA: Business Associate Agreement
4. BH: Behavioral Health
5. CAP: Corrective Action Plan
6. CAP/C: Community Alternatives Program for Children
7. CAP/DA: Community Alternatives Program for Disabled Adults
8. CHIP: Children's Health Insurance Program
9. CMS: Centers for Medicare & Medicaid Services
10. DHB: Division of Health Benefits
11. DHHS: Department of Health and Human Services
12. DOS: Date of Service
13. DSOHF: Division of State Operated Healthcare Facilities
14. DSS: Division of Social Services
15. EDI: Electronic Data Interchange
16. EFT: Electronic Funds Transfer
17. FAR: Federal Acquisition Regulations

18. FFS: Fee-for-service
19. FFY: Federal Fiscal Year
20. HHS: U.S. Department of Health and Human Services
21. HIPAA: Health Insurance Portability and Accountability Act
22. HITECH: Health Information Technology for Economic and Clinical Health Act
23. HIV: Human Immunodeficiency Virus
24. I/DD: Intellectual/Developmental Disability
25. IRS: Internal Revenue Service
26. LCSW: Licensed Clinical Social Worker
27. LEIE: List of Excluded Individuals/Entities
28. LEP: Limited English Proficiency
29. LHD: Local Health Department
30. LME/MCO: Local Management Entities-Managed Care Organizations
31. LTSS: Long Term Service and Supports
32. MID: North Carolina Department of Justice Medicaid Investigations Division
33. MMIS: Medicaid Management Information Systems
34. NC: North Carolina
35. NC FAST: North Carolina Families Accessing Services through Technology
36. NCAC: North Carolina Administrative Code
37. NCDPH: North Carolina Division of Public Health
38. NCGA: North Carolina General Assembly
39. NCHC: North Carolina Health Choice
40. NEMT: Non- Emergency Medical Transportation
41. NPI: National Provider Identifier
42. NPPES: National Plan and Provider Enumeration System 138.
43. OAH: Office of Administrative Hearings
44. OIG: Office of the Inspector General
45. OFAC: Office of Foreign Assets Control
46. PCCM: Primary Care Case Management
47. PCCMe: Primary Care Case Management Entity
48. PCP: Primary Care Provider
49. PHI: Protected Health Information
50. PHP: Prepaid Health Plan
51. PIP: Performance Improvement Program
52. PMPM: Per Member Per Month
53. PSO: North Carolina Department of Health and Human Services Privacy and Security Office
54. PTA: Privacy Threshold Analysis
55. RN: Registered Nurse
56. SAM: System of Award Management
57. SFTP: Secure File Transfer Protocol
58. SLA: Service Level Agreements
59. SMA: State Medicaid Agency
60. SMI: Serious Mental Illness

61. SNF: Skilled Nursing Facility
62. SOC: Service Organization Control
63. SSA: Social Security Act
64. SSADMF: Social Security Administration Death Master File
65. SUD: Substance Use Disorder
66. TBI: Traumatic Brain Injury
67. TCLI: Transition to Community Living Initiative
68. TDD: Telecommunications Device for the Deaf
69. TP: Tailored Plan
70. TPL: Third party liability
71. TTY: Text Telephone

III. Contract Term, General Terms and Conditions, and Other Provisions & Protections

A. Contract Term

Effective Date and Service Period: This Contract is effective the date both Parties have signed through June 30, 2024 ("Term").

B. General Terms and Conditions

1. ACCESS TO PERSONS AND RECORDS:

a. Pursuant to N.C.G.S. § 147-64.7 and G.S. § 143-49(9), the Department, the State Auditor, appropriate State or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with the **RECORD RETENTION** clause of the Contract. Amended or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such amendments or additions.

b. As required by 42 C.F.R. § 438.3(h), the State, CMS, the Office of inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of Contractor, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

c. Nothing in this section is intended to limit or restrict the State Auditor's rights.

d. This provision shall survive termination or expiration of this Contract.

2. ADVERTISING AND MARKETING:

a. Contractor agrees not to use this Contract as part of any commercial advertising or marketing of its products or services, without the written consent of Department. The Contractor may include the Department on a listing of existing customers.

b. Contractor shall:

i. Not distribute any marketing materials as that term is defined in 42 CFR 438.104(a) without first obtaining approval from the Department.

ii. Distribute the marketing materials to its entire service area as indicated in the Contract.

iii. Not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

iv. Not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.

3. AMENDMENTS:

This Contract may not be amended orally or by performance. The Contract may be amended only by written amendments executed by the Department and the Contractor.

4. ASSIGNMENT:

a. No assignment of Contractor's obligations or right to receive payment hereunder is permitted, other than an assignment due to a change in the Contractor's corporate structure, where the Department has approved the assignment. Notwithstanding the foregoing sentence, upon written request approved by the Department and solely as a convenience to Contractor, the Department may:

i. Forward Contractor's payment checks directly to any person or entity designated by Contractor; and

ii. Include any person or entity designated by Contractor as a joint payee on Contractor's payment check.

b. In no event will such approval and action obligate the Department to anyone other than Contractor, and Contractor will remain responsible for fulfillment of all Contract obligations. Upon advance written request, the Department may, at its discretion, approve an assignment to the surviving entity of a merger, acquisition, or corporate reorganization, if made as part of the transfer of all or substantially all of the Contractor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of this Contract.

5. AVAILABILITY OF FUNDS: All payments to Contractor, and all performance obligations of Contractor, are expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the Department for the purposes set forth in the Contract. If the Contract is funded in whole or in part by federal funds, the Department's performance and payment and Contractor's performance obligations will be subject to and contingent upon the continuing availability of said federal funds for the purposes of the Contract. If the Term of the Contract extends into fiscal years after that in which it is approved, such continuation of the Contract is expressly contingent upon the appropriation, allocation, and availability of funds by the N.C. General Assembly for the purposes set forth in this Contract. Notwithstanding any other term or condition of this Contract, if funds to effect full payment

are not available, or this contract is not approved by CMS, the Department will provide written notification to the Contractor and may terminate the Contract immediately and relieve the Contractor immediately from all performance obligations. If the Contract is terminated pursuant to this section, the Contractor agrees to terminate any services supplied to the Department under the Contract and relieve the Department of any further obligation thereof other than to pay for any services performed or obligated which cannot reasonably be avoided in conformance with the payment terms.

6. **BACKGROUND CHECKS AND DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION:** Consistent with the intent of Executive Order 158, signed August 18, 2020:

   a. The Contractor shall notify the Department if it, or any of its officers, directors, or persons in Key PCCM Roles performing under this Contract have, to the best of its knowledge after reasonable efforts to ascertain, been convicted of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes.

   b. Unless requested by a governmental or a law enforcement entity not to communicate on such matters, the Contractor shall promptly notify the Department of any criminal proceedings related to any of those crimes involving the Contractor or any of its then current officers or directors.

   c. The Contractor shall notify the Department of: (1) any civil proceedings not reduced to a final judgment as of the date of execution of the Contract that involves a claim or claims that cumulatively may affect the financial viability of the Contractor; (2) credible allegations of Medicaid or financial fraud against the Contractor or a Subcontractor received in writing; and (3) credible allegations that the Contractor or a Subcontractor violated any federal or state statute or regulation. Credible allegations are allegations that describe with sufficient particularity actions actually taken by the Contractor or a Subcontractor that a reasonable person could conclude rise to the level of a violation of an applicable statute or regulation.

   d. The Contractor agrees not to use any personnel or Subcontractors, or authorize Subcontractors, to use any personnel in the performance of this Contract, who have been convicted of any of the crimes listed in subpart a. above.

   e. The Contractor shall notify the State of any legal action likely to adversely affect the Contractor's ability to meet the requirements of the Contract.

   f. All notices required under this section shall be provided in writing within thirty (30) Calendar Days after the Contractor learns about the matter requiring notice

   g. The Department reserves the right to request a level 1 criminal background check on Contractor's employees or independent contractors performing under this Contract.

   h. Subject to all applicable federal and State statutes and regulations, when the Department requests a background check on a specified employee or independent contractor, the Contractor will seek a Criminal Record History Background Check from an authorized third party seller of such reports, and will, to the extent allowed under federal and State statutes and regulations, share the results with the Department.

i. Contractor shall keep any records related to these verifications in accordance with the **RECORD RETENTION** clause of this Contract**.**

7. **BENEFICIARIES:** This Contract shall inure to the benefit and be binding upon the Parties and their respective successors. It is expressly understood and agreed that the enforcement of the Terms and Conditions of the Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Department and Contractor. Nothing contained in this Contract shall give or allow any claim or right of action whatsoever by any third person. It is the express intention of the Department and Contractor that any such other person or entity receiving services or benefits under the Contract shall be deemed an incidental beneficiary only and not a contractual third-party beneficiary.

8. **CHOICE OF LAW AND FORUM**: The validity of this Contract and any of its terms and conditions or provisions, as well as the rights and duties of the Parties, are governed by the laws of North Carolina. Forum shall be in the District or Superior Courts of Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined. This section survives the termination of the Contract for any reason and may not be deemed to diminish any legal defenses of the Parties.

9. **CMS APPROVAL**: This contract and amendments are subject to approval by CMS pursuant to 42 C.F.R. § 438.3(r).

10. **COMPLIANCE WITH LAWS:**

a. Contractor shall comply with all applicable federal and state laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business and performance in accordance with this Contract.

b. Contractor must include in its Subcontractor Agreements an attestation clause that the Subcontractor must comply with all laws, rules, regulations, and licensing requirements applicable to Contractor's performance under this Contract, including but not limited to the applicable provisions of (a) Title XIX of the Social Security Act and Titles 42 and 45 of the Code of Federal Regulations; and (b) those laws, rules, or regulations of federal and State agencies having jurisdiction over the subject matter of this Contract, whether in effect when this Contract is signed, or becoming effective during the term of this Contract.

c. Clean Air Act

i. Contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.

ii. Contractor agrees to report each violation to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.

iii. Contractor agrees to include these requirements in each Subcontractor Agreement.

d. Federal Water Pollution Control Act

i. Contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C.

1251 et seq.

ii. Contractor agrees to report each violation to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the federal agency providing funds hereunder, and the appropriate Environmental Protection Agency Regional Office.

iii. Contractor agrees that these requirements will be included in each Subcontractor Agreement.

11. **CONTRACT ADMINISTRATORS**: Contract Administrators means the persons to whom notices provided for in this Contract shall be given, and to whom matters relating to the administration of this contract shall be addressed. Either Party may change its administrator or his/her address and telephone number by written notice to the other Party in accordance with the **NOTICES** clause of the Contract.

FOR THE DEPARTMENT:

Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick
Address 1 Physical Address	820 S. Boylan Ave., McBryde Building Raleigh, NC 27603
Address 2 Mailing Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7015
Email Address	kimberley.kilpatrick@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

Contract Administrator regarding day to day activities herein:

Name & Title	Sarah Gregosky
Address 1 Physical Address	820 S. Boylan Ave., McBryde Building Raleigh, NC 27603
Address 2 Mailing Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7027
Email Address	Sarah.gregosky@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

Contract Administrator for HIPAA and all Federal, State and Department privacy and regulatory matters herein:

Name & Title	Ryan Eppenberger, Privacy Officer
Physical Address	333 E. Six Forks Road, Raleigh, NC 27699-2501
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-814-0090
Email Address	Ryan.Eppenburger@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

Contract Administrator for all Federal, State and Department security matters herein:

Name & Title	Pyreddy Reddy, DHHS CISO
Physical Address	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.ContractAdministrator@dhhs.nc.gov

FOR THE CONTRACTOR:

Contract Administrator for all contractual issues listed herein:

Name & Title	John Alexander, Account Executive
Physical and Mailing Address	1000 CentreGreen Way, Suite 300 Cary, NC 27513
Telephone Number	919-763-6584
Fax Number	919-745-2532
Email Address	jalexander@communitycarenc.org

Contract Administrator regarding day to day activities herein:

Name & Title	Anna Boone, Executive Director of N3CN
Physical and Mailing Address	1000 CentreGreen Way, Suite 300 Cary, NC 27513
Telephone Number	919-926-3925
Fax Number	919-745-2532
Email Address	aboone@communitycarenc.org

Contract Administrator for HIPAA, privacy and security matters herein:

Name & Title	Sabrina Hilber, Director of Compliance and IT Assurance
Physical and Mailing Address	1000 CentreGreen Way, Suite 300 Cary, NC 27513
Telephone Number	919-745-2389
Fax Number	919-745-2532
Email Address	shilber@communitycarenc.org

12. **CONTRACT DISCLOSURES**: Unless otherwise provided herein, Contractor shall complete any initial disclosures required under the Contract within thirty (30) Calendar Days after execution unless another timeframe is approved by the Department. Disclosures should be sent to the Department's Contract Administrator in accordance with the **NOTICES** clause of the Contract.

13. **COOPERATION WITH OTHER STATE VENDORS:** Contractor shall reasonably cooperate with Department vendors that are providing goods or services to or on behalf of the Department in relation to Medicaid including those vendors providing services with respect to system integration, encounter processing, enrollment and eligibility, data analytics, and those engaged by the Department to monitor, validate, or verify Contractor's performance.

14. **COPYRIGHT:** North Carolina Public Records Laws identifies all documents created for public transactions/business as public records; therefore, no deliverable items produced in whole or in part under this Contract for the Department shall be the subject of an application for copyright by or on behalf of Contractor, except as otherwise provided herein. The State shall own all deliverables that Contractor is required to deliver to the Department pursuant to this Contract, except as provided herein.

    a. Contractor shall not acquire any right, title, and interest in and to the copyrights for goods, all software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products provided by the Department to Contractor.

    b. The Department shall, upon payment for the services in full in accordance with the payment terms of this Contract, own copyrighted works first originated and prepared by Contractor for delivery to the Department.

    c. The Department hereby grants Contractor a royalty-free, fully paid worldwide, perpetual, nonexclusive, irrevocable license for Contractor's business use, to non-confidential deliverables first originated and prepared by Contractor for delivery to the Department.

    d. Contractor shall retain sole ownership of all pre-existing intellectual property that it provides to the State as part of the deliverable(s), and the State shall have a royalty-free, fully paid, worldwide, perpetual, non-exclusive, irrevocable license to use such intellectual property solely for its operations.

    e. The intellectual property terms of this Contract do not: (i) affect Contractor's ownership of all intangible intellectual property that Contractor has developed or develops in the course of performance hereunder, (ii) prevent Contractor from selling similar services elsewhere, or (iii) prevent Contractor from marketing, licensing, or selling any and all

intellectual property it develops hereunder to other customers, provided no State confidential information is part of such intellectual property.

15. **COUNTERPARTS**: This Contract may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. Any signature page transmitted by electronic mail in portable document format will have the same legal effect as an original executed signature page.

16. **CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY**: Contractor shall make a good faith effort to recruit, train, promote, and retain a culturally and linguistically diverse workforce, who are responsive to the population in the service area, in accordance with applicable Federal and State law.

17. **DISCLOSURE CONFLICTS OF INTEREST:** The Contractor shall disclose any known conflicts of interest, or perceived conflicts of interest, as follows:

    a. Disclose any Ownership or Control Interest, or employment relationship to any associate or person with whom the Contractor is currently doing business that represents an actual or perceived conflict of interest related to this Contract.

    b. Disclose any Ownership or Control Interest, or employment relationship to any business or person with whom the Contractor executes an agreement that represents an actual or perceived conflict of interest related to this Contract. Disclose prior to employment or engagement by the Contractor, any firm principal, staff member, known by the Contractor to have a conflict of interest or perceived conflict of interest related to this Contract.

    c. All notices required by this subsection must be provided to the Department within thirty (30) Calendar Days of Contractor becoming aware of the conflict.

18. **DISCLOSURE OF OWNERSHIP INTEREST**: In accordance with 42 C.F.R. § 438.608(c)(2), the Contractor shall provide to the Department written disclosures of Ownership and Control Interests as required under 42 C.F.R. § 455.104, including:

    a. The name, address, date of birth, and Social Security Number or Tax Identification Number as applicable for any individual or corporation with a direct or indirect or combined Ownership or Control Interest in the Contractor, of five percent (5%) or more of the Contractor's equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;
    b. The name, address, date of birth, and Social Security Number of the Executive Director and the CEO of the Contractor;
    c. Whether the person with an Ownership or Control Interest in the Contractor is related to another person with Ownership or Control Interest in the Contractor or a Subcontractor as a spouse, parent, child, or sibling;
    d. The Name, Address, Date of Birth, and Social Security Number of the managing employees of the Contractor
        i. Upon effective date of the Contract;
        ii. Upon renewal or extension of the Contract; and
        iii. Within thirty-five (35) days after any change in the Contractor's ownership.

19. DISPUTE RESOLUTION:

a . The Parties agree that it is in their mutual interest to resolve disputes informally. In the event the Parties disagree as to their respective obligations or performance, or the performance of any Subcontractor to the Contract, the Parties agree to follow the process described in this clause, except as otherwise provided. Any claims arising under this provision shall be submitted in writing (Dispute Notice) to the other Party's Contract Administrator for contractual issues for resolution. The Parties shall meet, as needed, and negotiate in good faith and use all reasonable efforts to resolve such dispute(s). During the time the Parties are attempting to resolve any dispute, each shall proceed diligently to perform their respective duties and responsibilities under the Contract. Any agreement reached by the Parties shall be memorialized in writing, and if needed, via an amendment to the Contract. If a dispute cannot be resolved between the Parties within thirty (30) days after delivery of Dispute Notice, or another timeframe agreed to by the Parties, either Party may elect to exercise any other legal or administrative remedies available to it at law or in equity. This term shall not constitute an agreement by either Party to mediate or arbitrate any dispute.

b . Nothing in this section is intended to limit, restrict, or condition any other contractual or legal right of the Parties. All contract performance violations and deficiencies, including sanctions, remedial actions, and the assessment of liquidated damages, will be governed in accordance with the requirements and process specified in *Section V. Contract Performance*.

20. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE: This Contract, including the Contract Attachments, contains the entire understanding between the Parties and supersedes all prior and contemporaneous oral and written statements and agreements with respect to the subject matter contained herein:

The Order of Precedence is as follows:

a. The Contract, as amended;

b. Contract Attachments; and

c. Any other incorporated documents.

21. EQUAL EMPLOYMENT OPPORTUNITY: Contractor shall comply with all applicable Federal and State requirements and North Carolina Executive Order 24 dated October 18, 2017, concerning fair employment and employment of the disabled and concerning the treatment of all employees without regard to discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or veteran status, sexual orientation, gender identity or expression.

22. FORCE MAJEURE: Neither Party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations because of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, declared states of emergency, earthquake, hurricane, tornado, pandemics, or other catastrophic natural event or act of God.

23. GOVERNMENTAL RESTRICTIONS:

a. In the event any governmental regulations are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the Department as soon as practical, indicating the specific regulation which required such alterations. The Department and the Contractor reserve the right to accept any such alterations, including any price adjustments occasioned thereby, or to terminate the Contract pursuant to the terms of the Contract.

b. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part of the Contract after the effective date of the loss of program authority. The Department must adjust payment amounts specified in *Attachment A: PCCM Fees and Provider Payments* to remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor shall not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

24. HIPAA and HITECH:

a. DHHS has declared itself to be a hybrid entity under HIPAA with the Division of Health Benefits being a covered health care component. As such, this Contract and related activities are subject to HIPAA and HITECH. Contractor shall comply with HIPAA and HITECH requirements and regulations, as amended, including:

   i. Compliance with the Privacy Rule, Security Rule, and Notification Rule and confidentiality requirements in 45 CFR parts 160 and 164;

   ii. The development of and adherence to applicable Privacy and Security Safeguards and Policies;

   iii. Timely reporting of violations regarding the access, use, and disclosure of PHI; and

   iv. Timely reporting of privacy and/ or security incidents as provided in *Section III. C. Confidentiality, Privacy and Security Protections.*

b. Contractor will be performing functions on behalf of the Department that make Contractor a business associate for purposes of HIPAA regulations. Accordingly,

Contractor and this Contract are subject to the terms and conditions of *Attachment D: Business Associate Agreement*.

c. Contractor shall cooperate and coordinate with the Department and its Privacy and Security Office (PSO) as mandated by HIPAA and HITECH and accompanying regulations, or as requested by the Department, during performance of this Contract so that both Parties are in compliance with HIPAA and HITECH.

d. If any applicable federal, State, or local law, regulation or rule requires the Department or the Contractor to give persons written notice of a HIPAA breach or Cybersecurity Incident arising out of the Contractor's performance under this Contract and/or provide credit monitoring services for person impacted by such HIPAA breach or Cybersecurity incident, the Contractor shall bear the cost of the notice and any other costs related to or resulting from the HIPAA breach or Cybersecurity incident.

25. HISTORICALLY UNDERUTILIZED BUSINESS (HUBs): Pursuant to N.C. Gen. Stat. § 143-48 and Executive Order 150 (1999), the Department invites and strongly encourages participation with businesses owned by minorities, women, disabled individuals, disabled business enterprises, and nonprofit work centers for the blind and severely disabled. Contractor agrees to make a good faith effort to seek out and pursue opportunities to utilize HUBs, as defined in N.C. Gen. Stat. 143-128.4, within the scope of services of this Contract.

26. INDEMNIFICATION:

a. Contractor shall indemnify the State for any third-party claims, damages, or liabilities arising solely out of Contractor's gross negligence or intentional misconduct.

b. Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the Department and State under applicable law.

27. INDEPENDENT CONTRACTORS: Contractor is an independent contractor and not an employee or agent of the Department. Employees of the contractor are not employees of or have any individual contractual relationship with the Department. The Contract shall not operate as a joint venture, partnership, trust, agency, or any other similar business relationship.

28. INSURANCE: During the term of the Contract, the Contractor, at its sole cost and expense, shall provide commercial insurance coverage of such type and with such terms and limits as may be reasonably associated with the Contract. The Contractor must include in its Subcontractor Agreements an Insurance provision including the same types and amounts in this Contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:

a. **Worker's Compensation** - The Contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of five hundred thousand dollars ($500,000.00), covering all of Contractor's employees who are engaged in any work under the Contract.

b. **Commercial General Liability** - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of two million dollars ($2,000,000.00) Combined Single Limit.

c. **Automobile** - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used relating to the Contract. The minimum combined single limit shall be five hundred thousand dollars ($500,000.00) for bodily injury and property damage; five hundred thousand dollars ($500,000.00) for uninsured/under insured motorist; and five thousand ($5,000.00) for medical payment.

d. **Requirements** - Providing and maintaining adequate insurance coverage is a material obligation of the Contractor and is of the essence of this Contract. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina, or that are otherwise approved by the Commissioner of Insurance.

29. **LITIGATION:** In the event of third-party litigation against the Department related to the Contract, Contractor's performance, or services provided under the Contract, Contractor will cooperate with the Department fully in the defense of such litigation. This provision survives expiration or termination of the Contract.

30. **MEDIA CONTACT APPROVAL AND DISCLOSURE:** Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. The Department shall not refer any media or other inquiries to the Contractor or advise any other department or division of the State to do so, without first contacting the Contractor's Head of Communications and agreeing in principle on any expected messaging. In the event the Contractor is contacted by the media for information related to the terms of this Contract or a recipient of services under the Contractor shall make immediate contact with the Department as soon as practical after the contact occurs. Contractor must submit any proposed media release to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure. Department may, at its sole discretion, object to its release or require changes to the information before it is released. The requirements of this Section shall not apply to any information the Contractor is required by law or by any court of competent jurisdiction to disclose.

31. **NOTICES:** All notices permitted or required to be given by one Party to the other must be addressed and delivered to the other Party's Contract Administrator. Notices sent to anyone other than the Contract Administrator(s) are not effective. Unless otherwise specified in the Contract, any notices must be in writing and delivered by email to the then-current email address for the Contract Administrator. In addition, notices may be delivered by first class mail, commercial carrier (e.g., FedEx, UPS, DHL), or personally delivered, provided the notice is also emailed to the Contract Administrator(s).

32. **OFFSHORING:** Without the prior written consent of the Department, Contractor shall not:

a. Offshore any of its obligations under this Contract to any entity in any country other than the United States of America or Its territories.

b. Subcontract with any entity outside of the United States of America or its territories to store, use, access, or transmit any State-owned or State-provided data outside of the United States of America or its territories without the advance written approval from the Department. For clarity, all State-owned data must be housed, accessed, stored, and transmitted within the United States of America, or its territories.

33. **OUTSOURCING:** Contractor shall, upon request, disclose to inbound callers the location from which the call center services are being provided. If Contractor wishes to relocate or outsource any portion of performance to a location outside of the United States, or to contract with a subcontractor for any such performance, Contractor must obtain written permission from the Department. Contractor will not use employees or contractors located outside the territories of the United States to perform under this Contract.

34. **OWNERSHIP OF DELIVERABLES:** All reports, , and documentation created during the performance or provision of services hereunder that are not licensed to the Department or other State entity, or are not proprietary to the Contractor, are the property of the Department and must be returned to the Department, or destroyed, after the Contract ends. Proprietary Contractor materials shall be identified to the Department by the Contractor prior to use or provision of services hereunder, or in a reasonable time thereafter, and shall remain the property of the Contractor. Derivative works of any Contractor proprietary materials created during the performance of provision of services hereunder shall be subject to a perpetual, royalty free, nonexclusive license to the Department and the State. This term survives termination or expiration of the Contract.

35. **PAYMENT AND INVOICING:**

a. **Certification of Ownership and Control Interest.** The Contractor must have its CEO, CFO, or their delegate certify its submission of ownership and control interests and prohibited affiliations as described in this Contract to comply with the payment requirements of 42 CFR 438.600(b).

b. **Payment of Primary Care Case Management Fees.**

i. Department shall pay Contractor a monthly PCCM fee in accordance with Table 1: Payment to the Contractor of *Attachment A: PCCM Fees and Provider Payments.*

ii. Department shall periodically reconcile the Enrollment Assumption and Care Management Population Assumption specified in Table 1 of *Attachment A: PCCM Fees and Provider Payments* with Contractor's actual enrollment and adjust the monthly payment accordingly via Amendment.

iii. Reconciliation of assumed and actual enrollment will occur within forty-five (45) days of the end of each calendar quarter, within sixty (60) days of the end of the federal Public Health Emergency as defined in the Families First Coronavirus Response Act, and at least sixty (60) days prior to the Department implementing a new managed care program, but in no event will the monthly payment be adjusted more frequently than quarterly.

c. **Payment for Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP).**

The Contractor shall make care management payments as directed by the Department to Local Health Departments for services provided through the CMARC and CMHRP

programs in accordance with Table 2: Payment to Local Health Departments (LHD) of *Attachment A: PCCM Fees and Provider Payments*.

d. **Primary Care Provider Fees to be Paid by the Department**.

The Department will pay Carolina Access providers directly in accordance with Table 3: Primary Care Provider Fees to be Paid by the Department or Table 4: Temporary Rates, Primary Provider Fees to be Paid by the Department of *Attachment A. PCCM Fees and Provider Payments,* as applicable.

e. **Invoicing Requirements.** The following invoicing provisions shall apply to any invoice required under the Contract:

i. Invoices shall be sent to Department **electronically** to the following email address: Medicaid.FinanceAP@dhhs.nc.gov

ii. Questions regarding invoicing should be directed to the Medicaid accounting staff at 919-855-4114.

iii. Department shall pay Contractor on a net thirty (30) day basis from the date a correct invoice is received by Department.

iv. Department reserves the right to dispute an invoice after payment and require Contractor to refund the Department for any deliverables paid for but not delivered.

36. PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES: Contractor warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for obtaining any Contract or award issued by the State and its Departments and other agencies or entities. The Contractor further warrants that no commission or other payment has been or will be received from or paid to any third-party contingent on the award of any contract by the State, except as shall have been expressly communicated to the Department's Office of Procurement, Contracts and Grants in writing prior to acceptance of the Contract or award in question. The Parties expressly acknowledge that the Department is requiring the Contractor to use the approved Subcontractors, and no payments to those entities may be deemed a violation of this provision. Subsequent discovery by the Department of non-compliance with these provisions shall constitute sufficient cause for termination of the Contract. Willful violations of this provision may result in debarment of the Contractor as permitted by 9 NCAC 06B .1206, 01 NCAC 05B .1520, or other provision of law.

37. RECORD RETENTION:

a. Records of Contractor's performance under this Contract may not be destroyed except in accordance with applicable State and federal regulations. Records of Contractor's performance under this Contract must be retained for ten (10) years following its expiration or termination or from the date of completion of any audit, whichever is later. Any federal regulations that require a longer retention period shall supersede and control. If any litigation, claim, audit, or other civil or criminal action (collectively, "Actions') related to Contractor's performance under this Contract commences before the retention period has completed, all records relevant to the Actions must be maintained until the Actions are resolved.

b. Contractor will develop record retention policies for reports, financial records, and quality measures created for use under this Contract.

38. **RESPONSE TO STATE INQUIRES AND REQUESTS FOR INFORMATION**: The Contractor shall prioritize responding to inquiries from the Department, the North Carolina General Assembly, or other government agencies or bodies. The Contractor shall have a goal of responding to requests from the Department the next State Business Day after receiving a request marked as urgent. Contractor shall acknowledge receipt of urgent inquiries within one State Business Day and provide an anticipated timeframe for additional information or resolution.

39. **RIGHT TO PUBLISH:** The Department agrees to allow the Contractor to publish material associated with Contractor's products and services related to this Contract, provided the Contractor receives prior written approval from the Department. Other than presentations and publications expressly contemplated under this Contract, the Contractor shall submit for review any presentation or publication that will be given to outside parties that contains data and information relating to the terms of this Contract at least thirty (30) days in advance. The Contractor shall not advertise or publish information for commercial benefit concerning this Contract without the prior written approval of the Department.

40. **SEVERABILITY:** If a court of competent jurisdiction holds that a provision of the Contract violates any applicable law, each such provision will be deemed not part of the Contract, and all other provisions and requirements of the Contract shall remain in full force and effect.

41. **STATE CONTRACT REVIEW**: This Contract is exempt from the State contract review and approval requirements pursuant to N.C.G.S. § 143B-216.80(b)(4).

42. **SUBCONTRACTORS:**

    a. All Subcontractors must be approved by the Department, in writing.

    b. Contractor shall not knowingly contract for the administration, management, provision of care management services, or establishment of policies or provision for operational support of care management services with any Subcontractor that has been excluded from participation in federal health care programs pursuant to 42 C.F.R. 438.808(b), 42 C.F.R. 432.55(h), 42 C.F.R. 1001.1901(c), and/or 42 C.F.R. 1002.3(b).

    c. Contractor must submit a request to use a new Subcontractor to the Department ninety (90) days, or as soon as practical, prior to the start of services by a Subcontractor. The approved list of Subcontractors specified in *Section IV.E.4.b. Subcontractors* of this Contract serves as notice to the Department of Subcontractors being used by the Contractor to perform work under this Contract at the time of this agreement.

    d. The Contractor remains responsible for its obligations under the Contract, even if a Subcontractor is performing those obligations. Any contracts made by the Contractor with a Subcontractor must include an affirmative statement that the Department is an intended third-party beneficiary of the contract; that the Subcontractor Agreement is not a contract with the Department; and that the Department may audit the records of the Subcontractor to ensure the Subcontractor adheres to all applicable terms and conditions.

    e. Contractor shall provide the Department with complete copies of any contracts made by and between the Contractor and any Subcontractor upon request and within five (5) State Business Days of such request.

f. The Contractor's Subcontractor Agreements must include statements that:

i. The Subcontractor agrees that the state, the US DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect its premises, any books, records, contracts, computer or other electronic systems of the Subcontractor relating to its performance and payment under the Subcontractor Agreement, or of any of the Subcontractor's contractors;

ii. The Subcontractor agrees that the right to audit by the State of North Carolina, the US DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. That if the State, or the US DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, or the US DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

43. SURVIVAL: Those terms that by their inherent nature or by their express terms are intended to extend beyond the Term of the Contract survive the termination or expiration of the Contract.

44. TAXES: Any applicable taxes shall be invoiced as a separate item and in accordance with this paragraph and applicable laws.

a. G.S. § 143-59.1 bars the Department from entering into contracts with contractors if the contractor or its affiliates meet one of the conditions of G.S. § 105-164.8(b) and refuse to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under G.S. § 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the contractor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. The Contractor certifies that none of the conditions of G.S. § 105-164.8(b) apply to its obligations under this Contract.

45. TERMINATION: Any notice of termination made under this Contract shall be provided pursuant to the Notice provisions of this Contract.

a. **Termination without Cause**: Either Party may terminate this Contract, in whole or in part, by giving one hundred eighty (180) days prior written notice to the other Party. In the event the Contract is terminated for the convenience of the other Party, the Department will pay for all services performed and products delivered in conformance with the Contract up to the date of termination.

b. **Termination for Cause:** Pursuant to 42 C.F.R. § 438.708, and with notice and hearing as required by 42 C.F.R. § 438.710, the State has the authority to terminate this Contract and provide Medicaid benefits through other options included in the State Plan if the State has determined the Contractor has failed to:

i. Carry out the substantive terms of this Contract; or

ii. Meet applicable requirements in section 1932, 1903(m), and 1905(t) of the Social Security Act.

In the event the Contractor substantially fails to meet its performance obligations under the Contract, and the failure is not cured within thirty (30) days, or a longer time period

specified by the Department, the Department may send a Notice of Termination and Hearing.

c. The rights and remedies of the Parties provided above shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

d. **Transition Obligations of Contractor upon Contract Expiration or Termination for any reason:** In the event of termination of the Contract for any reason, Contractor shall reasonably assist in the transition of enrollees to another PCCM Entity as directed by Department and in accordance with the Transition of Care provisions and notice requirements of the Contract and federal law and regulation.

46. TIME IS OF THE ESSENCE: Time is of the essence in the performance of this Contract and all provisions that specify a time for performance.

47. TITLES AND HEADINGS: Titles and headings in this Contract are for convenience only and shall have no binding force of effect.

48. WAIVER: The failure to enforce or the waiver by a Party of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.

C. Confidentiality, Privacy and Security Protections

1. The applicable requirements of this Section survive expiration or termination of the Contract. The requirement to protect the privacy and security of State-owned data survives so long as Contractor holds State-owned data.

2. Confidential Information

a. Contractor shall maintain the privacy, security, and confidentiality of all confidential information, data, instrument, documentation, studies, or reports provided to Contractor pursuant to this Contract in accordance with the Privacy Rule at 45 CFR Parts 160 and 164, Security Standards at 45 CFR Parts 160, 162, and 164, and applicable Health Information Technology for Economic and Clinical Health Act (HITECH) provisions, including those obligations set forth in *Attachment D: Business Associate Agreement*. Contractor shall treat all individually identifiable health information as confidential information and shall not use, disclose, or make available such information except as provided under this Contract. Any disclosure, use, sale, or offer of confidential information except as contemplated under the Contract or approved in writing by the Department will be considered a material breach of the Contract.

b. The Contractor will include confidentiality provisions in its third-party contracts where those third-parties will access, store, process, and use State-owned data housed by Contractor that reflect obligations of data confidentiality and data security that are no less stringent than and are consistent with the requirements in this Contract, including compliance with applicable DHHS Privacy and Security Requirements, HIPAA, HITECH, Access to Persons and Records, and Record Retention requirements.

c. Excluding enrollee information, the Department will not request confidential information from Contractor, and Contractor will not intentionally include in its communications with

the Department any confidential information of third parties identified as such. Use or disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.

3. Privacy and Security Protections. Contractor shall comply with applicable Department and State policies, including State IT Security Policy and standards. These polices may be revised from time to time and Contractor shall comply with all applicable revisions. Contractor shall implement and maintain encryption algorithms meeting NIST encryption standards, environmental safeguards, firewalls, access controls, and other internal data security measures for the receipt, storage, and processing of confidential information using appropriate hardware and software necessary to monitor, maintain, and ensure data integrity in accordance with applicable federal and State regulations and DHHS privacy and security policies.

4. Use of Cloud Services. The Department approved Contractor's use of Amazon Warehouse Services (AWS) to host State-owned data used in the performance of Contract #37761 via letter from Dave Richard to Chris Woodfin dated December 9, 2020. That authorization is hereby extended to cover this Contract. In that letter, the Department acknowledges that Contractor properly submitted, and the Department approved, a System Security Plan (SSP) related to the storage of State-owned data in AWS cloud servers. Contractor will re-submit an SSP annually and will notify the Department of any changes to Contractor's use of AWS that might affect the SSP. Any change to a different cloud-hosting provider will require prior written approval from the Department.

5. North Carolina Identity Theft Protection Act and Other Protections: Contractor shall comply with the North Carolina Identity Theft Protection Act requirements, N.C. Gen. Stat. §132-1.10 and 75-65 regarding the protection of "identifying information" as defined at N.C. Gen Stat 14-113.20(b) and "personal information" as defined under N.C. Gen Stat. 75-61(10).

6. Information Technology
    a. Security Manuals: For all software owned or leased by Contractor that connects to State hardware or software, Contractor shall comply with applicable Department and State policies including implementation of internal data security measures to ensure data integrity in accordance with applicable state and federal regulations, DHHS Privacy Manual and Security Manual, and Statewide Information Security Policies and standards for those interfaces, to the extent such policies are written specifically to apply to private corporation and are expressly provided in writing to the Contractor. The Department Security Manual is available at https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security and the State Security Manual is available at https://it.nc.gov/resources/cybersecurity-risk-management/esrmo-initiatives/statewide-information-security-policies. These polices may be revised from time to time and the Contractor shall comply with all applicable revisions after a reasonable time to make any changes necessary due to the revisions.

    b. Enterprise Architecture Standards: For all software owned or leased by Contractor that connects to State hardware or software, Contractor shall comply with applicable

enterprise architecture standards for those interfaces, including the North Carolina Statewide Technical Architecture standards, which are located at https://it.nc.gov/services/it-architecture/statewide-architecture-framework. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems. To the extent any architecture to be used in performance of this contract is built prior to the execution of this Contract, Contractor shall provide documentation as requested by the Department to assess the security of Contractor's systems.

c. Modifications, Updates or Fixes to Contractor's Information Technology Systems: For all software owned or leased by Contractor that connects to State hardware or software, Contractor will adhere to the Department's applicable Change Management and control policies and procedures for those interfaces. Contractor shall not modify, update, or fix any IT system interface that shares information with the Department's Information Technology systems without the Department's prior written approval. Contractor's request for approval must be communicated to the Department no later than one hundred twenty (120) days prior to the change and contain a detailed description of the changes proposed by Contractor. Contractor must supplement its request with all clarifications and additional information requested by the Department. Contractor shall not place any modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's IT systems. The Department reserves the right to delay implementations if it perceives a risk to its operations.

d. Modifications, Updates, and Fixes Requested by the Department: For all software owned or leased by Contractor that connects to State hardware or software, Contractor shall promptly modify, upgrade, or fix any part of its interface that shares information with the Department's Information Technology Systems as requested by the Department. The Contractor shall not place any such modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's Information Technology Systems. The Contractor may not unilaterally refuse to make a modification, update or fix requested by the Department. In the event the Contractor disagrees with the Department on modification, update or fix requests, and Parties cannot come to agreement, the Parties agree to follow the Dispute Resolution clause of the Contract.

e. Patch Management: For all software owned or leased by Contractor that connects to State hardware or software, Contractor will apply patches based on applicable State requirements on or to any Information Technology Systems interfaces that share information with the Department's Information Technology Systems or which may impact the delivery of services to the Department's members. The State requirements for Patch Management are located at the following URL: https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf Contractor will coordinate patching activity with the

Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with Contractor patching. The requirement to apply the patch may come from Contractor or the Department, or an external organization such as https://www.us-cert.gov/.

f. Changes to Department Information Technology Systems: The Department anticipates changes to its Information Technology Systems. After the Department notifies Contractor of specific upcoming changes to any State system to which Contractor maintains an interface, Contractor will work with the Department to modify its Information Technology Systems in conformity with Departmental 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.

g. Department's Rejection of Contractor's Modifications, Updates or Fixes to Contractor's IT System interfaces: The Department reserves the right to reject any modification, update or fix that does not meet the Department's Information Technology standards or could impair the operation of the Department's Information Technology Systems.

h. Cost of Modifications, Updates, Fixes, and Patches to Contractor's IT Systems: Unless otherwise agreed by the Parties, the cost of all modifications, updates, fixes, and patches to Contractor's Information Technology System interfaces (whether proposed by Contractor or required by the Department) shall be borne solely by Contractor.

i. State LAN/WAN: Contractor shall not connect any of its own equipment to a State LAN/WAN without prior written approval by the State. Contractor shall complete all necessary paperwork as directed and coordinated by the Department's appropriate Contract Administrator to obtain the required written approval by the Department to connect Contractor-owned equipment to a State LAN/WAN.

7. Continuous Monitoring

a. Contractor shall adhere to the State Chief Information Officer's Continuous Monitoring Process requirements, and work with the Department to implement a risk management program that continuously monitors risk through the performance of assessments, risk analysis, and data inventory. The requirements are based on NIST 800-137, Information Security Continuous Monitoring for Federal Information Systems and Organizations" and originates from N.C. Gen. Stat. § 143B-1376, located online at: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_143B.html, and require the North Carolina State CIO to annually assess each agency and each agency's contractors' compliance with enterprise security standards.

b. Contractor shall assist the Department with risk assessment and security assessment of Contractor's critical systems and infrastructure.

c. Contractor shall perform the required assessments, either through a third-party or a self-assessment, on a three-year cycle (with a third-party assessment mandated every third year).

d. All findings identified in the assessment must be made available to the Department within thirty (30) days after assessment completion, along with a plan to remediate each finding requiring a remediation.

e. Contractor shall provide a risk assessment for its cloud-hosted providers or off-site hosting service providers. Contractor shall provide all findings identified in these risk assessments to the Department within thirty (30) days after assessment completion, to include a plan to remediate each finding requiring a remediation. Contract will annually provide an attestation of compliance and a third -party assessment report of compliance with statewide security policies.

f. Contractor will make available at its principal place of business annually a confidential summary of findings, including all open findings, from a SOC 2 Type II audit of the Data Platform. Contractor will make available for viewing at its principle place of business the complete SOCII report, upon reasonable request of the Department.

g. Contractor shall cooperate with the Department in their completing a Privacy Threshold Analysis (PTA) documenting the data classification and data fields hosted within the cloud, offsite, or vendor hosted environment. The PTA shall be reviewed and updated annually by the Parties and when changes have been made to the data being collected.

h. The DHHS Privacy & Security Office may perform periodic independent security assessment of Contractor's applications and key resources to include a vulnerability analysis, penetration testing, and risk analysis based on the latest NIST 800-53 requirements.

8. Secure Integration Services

   a. Contractor shall work with the Department and Department vendors to implement data exchanges to enable the transfer and receipt of enrollee information as enrollees transfer to different Medicaid programs.

   b. Contractor shall have the ability to exchange files through secure protocols, including strong encryption algorithms that meet industry encryption standards identified by NIST.

9. Physical Security: At all times at any State facility, Contractor's personnel shall cooperate with State site requirements, including being prepared to be escorted, providing information for badging, and wearing the badge in a visible location.

10. Significant Cybersecurity Incidents

    a. Contractor shall report all suspected and confirmed privacy/security incidents or privacy/security breaches involving unauthorized access, use, disclosure, modification, or data destruction to the DHHS Privacy and Security Office at https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security within twenty-four (24) hours after the incident is first discovered. If the privacy or security incident involves Social Security Administration (SSA) data or Centers for Medicare and Medicaid Services (CMS) data, the Vendor shall report the incident within one (1) hour after the breach is first discovered.

b. If any applicable federal, State, or local law, regulation or rule requires the Department or the Contractor to give persons written notice of a Cybersecurity Incident arising out of the Contractor's performance under this Contract and/or provide credit monitoring services for person impacted by such Cybersecurity incident, the Contractor shall bear the cost of the notice and any other costs related to or resulting from the breach.

D. Public Records and Trade Secrets Protections

1. Pursuant to N.C. Gen. Stat. § 132-1, et seq., this Contract and information or documents other than those containing individually identifiable health information provided to the Department under the Contract are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute.
2. Any proprietary or confidential information which conforms to exclusions from public records as provided by Chapter 132 of the General Statutes must be clearly marked as such with each page containing the trade secret or confidential information identified with bold face as "CONFIDENTIAL." If only a portion of each page marked "CONFIDENTIAL" contains trade secret information, the trade secret information shall be designated with a contrasting color or by a box around such information. Any material labeled as confidential constitutes a representation by the Contractor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C. Gen. Stat. § 66-152(3). Cost information may not be designated as confidential.
3. If any challenge, legal or otherwise, is made related to the confidential nature of information redacted by the Contractor, the Department will provide reasonable notice of such action to Contractor, and Contractor shall be responsible for the cost and defense of, or objection to, release of any material. The Department is not obligated to defend any challenges as to the confidential nature of information identified by the Contractor as being trade secret, proprietary, and otherwise confidential. The Department shall have no liability to Contractor with the respect to disclosure of Contractor's confidential information ordered by a court of competent jurisdiction.
4. If Contractor marks any part of the Contract, Amendments to the Contract, or other documents or materials as confidential, a redacted copy of this Contract and any subsequent amendments, documents, or materials relating to or provided as part of this Contract, shall be provided to the Department within thirty (30) days after execution or submission to the Department. Redacted copies must clearly indicate where information has been redacted. In lieu of redacting information by obscuring, Contractor may replace the information, paragraphs or pages with the word "Redacted." By submitting a redacted copy, the Contractor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions redacted are properly subject to redaction. Redacted copies provided by Contractor to the Department may be released in response to public record requests without notification to the Contractor.
5. This Term survives the expiration or termination of the Contract for any reason.

IV. Scope of Services

A. Enrollees

1. Eligibility to Enroll in the PCCM Entity
    a. The Department shall maintain sole authority for performing, managing, and maintaining North Carolina Medicaid and NC Health Choice eligibility.
    b. Local Departments of Social Services (DSSs) are delegated the administration and determination of eligibility for NC Medicaid and Health Choice.
    c. The Department shall be responsible for determining if a beneficiary is PCCM Mandatory, Exempt, or Excluded at any point in time and shall inform the beneficiary of their enrollment status.
    d. The Contractor shall be responsible for adhering to eligibility and enrollment determinations made by the Department.
    e. The Contractor will provide services to select eligible beneficiaries in the following eligibility categories:
        i. PCCM Mandatory:
            1. Beneficiaries eligible for Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plans (TP) until such time that the BH I/DD TP Contracts come into effect.
            2. Beneficiaries being served through the Community Alternatives Program for Children (CAP/C) or Community Alternatives Program for Disabled Adults (CAP/DA).
            3. Medically needy Medicaid beneficiaries.
            4. Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.
        ii. Exempt PCCM Enrollment with opportunity to opt-in:
            1. Beneficiaries eligible for the EBCI Tribal Option
            2. Beneficiaries eligible for the Foster Care Plan until such time that the Children in Foster Care Plan Contract come into effect
        iii. Exempt PCCM Enrollment with opportunity to opt-out:
            1. 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.
2. PCCM Enrollment and Disenrollment
    a. The Department will be responsible for enrolling beneficiaries into and disenrolling beneficiaries from the PCCM entity.
    b. The Department through its vendor partners will transmit enrollment files using the standard file format defined by the Department.
    c. Any beneficiary not on the enrollment files sent to the Contractor are deemed disenrolled from the PCCM Entity.
    d. The Department shall restrict enrollment to beneficiaries who reside sufficiently near one of the Contractor's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation. 42 C.F.R. § 438.3(q)(2).
    e. The Contractor shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, up to the limits set in

this Contract, unless authorized by CMS. 42 C.F.R. § 438.3(d)(1). The Department shall ensure automatic reenrollment of an enrollee who is disenrolled solely because he or she loses North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).

3. Enrollee Engagement
    a. The Contractor shall help Enrollee and their Authorized Representatives with understanding the PCCM entity, understanding their rights and responsibilities, and accessing available benefits and services in-person, telephone, by mail, and online/electronically. 42 C.F.R. 438.10(c)(7).
    b. The Contractor shall develop Member Participation and Member Education and Materials Policies describing how the Contractor will engage, educate, and assist Enrollees, and the Contractor will submit to the Department for review within sixty (60) Calendar Days of contract approval and annually thereafter. The Contractor shall use standard managed care terminology in all communications with enrollees as defined in *Attachment C: Managed Care Terminology Provided to PCCM* Pursuant to 42 C.F.R. § 438.10(c)(4)(i).
    c. The Contractor shall have staff who are responsible for the following functions:
        i. Explaining operations of the PCCM entity to enrollees, including transition of care
        ii. Explaining the role of their PCP
        iii. Explaining what to do in an emergency medical situation;
        iv. Assisting enrollees with obtaining non-care management Medicaid services
        v. Referring to their PCP in response to requests for mental health assistance;
        vi. Responding to enrollee questions and complaints;
        vii. Responding to questions about the Enrollee Handbook;
        viii. Explaining how enrollees can file a grievance against the Contractor; and
        ix. Referring enrollees to the Enrollment Broker and Ombudsman Program, as applicable, to resolve issues.
    d. Enrollee Services Website
        i. The Contractor shall provide content for a website that enrollees can access, to be hosted by the Department. 42 C.F.R. 438.10(c)(3).
        ii. The website content to be provided by the Contractor shall include:
            1. The Enrollee Handbook with the Contractor's additions, which will include;
                a. How to contact PCCM entity staff and care managers;
                b. Enrollee grievance procedures;
            2. Health promotion and educational materials;
            3. Any specific prevention, population health, or care management programs offered by the PCCM entity; and
            4. Other information the Contractor believes would support enrollees and their families.
    e. Communications with enrollees
        i. The Contractor shall communicate with enrollees and their authorized representatives in a culturally competent manner with deference to the method requested by the enrollee where appropriate, including Telelanguage sign language interpreters, and occurs in a timely manner privacy and independence of the individual with a disability.
        ii. In communications with enrollees, the Contractor shall use the term Member to describe a beneficiary enrolled in the PCCM program.

iii. The Contractor shall ensure that the information the Contractor adds to the Enrollee handbook is written in a culturally competent manner that may be easily understood and is readily accessible.

iv. In accordance with 42 C.F.R. § 438.10(c)(6), the Contractor shall ensure any Contractor-created materials that are provided electronically to enrollees are:
   1. In a format that is readily accessible;
   2. In an electronic form which can be electronically retained and printed;
   3. Consistent with content and language requirements; and
   4. With notification to enrollees that information is available in paper form without charge upon request within five (5) business days of the request.

v. The Contractor may provide information required to be communicated to enrollees in any of the following manners:
   1. Mailing a printed copy of the information to the enrollee's mailing address provided by the Department;
   2. Emailing the information, after receiving the enrollee's agreement to receive information via email;
   3. Providing information to be posted on the Department's website and advising the enrollee in paper or electronic form that the information is available on the internet; and
   4. Providing the information by any other method that can reasonably be expected to result in the enrollee receiving the information. 42 C.F.R. § 438.10(g)(3).

vi. The Contractor shall not construe requirements herein to limit or alleviate its obligation to communicate directly with the enrollee or their Authorized Representative as required under the Contract or under federal or state law or regulation.

vii. The Contractor shall provide auxiliary aids and services at no cost for enrollees with disabilities who cannot access this information online, upon request of the enrollee.

f. Written and Oral Enrollee Materials

i. The Department must make interpretation services available to each beneficiary and require the Contractor to make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. 42 CFR 438.10(d)(4).

ii. The Contractor shall provide all written materials to enrollees consistent with the following:
   1. Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).
   2. Use a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii).
   3. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees with disabilities or limited English proficiency. 42 C.F.R. § 438.10(d)(6)(iii).
   4. For materials that are critical to obtaining services, including provider directories, Enrollee Handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in

its particular service area, including taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the Contractor's customer service unit.42 C.F.R. § 438.10(d)(3)

5. The Contractor shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6).

g. Mailing Materials to Enrollees
   i. The Contractor shall notify the Department monthly of all returned mail due to incorrect mailing address in an electronic format defined by the Department in subsequent guidance, as described in *Attachment B. Deliverables and Reporting Requirements.*
   ii. If the Contractor identifies a new, updated address, the Contractor shall:
      1. Resend only Member specific information at no additional cost to the Department or the Member; and
      2. Notify the Department using the Change in Member Circumstances report as described in *Attachment B. Deliverables and Reporting Requirements*~~)~~
   iii. All materials mailed to enrollees, and, when applicable, authorized representatives, shall be sent via United States Postal Service.

h. Translation and Interpretation Services
   The Contractor shall make available to enrollees those interpretation services required to be provided to enrollees under 42 CFR 438.10(d)(4) and (5). This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language where available. Oral interpretation is limited to those available through the Telelanguage service used by the Contractor.

i. Enrollee Welcome Letter
   i. The Contractor shall send an enrollee Welcome Letter to new enrollees within fifteen (15) business days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment, using the address provided on the enrollment file.
   ii. Subject to receipt of all necessary information from the Department, the Contractor shall include the following in the initial enrollee Welcome Letter and upon Redetermination:
      1. A welcome letter that notifies the enrollee of their enrollment in the PCCM entity and provides:
         a. That the Contractor has assumed responsibility for care management for the enrollee;
         b. Information on how to access the Department's online provider directory and how to request a hardcopy;
         c. Information on how to access care management services;
         d. Information provided by the Department on how to opt in and opt out of PCCM program, for exempt populations;
         e. Information on how to access the Enrollee Handbook, including how to request a printed copy (42 C.F.R. § 438.10(c)(6));
         f. How to select or change an PCP;
         g. Why an enrollee might be auto-assigned an PCP;

h. How to arrange for non-emergency transportation;
i. How to request assistance in arranging initial visit to his or her PCP; and
j. Contact information provided by the Department for the Ombudsman Program.

2. The Contractor shall submit a sample copy of the contents of its enrollee Welcome Letter to the Department for review at least ninety (90) Calendar Days prior to use with enrollees, and annually thereafter if changes are made.

j. Enrollee Handbook
   i. The Contractor shall use the Department's model Enrollee Handbook and provide the completed Enrollee Handbook to the Department to post on the Department's website. 42 C.F.R. § 438.10(c)(4)(ii).
   ii. The Contractor shall provide information in the enrollee Welcome Letter to each enrollee on how to access the Enrollee Handbook, including how to request a copy in print form, which serves as a summary of benefits and coverage. 42 C.F.R. § 438.10(g)(1).
   iii. The Contractor shall ensure that all Enrollee Handbook information added by Contractor complies with federal and Department information requirements, including those related to accessibility, reading level, font size, cultural competency and literacy standards.
   iv. In accordance with 42 C.F.R. § 438.10(g), the Department shall ensure its model Enrollee Handbook provided to the Contractor meets all the requirements specified in this regulation.
   v. In accordance with 42 C.F.R. § 438.10(g), the Contractor shall ensure that the Enrollee Handbook information added by the Contractor is accurate and up-to-date.
   vi. The Contractor shall submit the Enrollee Handbook with the Contractor's additions to the Department for review one hundred thirty-five (135) days after execution of the Contract.

k. Enrollee Education
   i. The Contractor shall use NCQA-accredited enrollee education materials.
   ii. The Contractor shall solicit enrollee feedback through an enrollee experience survey sent to a sample of enrollees who are actively managed by the Contractor.

4. Enrollee Rights and Responsibilities
   a. The Department expects the Contractor to treat enrollees with dignity and respect, to protect enrollees' rights, to inform enrollees of their responsibilities as participants in the PCCM Program, and ensure each enrollee is not subject to any unlawful discrimination in the course of obtaining or receiving services from the PCCM entity.
   b. The Contractor shall have written policies regarding the enrollee rights listed below and shall ensure its employees and contract employees observe and protect those rights.
      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 enrollee's condition and ability to understand;
      iv. Participate in decisions regarding his or her health care, including the right to refuse treatment;

v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; and
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.

c. The Department shall guarantee enrollees have the rights listed in the Contractor's written policies referenced above.
d. The Contractor 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.
e. The Contractor shall ensure that Enrollees are free to exercise their rights and that the exercise of those rights does not adversely affect the way the Contractor or its Network PCPs treat Members. 42 C.F.R. § 438.100(c).
f. The Contractor shall comply with any other applicable federal and state laws. 42 C.F.R. § 438.100(d).

5. Enrollee Grievances
   a. PCCM enrollee Grievance Procedures
      i. The Contractor shall develop and maintain enrollee grievance procedures, which shall be submitted to the Department for review ninety (90) Calendar Days after execution of the Contract, consistent with the grievance process that is part of the Model Enrollee Handbook information supplied by the Department.
      ii. The Contractor shall establish and maintain a Grievance process through which enrollees may express dissatisfaction about any matter related to this Contract other than an Adverse Determination made by the Department. Grievances may be related to, but are not limited to, issues regarding quality of care, dissatisfaction with case manager or other PCCM staff, complaints related to PCPs, professional conduct, failure to respect Member's rights, and program fraud.
      iii. The Contractor shall allow the enrollee to file a grievance in writing or verbally at any time and shall acknowledge receiving the grievance.
      iv. The Contractor shall give enrollees assistance in completing forms and other procedural steps in the grievance process, including providing translation and interpretation services as described in the Translation and Interpretation Services section of this Contract.
      v. Depending on the nature of the grievance, the Contractor shall make a decision regarding the grievance and, where appropriate, provide notice to the enrollees of its decision within forty-five (45) Calendar Days of receipt of the grievance.
   b. Enrollee Grievances Recordkeeping and Reporting
      i. The Contractor shall maintain a Member Grievance Log, as described in *Attachment B. Deliverables and Reporting Requirements*, and submit to the Department on a quarterly basis.
      ii. The Contractor shall maintain records of all such enrollee grievances consistent with the record retention terms of the Contract following closure of the grievance and shall review the information as part of its ongoing monitoring procedures.

c. Filing Grievances Directly with the Department
    i. If the Department is contacted by an enrollee, Authorized Representative of a enrollee, family members or caregivers of a enrollee, advocates, the Ombudsman Program, or other individuals/entities with a grievance regarding concerns about the care management or lack of care management an enrollee is receiving for which Contractor has not issued a notice of decision, the Department shall notify the Contractor of the grievance. The Contractor shall respond to the grievance within forty-five (45) Days of the Department informing the Contractor of the Grievance. The Contractor shall keep the Department reasonably informed about progress on resolving concerns and shall advise the Department of final resolution.
    ii. Contractor shall include in all notices of Grievance decisions issued by Contractor to a member, information that if the member is dissatisfied with Contractor's decision, the Member can file a Grievance directly with the Department by contacting the NC Medicaid Ombudsman. The notice shall include telephone, email, and website contact information for the NC Medicaid Ombudsman.
    iii. Contractor shall provide Department with all information used in reaching a grievance decision within five (5) business days of the Department making a request for that information.

d. Enrollee Appeals Process
   The Department shall be responsible for receiving and responding to enrollee appeals regarding Notices of Adverse Determination.

B. Benefits and Care Management

1. Family Planning Services
   The Contractor shall not restrict the Member's free choice of family planning services, supplies and providers. 42 C.F.R. § 431.51(b)(2).
2. Emergency Services
   The Contractor shall allow Members to obtain emergency services regardless of whether the case manager referred the Member to the provider that furnished the emergency services. 42 C.F.R. § 438.114(c)(2).
3. Care Management
   a. The Contractor shall provide access to appropriate care management and coordination support across multiple settings of care, including primary care and connections to specialty care, pharmacies, and community-based resources.
       i. Enrollees with identified high medical, behavioral, social, or resource needs and other priority populations defined below should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan.
       ii. The Contractor shall operate a care coordination and care management program that meets the requirements of this Contract.
   b. PCCM Services
       i. Based on risk stratification, and the findings from care needs screenings and comprehensive needs assessments as appropriate, the Contractor shall provide enrollees with care management appropriate to his or her needs.

ii. The Contractor shall provide the following care coordination for enrollees, as appropriate:
    1. Assist enrollees as they schedule medical appointments;
    2. Assistant enrollees as they attempt to obtain proper medical equipment;
    3. Provide appropriate health education and health coaching; and
    4. Assist enrollees with obtaining appointments for age-appropriate immunizations, preventive screenings, and routine well-care visits.
iii. The Contractor shall assist enrollees with the following activities related to improving enrollee health:
    1. Managing chronic disease (i.e. disease management programs);
    2. Patient self-management and goal-setting;
    3. Addressing gaps in care (children and adults); and
    4. Managing medications.
iv. For enrollees with identified unmet health-related resource needs, the Contractor shall, as part of care coordination:
    1. Refer enrollees to community and social support providers to address enrollees' unmet health-related resource needs; and
    2. Modify their approaches based on observed outcomes.
v. The Contractor shall coordinate with local health departments, obstetricians, midwives, family physicians and other providers involved in the care of an enrollee who is pregnant or recently delivered.
vi. Contractor will refer enrollees to CMARC and CMHRP for care management if they meet eligibility criteria for the programs.

c. Identification of High-Needs Enrollees Needing Care Management
    i. Care Needs Screening
        1. The Contractor shall undertake best efforts, as defined below, to conduct a Care Needs Screening (CNS) of every newly enrolled enrollee on the enrollment file provided to the Contractor from the Department, on the following time frames:
            a. Within ninety (90) days for all newly enrolled PCCM enrollees,
            b. Within fourteen (14) Calendar Days for all newly enrolled enrollees in the Aged, Blind, Disabled (ABD) Category of Aid, and
            c. Annually thereafter.
        2. For enrollees enrolled prior to June 4, 2021, the Contractor shall undertake best efforts to conduct a Care Needs Screening no later than June 30, 2022.
        3. The Department defines "best efforts" as including at least two (2) documented follow up attempts to contact the enrollee if the first attempt is unsuccessful.
        4. The Contractor's shall establish a tool to conduct Care Needs Screening, for which the template shall be submitted to the Department for review prior to use with Members. At minimum, the tool shall identify will include screening for:
            a. Chronic or acute conditions;
            b. Chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;

c. Behavioral health needs, including opioid usage and other substance use disorders, and intellectual/developmental disabilities;
d. Enrollees at risk of requiring long-term services and supports (LTSS);
e. Medications—prescribed and taken; and
f. Other factors or conditions the Contractor deems appropriate to inform available interventions for the enrollee.

ii. The Contractor shall include unmet health-related resource need questions provided by the Department for use in all Care Needs Screenings, covering four (4) priority domains.
1. Housing;
2. Food;
3. Transportation; and
4. Interpersonal Safety.

iii. If an enrollee appears on the monthly enrollment file more than ninety (90) days after that enrollee is removed from the monthly enrollment file, the Contractor shall conduct the Care Needs Screening within ninety (90) days.

iv. The Contractor will make the results of the Care Needs Screenings available to Primary Care Providers who have signed the Contractor's Participation Agreement via the Data Platform within seven (7) days of the screening. If a PCP does not have a signed Participation Agreement with the Contractor, the Care Needs Screening will be made available upon request to the PCP.

v. In the event that the Care Needs Screening identifies that a Comprehensive Needs Assessment (CNA) is needed, and the enrollee consents, the Contractor will perform a CNA to determine that enrollee's care management needs.

d. Identification of Priority Populations through Risk Scoring and Stratification

i. The Contractor shall develop and use a risk stratification tool to stratify all enrollees provided on the daily enrollment and weekly Claims files from the Department. The Contractor shall evaluate the effectiveness of its risk stratification tool at least annually.

ii. The Contractor shall develop and implement targeted interventions that are appropriate for each risk level and priority population. Interventions should be consistent with evidence-based or evidence-informed practices, clinical guidelines, and recommended treatments.

iii. The Contractor shall describe its risk stratification approach and targeted interventions in the Care Management Policy.

iv. The Contractor shall use risk scoring and stratification to identify Members who are part of "priority populations" for care management and should receive a Comprehensive Assessment to determine their care management needs.

v. Priority populations include:
1. Individuals with Long Term Services and Supports (LTSS) needs;
2. Adults and children who: have HIV or AIDS; have an I/DD or SUD diagnosis; have chronic pain; have an Opioid Addiction; have TBI; are in a Neonatal Intensive Care Unit; have neonatal abstinence syndrome; all as identified on the enrollment files, the claims files, or determined through a CNS
3. Enrollees identified by the Contractor as at Rising Risk;
4. Enrollees who are:

a. Homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
b. Experiencing domestic violence or lack of personal safety as determined by the CNS; or
c. Respond to CNS social determinants of health (SDOH) questions as needing assistance in at least three SDOH areas;

5. Enrollees at high risk for readmission who have been discharged from a hospital or facility;
6. Enrollees in foster care;
7. Enrollees transitioning out of foster care; and
8. Other priority populations as determined by the Contractor.

vi. The Contractor's risk scoring methodology and stratification methodology shall take into account, at a minimum, the following information, as available and relevant:

1. Care Needs Screening results, including the content of the screening assessing unmet health-related resource needs;
2. Claims history;
3. Claims analysis;
4. Pharmacy data;
5. Immunizations;
6. Lab results;
7. Hospital utilization;
8. Member's zip code; and
9. Member's race and ethnicity.

e. Comprehensive Needs Assessments (CNA) for High-Risk Enrollees

i. The Contractor shall perform a CNA for consenting enrollees, who are:

1. Identified through a Care Needs Screening or risk stratification as being within a priority population;
2. Referred to the PCCM entity for care management by any person or entity, including the Member (self-referral).

ii. The Contractor's CNA must assess:

1. What current healthcare services the enrollee is receiving;
2. What potential healthcare services might benefit the enrollee, subject to confirmation by a healthcare provider
3. What social services the enrollee is currently using;
4. The current and relevant past treatment status of the enrollee's medically-identified physical health conditions, including dental conditions;
5. The current and relevant past treatment status of medically-identified mental health and substance use disorders, including tobacco use disorders;
6. The current and relevant past treatment status of medically-identified physical, intellectual, or developmental disabilities;
7. The current status of any advanced directives, including advance instructions for mental health treatment;
8. The enrollee's adherence with medications prescribed for the enrollee;
9. What informal, caregiver, or social supports, including peer support, are currently available to the enrollee

10. The enrollee's Social Determinants of Health (SDOH) needs, using questions provided by the Department covering:
    a. Housing
    b. Food
    c. Transportation
    d. Interpersonal Violence/Toxic Stress;
        i. At the Contractor's option, for adults only exposure to adverse childhood experiences (ACEs) or other trauma; and
        ii. Risk factors that indicate an imminent need for LTSS.

iii. The Contractor shall develop methodologies and tools for conducting the Comprehensive Assessment, as appropriate for differing Member demographics and needs.

iv. The Contractor shall conduct the CNA, whether in person or telephonically, in a manner that respects the needs of each participant.

v. The Contractor shall use best efforts to complete a CNA for enrollees in active care management:
    1. Within thirty (30) days of consenting to care management and annually thereafter if the enrollee is still actively care managed by the Contractor;
    2. Upon documentation of a significant change in the enrollee's circumstances that indicate a new CNA is warranted; and/or
    3. At the request of the enrollee or their provider.

vi. The Contractor shall document and store CNA responses in its Data Platform and make it available to care team members who have executed the Contractor's participation agreement, within fourteen (14) Calendar Days of completion of the assessment.

vii. If the CNA indicates that the enrollee does not require care management, the Contractor shall document that determination and will not be required to develop a Care Plan.

f. Development of Care Plans

i. The Contractor shall develop person-centered Care Plans based on the responses to an enrollee's CNA and the enrollee's consent.

ii. The Care Plan will be developed collaboratively with appropriate input from the care team and the enrollee.

iii. The Contractor shall undertake best efforts to complete each Care Plan within thirty (30) Calendar Days after completion of the CNA.

iv. The Contractor shall ensure that each Care Plan incorporates relevant findings of the Care Needs Screening (including unmet health-related resource need questions), claims analysis and risk scoring, the Comprehensive Assessment, any available medical records, and other sources as needed.

v. Each Care Plan shall contain:
    1. Measurable goals;
    2. Assessments of potential Medical needs including any behavioral health, intellectual/developmental disability, and/or dental needs, subject to confirmation by a healthcare provider;
    3. Recommended interventions to address medication adherence;

4. Recommendations for any social, educational, and other services for the enrollee.

vi. The Contractor will update Care Plans regularly to address identified gaps in care, incorporating input from care team members and the enrollee:
1. At minimum every twelve (12) months, for actively care managed enrollees;
2. Upon documentation of a significant change in the enrollee's circumstances that indicate an updated Care Plan is warranted
3. At the request of the enrollee or their PCP; or
4. When a re-assessment occurs that indicates an updated Care Plan is warranted.

vii. The Contractor shall document and store the Care Plan in its Data Platform and make it available to care team members who have executed the Contractor's participation agreement.

viii. The Contractor shall share the Member Action Plan, an enrollee-facing version of the care plan, with the enrollee within thirty (30) days of completion as appropriate.

g. Care Management Services

i. Care Management services include:
1. Coordination of communication among care team members who provide physical health, behavioral health, intellectual/developmental disability, and social services for enrollees;
2. Medication reconciliation and encouraging medication adherence;
3. Tracking Care Plan goal progress through routine care team reviews;
4. Follow-up with the enrollee about referrals suggested by the Contractor;
5. Coordination of peer support, when available
6. Training on self-management, as relevant; and
7. Transitional care management, as needed.

ii. The Contractor shall assist enrollees as appropriate and as applicable in addressing the following unmet resource needs:
1. Assist enrollees who are homeless or have unstable or insecure housing with referrals to organizations that help provide securing housing.
2. Assist enrollees who indicate they need legal assistance by providing referral information to potential providers of legal assistance for Medicaid beneficiaries.

iii. Subject to the Contractor executing an appropriate contract with Unite USA, and subject to the continuing adherence to the conditions and requirements listed below, the Contractor will input enrollee information into NCCARE360, which application will then make enrollee referrals to various social service entities. The conditions and requirements include:
1. The Department shall ensure Unite USA obtains all necessary authorizations before any enrollee data is used for any non-HIPAA related purpose
2. The Contractor will input enrollee information into NCCARE360 once the following actions are completed:
a. The Contractor obtains authorization to put enrollee data into NCCARE360; and

b. Unite USA obtains authorization from those enrollees entered into NCCARE360 to use their data for specific non-HIPAA purposes that are the community resources connected to NCCARE360.

3. The Department expressly agrees the Contractor will not be liable for any breaches of data that occur related to the Contractor using NCCARE360, and the Contractor will not indemnify the Department or any other entity against any claims that arise from the use or misuse of NCCARE360, other than claims caused by the intentional misconduct of the Contractor.
4. The Parties acknowledge that the Contractor will not receive any referrals from NCCARE360.
5. If at any time the Contractor determines that NCCARE360 or any software required to access or use NCCCARE360 interferes with the operations of the Contractor or creates a risk to the security or stability of the Contractor's Data Platform, the Contractor may immediately cease using NCCARE360 and notify the Department of its decision within two business days. If at any time the Contractor determines its contractual arrangement with Unite USA is likely to result in a significant financial risk to the company, or poses a material risk of jeopardizing the Contractor's: (i) 501(c)3 status; (ii) ability to receive federal or state funds; or (iii) ability to participate in federal or state programs or contracts, the Contractor may terminate its contract with Unite USA and will notify the Department of its decision within two business days.
6. The Parties acknowledge the Contractor has no control over the use or transmission of enrollee data in NCCARE360. Therefore, the Department shall hold the Contractor harmless and shall not make or support any claims against the Contractor for any use or misuse of data entered into NCCARE360, and shall not impose on the Contractor any penalty or liability for any breach caused by the use or misuse of NCCARE360. This limitation will not apply to the intentional misconduct of the Contractor's employees. The Contractor agrees to notify the Department if it learns that a data breach has occurred that the Contractor reasonably believes might affect enrollee data.
7. The Parties acknowledge that the Contractor is not responsible for enforcing any rights the Department may have regarding enrollee data entered into NCCCARE360. The Department will be solely responsible for enforcing its rights against the owner or any user of NCCARE360.

iv. If Contractor determines that the enrollee's referral was not completed, Contractor will attempt to make additional referral to meet enrollee's needs.

v. The Contractor shall use care managers to provide Care Management services to enrollees.

vi. The Contractor shall coordinate care management communications among the members of the multi-disciplinary care team managing care for an enrollee. These care teams may include, as appropriate:

1. The enrollee;
2. Caretaker(s)/legal guardians;
3. Assigned PCP;
4. PCCM Care Manager;
5. Behavioral health provider(s);

6. Specialists;
7. Nutritionists;
8. Pharmacists and Pharmacy Techs; and
9. Other individuals providing care to the enrollee.

vii. The Contractor shall inform enrollees of:
1. The rationale for implementing care management services;
2. The nature of the care management relationship; and
3. Circumstances under which enrollee information may be disclosed to third parties.

viii. The Contractor shall develop a Care Plan close-out process that includes notifying the enrollee. Termination of LTSS services may not be used as the sole basis for the Contractor closing out care management services for those enrollees no longer receiving LTSS services.

h. Transitional Care Management

i. The Contractor shall develop a methodology for identifying enrollees being discharged from a care facility who are at risk of readmissions and other poor outcomes. This methodology may take into account:
1. Frequency, duration and acuity of inpatient, Skilled Nursing Facility (SNF) and LTSS admissions or ED visits;
2. Discharges and pending discharges from inpatient behavioral health services, facility-based crisis services;
NICU discharges and pending discharges; and
3. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the Contractor may prioritize.

ii. As part of transitional care management, the Contractor shall:
1. Outreach to the Member's assigned PCP and other medical providers for knowledge transfer and smooth transition of care;
2. Outreach to provider to inquire about receipt of discharge plan;
3. Make best effort to obtain copy of discharge plan and if received, review with enrollee;
4. Outreach to practice regarding scheduling outpatient follow-up visit within a time frame appropriate to the specific circumstances for that enrollee;
5. Conduct medication management, including reconciliation, and support medication adherence;
6. Ensure that a care manager is assigned to manage the transition;
7. Encourage the enrollee to schedule a follow-up visit with their PCP, if discharged to home, within fourteen (14) Calendar Days of discharge;
8. Ensure that the assigned care manager follows-up with the enrollee following discharge; and
9. Develop a protocol for determining the appropriate timing and format of such outreach.

iii. The Contractor shall ensure that Comprehensive Assessment is completed and current for all Members upon completion of transitional care management, including re-assessment for Members already assigned to care management as needed.

iv. The Department shall ensure the Contractor has access to an ADT data from NCHIEA that identifies when enrollees are admitted, discharged, or transferred from one care setting to another, in real time or near real time.

v. When the Contractor receives notice of any of the following alerts, the Contractor will respond promptly, and will attempt to follow-up with the enrollee as appropriate to discuss potential outpatient services needed:
   1. Same-day or next-day outreach for Contractor-designated high-risk subsets of the population with ED visit;
   2. Same-day or next-day outreach for Contractor-designated high-risk subsets of the population, such as children with special health care needs discharged from the hospital; and
   3. Additional outreach within several days after the alert to address outpatient needs (e.g. to assist with scheduling appropriate follow up visits or medication reconciliations post discharge).

vi. When the Contractor receives notice an enrollee has been discharged from a LTSS setting, the Contractor shall attempt to contact the LTSS care managers or healthcare providers for that enrollee to gather relevant information about the enrollee's prior care.

i. Transition of Care

   i. Transition of Care refers to a Medicaid beneficiary 1) moving from a PHP or Tribal Option to Medicaid Direct or 2) moving from Medicaid Direct to a PHP Or Tribal Option.

   ii. The Contractor shall perform the following Transition of Care activities:
      1. Establish the necessary protocols and process to identify enrollees and ensure timely and accurate information transfer and communication, including warm handoffs, with PHP or Tribal Option;
      2. Send and receive enrollee care plans with PHP or Tribal Option, as applicable; and
      3. Participate in Department-sponsored Transition of Care planning and testing activities the Department deems necessary to ensure effective development and implementation of Transition of Care requirements.

   iii. For all enrollees transitioning to the Contractor, excluding enrollees disenrolling due to extended nursing facility stay or due to Tailored Plan eligibility and not otherwise enrolled in an LME/MCO, the Contractor shall prioritize new enrollees for care management for a minimum of sixty (60) calendar days after the enrollee's transition. The Contractor may then reassess the Member for continued complex care management eligibility.

   iv. The Department shall document the policies and procedures required of the Contractor to fulfill the requirements of the Contract in the Transition of Care Policy for PCCM.
      1. The Department shall seek input from the Contractor prior to making any modifications, including feedback on timeline to implement changes and required system development and testing.
      2. If changes are made to the Transition of Care Policy for PCCM, the Department shall provide the Contractor with at least thirty (30) business

days before the Contractor can be obligated to comply with its terms or other mutually agreed upon timeline.

3. The Contractor will not be required to follow any requirements revisions in the policy proposed after July 1, 2021 to which it objects, unless the parties mutually agree on changes to make it acceptable to the Contractor and the Department.

v. The Contractor will have ten business days after execution of the Contract to ask questions and to object to any requirements revisions proposed after July 1, 2021 in the Transition of Care Policy for PCCM.

vi. The Contractor shall develop policies, processes, and procedures to fulfill the transition of care requirements and transitional care management in the Contract.

j. Data Sharing with Providers

i. All PCPs that execute the Contractor's participation agreement will be able to have access to the Contractor's Data Platform, enabling the PCP to see the data provided to or created by the Contractor for that PCP's enrollees, or practice in the case of quality measures.

ii. The Contractor shall make available practice-level quality measure performance data and gap in care information (for measures in *Attachment H: Program Performance Metrics Reporting Requirements*) with CCNC enrolled PCPs at each quarter and annually.

k. Care Management Staffing

i. Care Management Director

1. The Contractor shall have a Care Management Director who is responsible for all PCCM care management activities.
2. Appropriate care management leadership will meet with the Department on a monthly basis or as otherwise agreed between the parties to discuss progress and performance improvement opportunities.

ii. Care Managers

1. The Contractor shall ensure that the clinician leading the care team has the minimum credentials of RN or LCSW.
2. Care managers must have competency in:
   a. Comprehensive Needs Assessments and care planning;
   b. Motivational interviewing;
   c. Self-management;
   d. Trauma informed care;
   e. Cultural competency;
   f. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
   g. Understanding and assessing for Adverse Childhood Experiences (ACEs) and trauma.
3. The Contractor will train its care managers on:
   a. Strategies to promote enrollee self-management;
   b. Strategies to encourage medication adherence;

c. Motivational interviewing;
d. Completing CNAs and person-centered Care Plans;
e. Strategies for communicating across the care team;
f. Strategies for addressing current or potential LTSS needs;
g. Execution of Comprehensive Assessments of Members;
h. Waiver services available only through BH I/DD TPs, BH I/DD TP eligibility criteria, and the process for a Member who needs a waiver service that is available only through LME/MCOs to transfer to a LME/MCO Strategies for enrollees who have identified behavioral health issues;
i. Transitional care management;
j. Cultural competency and implicit bias;
k. Strategies specific to care managing dually-eligible enrollees;
l. Strategies for care managing children in foster care;
m. Strategies for Trauma-Informed Care and care managing enrollees with ACEs and Trauma; and
n. Strategies for understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level.

4. The Contractor shall ensure that care managers remain conflict-free, which shall be defined as not providing care management services or oversight for enrollees with whom they are related by blood or marriage, financially responsible, or legally allowed to make financial or health related decisions for.

l. Care Management Policies and Processes
   i. The Contractor shall develop comprehensive Care Management Policies, and other documents including procedures, workflows, or another other documents that demonstrate the Contract's approach to meeting all the Care Management requirements of the Contract. The Contractor shall submit the Policies for review by the Department ninety (90) Calendar Days after Contract effective date and annually thereafter.
   ii. The Care Management Policies shall include:
      1. How to conduct a Care Needs Screening (CNS), including:
         a. What questions comprise a CNS;
         b. How to perform a CNS;
         c. Strategies to encourage complete enrollee responses;
         d. Timelines for completing and readministering the CNS;
      2. How to identify an enrollee as in need of care management services:
         a. A definition of the Contractor's priority populations, including description of population, how they are identified;
         b. A description of claims analysis and risk stratification;
         c. A description of the ways an enrollee may be referred for care management; and
         d. A description of how to communicate with the care team and the enrollee about the Contractor's care management services.
      3. A description of Risk scoring and stratification:
         a. What data is used to create risk scores;

b. How are risk scores calculated;
c. Methodology for identifying members of priority populations;
d. What is the risk score range for each stratification;

4. A description of the Comprehensive Needs Assessment (CNA), including:
   a. What questions are asked;
   b. How are CNAs conducted;
   c. Approach to determining when high-need Members will receive face-to-face interactions;
5. Care Plans, including:
   a. Approaches for involving and communicating with the care team;
   b. Strategies for developing Care Plans to achieve the enrollee's Care Plan goals and
   c. Process for and frequency of Care Plan updates;
6. Processes specific to children in Foster Care;
7. Processes specific to TCLI;
8. Processes specific to transitional care management and transition of care;
9. Training and Qualification of care managers and other multidisciplinary team members including timing/frequency of training and ongoing continuing education;
10. Linkages with community resources for Members as needed, including for those identified as having unmet health-related resource needs; and
11. Providing information and navigation regarding community providers of social services. Transitional care management, including the approach to working with Members with LTSS needs.

4. Care Management for Children in Foster Care
   a. Children in Foster Care are defined by the eligibility codes provided by the Department on the enrollment files sent to Contractor.
   b. Children in Foster Care includes these discrete populations:
      i. Children in custody of the Department of Social Services (DSS);
      ii. Children receiving extended foster care, who are between eighteen (18) to twenty-one (21) years old; and
      iii. Former Foster Youth.
   c. On the earlier occurrence of foster children first appearing on the Department's enrollment file with an indicator they have moved from Medicaid Managed Care or a Tribal Option, or when the Contractor receives a call from DSS that a foster child has entered their custody and requests transition assistance, those foster children for whom the Contractor has consent will be eligible for complex care management services for up to sixty days, or longer based on the results of that child's comprehensive needs assessment.
   d. The Department will provide the following services for all foster children entering the Medicaid Direct program:
      i. Identify on its enrollment files all foster children transitioning from Medicaid Managed Care or a Tribal Option into Medicaid Direct; and
      ii. Ensure the entity previously managing the foster child provides the Contractor all records related to that foster child.
   e. The Contractor will provide the following Foster Care services:
      i. Risk Stratification using available utilization, care gaps and pharmacy claims data.

1. The risk stratification approach shall incorporate the "Red Flag" criteria as described in "Best Practices for Medication Management for Children & Adolescents in Foster Care" to identify children for care management using available data as provided by the Department.
2. Foster Children under the age of 5, who are prescribed medications will receive care management from Contractor.

ii. Receive referrals for, provide referral information to the foster child for, and follow up on referrals made for physical and behavioral health services, as well as pharmacy, vision, and dental services.

iii. Monitor the individual's well care visits, including immunizations, to assess whether they are being done in accordance with guidelines such as the North Carolina Health Check guidelines and the American Academy of Pediatrics (AAP) Health Care Standards Enhanced Visit Schedule for Children in Foster Care, and encourage the individual, their legal representative, or their PCP, as appropriate, to schedule these enhanced visits as necessary.

iv. Conduct meetings, whether in person or remotely, at times and places and in manners that respect the needs of each participant.

v. Once the Department and the Contractor implement a care needs screening process, the Contractor will perform care needs screenings consistent with that agreed-upon process.

vi. Based on the foster child's care needs screening responses, the comprehensive needs assessment, or input from DSS where available, provide referrals for applicable social determinants of health community resources.

vii. Upon consent, perform a comprehensive needs assessment no later than thirty (30) days after the individual is identified through risk stratification or through the care needs screening as requiring a comprehensive needs assessment, and subsequently whenever either the individual's circumstances change significantly, the individual, their representative, or their provider requests one, or annually so long as they are at that time actively care managed. The comprehensive needs assessment will include circumstance-appropriate questions to assess, as relevant, areas such as the following:

1. Exposure to adverse childhood experiences or other trauma;
2. Exposure to abuse, sexual activity, exploitation, second-hand smoke;
3. Financial needs and resources;
4. Caregiver needs, resources, and involvement;
5. Disability needs;
6. Education status;
7. Employment status;
8. Literacy issues;
9. Health literacy;
10. Medication issues and understanding;
11. Current support services received;
12. Physical or mental conditions requiring a course of treatment or regular care monitoring;
13. Relevant cultural considerations such as ethnicity, religion, language;
14. Self-management capacity assessment; and
15. Permanency goals and services/supports needed to move toward these goals.

viii. Utilize best practices described in "Best Practices for Medication Management for Children & Adolescents in Foster Care" from the North Carolina Pediatric Society/Fostering Health NC[1] to conduct medication management.
   1. The Contractor will use data provided by the Department and collected through the CNS and comprehensive assessment to identify the individual's current prescribed medications and medication history.
   2. Medication management includes, at a minimum, the following components:
      a. Using available data, the Contractor will identify prescribed medications that could cause harm if not available to the individual, including medications that have a potential for withdrawal symptoms, medications that could lead to disease re-occurrence if stopped, and medications that could be needed during an emergency.
      b. For individuals prescribed one (1) or more psychotropic medications, the Contractor will work to identify potentially harmful aspects of the individual's medication regimen, including inappropriate psychotropic polypharmacy. For individuals identified as having a potentially harmful or inappropriate psychotropic medication regimen, the Contractor will coordinate with the individual's PCP or pharmacist to recommend that there is an in-depth assessment of the individual's medication regimen and adjust prescriptions, as necessary.
      c. For individuals prescribed one (1) or more antipsychotic medications, the Contractor will make best effort to follow up with the provider to recommend appropriate metabolic monitoring.

ix. Based on the foster child's comprehensive assessment, input from DSS where available, or a foster care screening for those in DSS custody or receiving extended foster care services, create and implement Care Plans. Implementation will include:
   1. Individualizing each Care Plan with relevant collaboration from all appropriate parties, including DSS and LME-MCOs, as needed.
   2. Making the Care Plan available in the Data Platform, with a target to have Care Plans in the Data Platform seven business days after completion of the comprehensive needs assessment for that foster child.
   3. Providing a Member Action Plan to the individual or their legal representative upon completion of the Care Plan, which includes:
      a. Care Team contact information;
      b. Any medication issues;
      c. Information about the individual's physical and/or behavioral health condition(s) and needs;
      d. Personal self-management and wellness goals; and
      e. Action steps to achieve self-management and wellness goals.
   4. Monitoring progress toward Care Plan goals and encourage completion of all goals.
   5. Monitoring and encourage adherence to treatment regimens and wellness activities.
   6. Communicating Care Plan progress and any unmet needs to the foster child's

[1] Available here: https://cdn.ymaws.com/www.ncpeds.org/resource/collection/715AED5E6572-4109-AD5E-1F064520FD69/BP_for_Medication_Management_July_2020.pdf

care team.

x. Provide access to the Data Platform to see all relevant data for the foster child to all applicable care team entities that have signed a participation agreement with the Contractor.

xi. Educate foster children, or their legal representative, on the importance of medication and well visit adherence.

xii. Conduct transitional care management.

f. The following services will be provided to DSS and to those foster children in the custody of DSS:

i. Coordinate with DSS for children involved in the child welfare system, except former foster youth.

ii. Attempt to coordinate with LME-MCOs for individuals with behavioral health needs. The Contractor shall attempt to:

1. Coordinate with LME-MCOs on the development of Care Plans;
2. Engage LME-MCOs as needed to ensure individuals are connected to needed behavioral health services and collaborate with the LME-MCO to identify and address any barriers to receiving treatment;
3. At the request from LME-MCO, assist with development of an individual's Person Centered Plan or an Individual Support Plan;
4. At the request of the LME-MCO, participate in the development and implementation of an individual's crisis plan; and
5. Invite the LME-MCO to participate in the individual's care team meetings, as appropriate.

iii. In an effort to avoid duplicative assessments and services, collaborate with the other case management serving entities to determine what needs are being met by the other entity and what the Contractor needs to assist with. (i.e. other case management entities may not complete medication reconciliation/medication reviews, in this case the contractor would complete the medication reconciliation/medication review.)

To avoid duplicate services, The Contractor may not contact the foster child. Contact with care team members in this instance will count for the penetration rate for the foster care population.

iv. For individuals identified as high-risk through risk stratification or the care needs screening, offer an initial meeting with the individual's assigned DSS Worker (in person, by video, or telephonically) within seven (7) days of the individual's identification as high-risk. During the initial meeting, the Contractor shall attempt to gather the following information for assessment, care planning and coordination including as appropriate and provided by the DSS:

1. DSS Child Health Summary Components, to the extent available;
2. Placement logs;
3. Individual's family history and foster care placement status;
4. Immediate healthcare needs, including behavioral health and unmet health-related resource needs;
5. Individual's medication history;
6. Child Maltreatment Evaluations, as applicable;
7. Key updates on individual's permanency planning process;
8. Identification about whether there are any restrictions to communicating with

the biological parent, including termination of parental rights or court order restricting communication; and

9. Other information necessary for informing the assessment and care planning processes.
10. As necessary and appropriate, identify healthcare services and health-related services that are necessary to promote reunification and develop a plan for the DSS Worker to make necessary referrals.
11. Invite the DSS Worker to participate in the individual's care team meetings, with consent from the individual or their legal representative.

v. For individuals identified as high-risk through risk stratification or the care needs screening and actively managed, attempt to meet with the individual's assigned DSS Worker as needed (in person, by video, secure email or telephonically) to gather updates on the following:
   1. Individual's foster care placement status;
   2. Key changes in the individual's healthcare needs, including behavioral health needs;
   3. Key updates on individual's permanency planning process; and
   4. Other information necessary for informing the individual's Care Plan.

vi. Perform a foster care screening on foster children after their complex care management needs are addressed, which includes assessments related to areas such as:
   1. Status of current placement;
   2. Caregiver and child adjustments and issues related to current placement;
   3. Permanency planning;
   4. Well child visit scheduling and adherence;
   5. Dental visit scheduling and adherence;
   6. Behavioral health visit scheduling, adherence, and concerns;
   7. Emergency Department and in-patient utilization;
   8. Medical needs and issues;
   9. Social needs and issues;
   10. Responses to biological family visits;
   11. Medication changes and issues;
   12. School concerns;
   13. 504/IEP plan status; and
   14. Pregnancy status.

vii. Respond the next business day to requests from DSS to assist in transition care planning for foster children entering the custody of DSS.

viii. Respond the next business day to requests from a PHP or Tribal Option to participate in a warm hand-off exchange of information for those foster children leaving their program and entering the custody of DSS.

ix. Enter into the Data Platform the Child Health Summary Components that are received from DSS, such receipt being in a form mutually acceptable to the Contractor and DSS.

x. When requested by DSS, assist in developing the foster child's transitional living plan.

xi. Work with the appropriate DSS and PCP to identify key healthcare-related goals

and objectives for the foster child's transitional living plan.

xii. Approximately ninety (90) days before a foster child transitions out of this population, when requested by DSS, the Contractor will:
   1. Help develop a ninety (90) -Day Transition Plan that includes the most up-to-date provider information available to the Contractor and identifies key healthcare-related goals and objectives for the foster child.
   2. Supplement the ninety (90) -Day Transition Plan with a Member Action Plan (MAP) on paper, electronically, or both, that includes critical healthcare-related information, guidance on achieving healthcare goals, summary of scheduled visits with a recommended future schedule, and a list of medications currently prescribed for the foster child with guidance on their use.

g. The following services will be provided to unadopted former foster youth: At least six (6) months prior to the foster child's twenty-sixth (26th) birthday, the Contractor shall attempt to contact the foster child to discuss:
   i. The foster child's options for obtaining health insurance coverage after their twenty-sixth (26th) birthday.
   ii. The need for the foster child to create a plan to transition their healthcare, dental, and vision services as applicable, and medications to their chosen sources for these services.

C. Quality

1. The Department shall monitor quality of services provided by the Contractor and PCPs.
2. Quality Management Committee
   a. The Contractor shall establish a quality management committee to oversee quality of care for Members.
   b. Upon the Department's request, the Contractor shall submit within 5 business days, summary notes and outcomes of quality management committee meetings.
3. Quality Measure Set
   a. The Contractor shall report measures aligned to a range of specific goals and objectives used to drive quality improvement and operational excellence. The annual PCCM Quality Measure Set will be compared to baseline data and targets provided by the Department for measures on the population managed by the Contractor.
   b. The Contractor shall report the set of quality and administrative measures listed in *Attachment H: Program Performance Metrics Reporting Requirements*.
   c. The Department shall provide the Contractor detailed specifications around measure reporting, stratification, and data submission at least one hundred twenty (120) Calendar Days prior to the first report due date and at least four (4) months before any changes will be implemented.
   d. The Contractor shall provide data within ten (10) business days or other mutually agreed upon timeline, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.
4. Quality Assessment and Improvement (QAPI)
   a. The Contractor shall submit an annual Quality Assessment and Improvement Plan within ninety (90) Calendar Days of contract effective date and annually thereafter on March 1st to the Department for review and approval.
   b. The Contractor and the Department shall address mutually-agreed upon 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. The QAPI plan must include the following elements:

i. Completion of up to two performance improvement projects (PIPs) as agreed between the Contractor and the Department and defined in this Section;
ii. Collection and submission of all quality performance measurement data in the approved PCCM Quality Measure Set;
iii. Mechanisms to detect both underutilization and overutilization of services based on available data;
iv. Mechanisms to assess the quality of care for Members with special health care needs;
v. Mechanisms to assess the quality of care provided to Members needing long-term services and supports;
vi. Mechanisms to incorporate population health programs targeted to improve outcomes measures; and
vii. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS services and programs;
viii. Mechanisms to assess and address health disparities.
ix. A Provider Support Plan.

5. Performance Improvement Projects (PIPs)
   a. The Contractor will conduct two (2) PIPs in the first Contract Year. that are mutually agreed upon, which shall be described in the annual Quality Assessment and Improvement Plan (QAPI). The Contract shall be amended annually to confirm the number of PIPs to be completed by the Contractor based on the population served under the Contract.
   b. The Contractor will identify the PIPs based on performance on a quality measure in the PCCM Measure Set and will submit the proposed PIPs to the Department for review and approval.
   c. The Contractor shall send a quarterly report to the Department outlining progress on PIPs on the required reporting schedule.
6. Quality Improvement - Provider Support
   a. The Provider Support Plan shall include:
      i. The list of provider supports;
      ii. How the Contractor will provide in-person and online support;
      iii. Which providers will be supported, how they were selected, what are the goals and planned technical support activities for the selected providers, and what metrics will measure those goals; and
      iv. Detailed information regarding how its proposed provider support activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy.

D. Providers

1. Choice of Doctor
   a. The Department shall ensure that each Member has a choice of PCP to the extent possible and appropriate.
   b. Primary Care Provider (PCP) Assignment
      i. The Member shall be assigned to a PCP by the Department or delegate

1. Members shall have the option to select a PCP.
2. Members who do not select a PCP will be assigned a PCP by the Department.

c. Members shall be able to change their PCP at any time by contacting their local Department of Social Services.
d. The Contractor shall ensure its Enrollee Handbook informs Members enrollees that they can receive healthcare services from any Medicaid-enrolled PCP, regardless of whether that PCP participates in the PCCM program, and shall refer enrollees seeking services to a list of providers on the Department's website.

2. Primary Care Providers
   a. The Contractor shall work with those PCPs who are eligible to participate in the PCCM program, as determined by the Department, and that sign the Contractor's Participation Agreement, as required under the current State Plan.
   b. The Contractor shall have agreements with PCPs that are, at minimum:
      i. Actively enrolled in NC Medicaid; and
      ii. Enrolled as a Carolina Access provider.
   c. The Parties acknowledge that this Contract, as a state-wide arrangement for all Medicaid-eligible practices, includes a sufficient number of physicians and other practitioners to ensure that the services under the Contract can be furnished promptly and without compromising the quality of care. 42 C.F.R. § 438.3(q)(3).
   d. PCP Updates
      The Contractor shall submit monthly updates of the CCNC Enrolled PCPs to the Department (including enrollment, disenrollment, or termination) in a format provided by the Contractor as described in *Attachment B. Deliverables and Reporting Requirements*. The Department shall be responsible for notification to beneficiary of disenrollment and transitioning them to a new PCP.
   e. Provider Participation Agreement
      i. The Contractor shall check the provider's enrollment status in NCTracks before executing Contractor's Participation Agreement with that PCP.
      ii. The Provider Participation Agreement shall include:
         1. PCP requirements to serve as a Medical Home, including:
            a. Provide twenty-four (24) hour contact for services and consultation or referrals;
            b. Automatic referral to the ER is prohibited;
            c. Office hours of at least thirty (30) hours per week;
            d. Provide primary and preventative services as defined in Medicaid policy;
            e. Maintain unified patient records;
            f. Transfer Medical Records to a new PCP within thirty (30) days; and
            g. See enrolled patients within the following standards of appointment availability:
               i. Emergency care: immediately upon presentation or notification;
               ii. Urgent care: within twenty-four (24) hours of presentation or notification;
               iii. Routine sick care: within three (3) days presentation or notification;
               iv. Routine well care: within thirty (30) days of presentation or notification (or fifteen (15) days if Member is pregnant); and

v. Hospital discharge: within two (2) weeks of discharge.

h. Arrange for call coverage or other back-up to provide service in accordance with any of the Contractor's standards for Provider accessibility.

i. Inform the Contractor as soon as practical of any unauthorized disclosure or misuse of any PHI or personal identifying information of which the PCP becomes aware.

j. Use the Contractor's Data Platform to access patient information where applicable to improve patient care.

k. Follow requirements regarding patients' records, including:

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

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

iii. Make copies of such records available to the Contractor and the Department in conjunction with its regulation of the Tribal Option PCCM entity. The records shall be made available and furnished immediately upon request, at no cost to the requesting party, in the manner requested.

l. Cooperate with the Member in regard to Appeals and grievance procedures.

m. Right to file a grievance with the Contractor or with the Department.

n. Provide data and information to the Contractor.

2. PCP requirements to implement the Contractor's quality improvement activities, such as administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

3. Contractor requirements to provide data and reports to the PCP as described in this Contract.

4. An attestation that the PCP will maintain its enrollment with the Department as a Medicaid provider while it operates under the Contractor's participation agreement and will notify the Contractor immediately if the PCP's Medicaid enrollment with the Department terminates for any reason.

5. A statement that the PCP will comply with all applicable laws, such as HIPAA, and will comply with the Contractor's data use policies.

6. A statement that the PCP will cooperate with any Subcontractors to the same extent as the Contractor.

7. A statement that the PCP will not attempt to hold the State liable for any damages, or the Contractor liable for any damages other than those directly caused by the intentional misconduct of the Contractor.

8. A statement that the participation agreement has been reviewed by the Department as written.

iii. The Contractor shall terminate the Participation Agreement with any provider after receiving notice on the Department's Provider Enrollment File that the PCP has been disenrolled from NC Medicaid or is no longer a CAII provider

iv. The Contractor shall not employ or enter into an agreement with any Provider excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).

3. Department Review of Agreement
    i. The Contractor shall submit its Provider Participation Agreement to the Department for review before July 1, 2021.
    ii. The Contractor shall re-submit its Provider Participation Agreement to the Department for review at least ninety (90) Calendar Days before use with Providers when significant changes are proposed. PCCM Payments to Providers
4. The Department shall pay PCPs for services provided to enrollees in accordance with the NC Medicaid fee schedule and NC Medicaid State Plan.

E. Program Operations

1. Service Lines
    a. The Contractor shall operate a member service line that collectively cover the following functions and topics:
        i. Information about available PCCM services and how to access,
        ii. Information on general benefits available to the enrollee through NC Medicaid Direct,
        iii. Ability to connect the enrollee with their assigned Care Manager,
        iv. Ability to resolve enrollee questions related to care management services,
        v. Collect enrollee grievances, and
        vi. Direct enrollee back to the Department or Department vendor, as appropriate.
    b. The Contractor's service lines shall have capacity to handle:
        i. Inbound and outbound telephone calls during the Contractor's hours of operation;
        ii. Calls from enrollees with limited English proficiency using the Telelanguage tool, or a similar service if approved by the Department;
        iii. Calls from deaf, hard of hearing, and deaf-blind callers, to include TTY.
        iv. After-hours calls, defined as calls received outside of the Contractor's business hours of Monday through Friday, 8:00AM until 4:30PM Eastern Standard Time. The after-hours call functionality must include:
            1. Providing instruction for a call back in response to incoming calls during non-business hours;
            2. An automatic call back option;
            3. The call back shall be made the following business day during normal hours of operations, where practical; and
            4. The Department-provided after-hours messages.
        v. An Automated Voice Response System (AVRS) which:
            1. Allows transfers to the Department, PHPs, LME/MCOs or Tribal Option.
            2. Provides numbers for PHPs, LME/MCOs and Tribal Option; Uses instructions and options that are easy to understand by the expected users of the system
            3. Works in conjunction with an Automated Call Distributor (ACD) which routes calls to appropriate and available staff:
                a. When an enrollee desires to speak with a live person; and
                b. Based on unique Member needs such as Spanish speaking caller needs.
    c. The Contractor's service line(s) shall be accessible via toll-free telephone line.

d. The Contractor shall notify the Department of a service line call outage during business hours within four (4) hours.
e. The Contractor shall ensure the service lines are staffed with professionals who have sufficient training and knowledge on North Carolina Medicaid and Health Choice and the PCCM entity program as defined in the Contract.
   If a beneficiary calls the Contractor by mistake, the Contractor shall transfer the beneficiary to appropriate PHP, LME/MCO or Tribal Option or provide contact information for reaching the PHP, LME/MCO or Tribal Option, as appropriate, including their operating hours if receiving call center is closed.
f. The Contractor shall create records of all service line interactions with enrollees or their Authorized Representatives. The record must include:
   i. The enrollee name
   ii. The enrollee's phone number, if provided;
   iii. Notes summary of the reason for the call, the response provided, and whether the call was resolved;
   iv. The time and date of the call;
   v. Name of employee who handled the call; and
   vi. Whether Telelanguage was involved.
g. Call Scripts
   i. The Contractor will use call scripts provided by the Department, supplemented where appropriate by the Contractor. The Department must provide the following scripts:
      1. Available PCCM care management services and how to access them;
      2. Available Medicaid and NC Health Choice Benefits;
      3. Available community resources:
      4. Contact information for the Department, PHPs, LME/MCOs and Tribal Option, local DSS offices, Enrollment Broker, and NC Medicaid Member Ombudsman;
      5. Contact information for available behavioral health resources; and
      6. Member Grievance process, as described in *Section IV.A.5. Enrollee Grievances*.
   ii. The Contractor shall submit supplemented call scripts to the Department for review:
      1. Thirty (30) Calendar Days prior to use with intended audience; and
      2. Any time new supplemental language is added or removed by the Contractor after 7/1/2021. The Contractor shall provide documentation that it has obtained service lines to the Department within ninety (90) days after Contract Execution.
h. Service Line Policy
   i. The Contractor shall develop and maintain a Service Line Policy that will be made available to the Department, upon request.
   ii. The Policy shall include:
      1. Service line process flows and call-tree routing options and
      2. Call quality assurance and monitoring approach.

2. Reporting
   a. The Contractor shall comply with all the reporting requirements in *Attachment B: Deliverables and Reporting Requirements*.

b. The Department may request the Contractor submit additional reports both ad hoc and recurring.
c. The Contractor shall submit all reports electronically to the Department.
d. The Contractor shall ensure all reports are complete and represent the information in Contractor's databases.
e. The Contractor shall reasonably cooperate to provide necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements.

3. Business Continuity
   a. The Contractor shall develop and maintain a Business Continuity Plan.
   b. The Contractor shall submit the Business Continuity Plan to the Department for review within one hundred twenty days (120) Calendar Days of Contract Execution.
   c. The Business Continuity Plan covers the following topics:
      i. Business Continuity Plan
         1. Mission, Purpose, Objectives, and Scope
         2. Assumptions
         3. Business Impact Analysis
            a. Training
            b. Technology
               Data/Security Protocol
            c. Quality Improvement
            d. Services Delivery
               Restoration of Care Management Services
            e. Staffing
         4. Threat and Risk Analysis
            a. Technology
            b. Weather
            c. Facilities
            d. Disaster
            e. Pandemic
         5. Activation Strategy
            a. Criteria
            b. Procedures
            c. Notifications
            d. Escalation
         6. Emergency Contacts
         7. Vendor Contacts
         8. Regional Operations Call Tree
   d. The Contractor shall notify the Department each time the Business Continuity Plan is activated within four (4) business hours of an event.
4. Subcontractors
   a. The Contractor shall have the right to use Subcontractors to perform any of Contractor's care management and provider support obligations under this Contract.
   b. The approved list of Subcontractors includes:

i. Northwest Community Care Network;
ii. Charlotte-Mecklenburg Hospital Authority;
iii. Access East, Inc.; and
iv. Duke Integrated Network, Inc. dba Duke Connected Care, LLC.

c. The Contractor must submit any proposed new Subcontractor for approval by the Department at least ninety business days prior to the proposed start date for that Subcontractor.
d. The Department shall have the right to approve or reject any newly proposed Subcontractor.
e. The Contractor will not be required to use any Subcontractor that does not enter into an appropriate Subcontractor Agreement with the Contractor, as determined by the Contractor.
f. The approved Subcontractor Agreement must contain the following statements:
    i. An introduction that provides for the legal name, any d/b/a name, and the physical address for any Subcontractor.
    ii. A Declarations section that establishes the following facts:
        1. The Subcontractor Agreement is made pursuant to the Medicaid Direct contract between the Department and the Contractor.
        2. The Contractor is authorized, pending approval of the Subcontractor by the Department, to permit the Subcontractor to perform the obligations of the Contractor under the Medicaid Direct contract for the practices identified between The Contractor and the Subcontractor that are part of the Subcontractor's clinically integrated network (CIN).
        3. The Subcontractor will be operating under the supervision of the Contractor for all aspects of the Subcontractor's performance related to the Subcontractor Agreement.
        4. The Subcontractor Agreement will supersede any prior agreements between the Contractor and the Subcontractor related to performing care management activities on behalf of the Department.
        5. The Subcontractor must comply with all the attestations, representations, and certifications in the Medicaid Direct contract that apply to the Contractor.
        6. The Subcontractor is a subcontractor business associate to the Contractor, who is a business associate to the Department, for all protected health information of the Department or of the Contractor used or accessed by the Subcontractor, and as such Subcontractor must execute the Subcontractor Business Associate Agreement provided by the Contractor.
        7. The specific populations for which the Subcontractor will perform under the Subcontractor agreement.
        8. The Department is an intended third-party beneficiary to the Subcontractor Agreement and has the right to enforce any obligations in the Subcontractor Agreement against the Subcontractor.

9. The Department and the Contractor shall each have the right to audit the records of the Subcontractor related to their performance under the Subcontractor Agreement to ensure adherence to its terms.
10. The Subcontractor must use the Contractor's Data Platform to identify priority enrollees, load referrals, enter enrollee responses to care needs screens and comprehensive needs assessments, create and update care plans, record all data related to care management activities, and to access and use quality and performance measures.
11. The Subcontractor is executing the Subcontractor Agreement on behalf of all the Subcontractor's advanced medical homes (AMHs) participating in its CIN.
12. The Subcontractor must follow all policies and procedures developed by either the Department or the Contractor pursuant to the Medicaid Direct contract.
13. The Subcontractor will be solely responsible for training all its personnel to the standards identified in the Medicaid Direct contract.

iii. A Performance Obligations section that includes the following statements:

1. The Subcontractor must perform all the background checks, validations, and other verifications listed in the Medicaid Direct contract.
2. The Subcontractor must provide the Contractor by the end of each month the most current list of AMHs participating in the Subcontractor's CIN, which list must include the legal name, any d/b/a used, any group practices with the individual practices listed for each group practice, and the physical address for each AMH.
3. The Subcontractor must provide the Contractor at least thirty days' advance notice of any AMH leaving the Subcontractor's CIN.
4. Descriptions of the specific care management activities to be performed by the Subcontractor, including also transition of care activities, which descriptions must be consistent with the activities described in the Medicaid Direct contract.
5. The Subcontractor must execute an agreement with the entity Unite USA, Inc. to use their application NCCARE360 to make referrals to social services related to identified social determinants of health needs for enrollees, or the Subcontractor must provide to the Contractor the reason why it was unable to reach an appropriate agreement.
6. A description of the reports required from the Subcontractor, which must include the format, content, transmission method, and timing for each report.
7. A payment section that describes how the Contractor will make payments to the Subcontractor, including any conditions under which payments may be withheld or any withholding of funds from the Department to the Contractor may be allocated to the Subcontractor.
8. A Risk Allocation section that includes the following statements:
    a. Neither party will be liable for performance or failure to perform for improperly assigned or designated enrollees

b. Neither party will be liable for failures to perform when the failure is based on incomplete or inaccurate data provided by third parties, such as a lack of proper notice regarding enrollee opt-outs.
c. Neither party will be liable for failures of third-party applications.
d. Force majeure events will excuse performance only so long as the party, using any reasonably available means, is prevented from performing through no fault of the party.
e. The parties must indemnify the State against any negligence or intentional misconduct of that party and its agents that results in a third-party claim against the State.
f. The State will not accept any liability for either the negligence or the intentional misconduct of either party that results in any third-party claims.
g. The Subcontractor must indemnify the Contractor against any third-party claims arising from the negligence or intentional misconduct of the Subcontractor and its agents.
h. The Subcontractor must maintain all types and levels of insurance described by the Department in its Medicaid Direct contract with the Contractor.
i. Other than for indemnification claims, the aggregate liability of a party to the other party will be limited to the amounts of insurance carried by that party unless the party fails to maintain the types and amounts of insurance required by the Department.

iv. A Contract Control section that includes the following statements:
1. The Subcontractor agreement may only be amended as approved by both parties and the Department.
2. The Subcontractor may not transfer or assign any of its rights or obligations to any other entity.
3. Governing law must be North Carolina, and venue must be Wake County, North Carolina.
4. The Subcontractor Agreement with its attachments is the complete agreement between the Contractor and the Subcontractor.
5. The State is the only intended third-party beneficiary to the Subcontractor Agreement.
6. Notices other than for breach or termination may be made by email. Notices related to breaches or termination must be mailed with return receipt or through a national overnight carrier that provides confirmation of delivery.
7. The various provisions of the Subcontractor Agreement are severable
8. Provisions such as indemnification that by their nature are intended to survive termination or expiration will survive.
9. The Term of the Subcontractor agreement will match the Term of the Medicaid direct contract, with the understanding the Contractor may terminate the Subcontractor Agreement before the Medicaid Direct contract terminates.

10. The Contractor will provide the circumstances under which the contractor may terminate the Subcontractor Agreement.
11. Upon termination, the Subcontractor must stop using the Contractor's Data Platform and must destroy all data received from the Contractor of must return it to the Contractor.
12. A waiver of a right or obligation will not amend the Subcontractor Agreement or prevent any future enforcement of that right or obligation.

g. The Contractor may add additional contract terms to the Subcontractor Agreement that are not inconsistent with the obligations in the Medicaid Direct contract.

F. Financial Requirements

1. The Contractor shall submit financial information to the Department, including:
   a. Cumulative quarterly financial report. The report shall contain a detailed accounting of the total payments received from the Department during the reporting period and how payments were spent, including the following information:
      i. The amount and percentage of payments spent during the reporting period to support the following categories of work:
         1. Care Management services and activities
         2. QI/provider support activities; and
         3. Administration and overhead.
   b. Annual audited financial statements. The audited annual financial statements must be certified by an independent public accountant.
2. The Contractor and Department agree to participate in meetings to review financial reporting quarterly as requested by the Department.
3. The Contractor shall reasonably assist the Department in verifying any reported information upon the Department's request. The Department may use any appropriate, efficient or necessary method for verifying this information including:
   a. Fact-checking;
   b. Auditing reported data;
   c. Performing site visits; and
   d. Requesting additional information.
4. If the Department determines that there are errors or omissions in any reported information, the Contractor shall dispute that determination or produce an updated report that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated report to the Department within ten (10) business days from the Department's request for the updated report, or as soon as practical thereafter.

G. Administration and Management

1. Program Administration
   a. During the Term of the Contract, and in future years, the Department will modify its Medicaid and NC Health Choice Programs, including the PCCM entity 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 Contractor shall review such memos and bulletins to assist in staying informed of program changes.

The Department will notify the Contractor directly of any memo's or bulletins that substantively change the program.

b. The Contractor shall work cooperatively with the Department to be good stewards of Department funds and Department personnel time and to ensure effective administration of the PCCM entity.
c. In partnership with the Department, the Contractor shall develop processes and procedures to ensure the Contractor is soliciting stakeholder input, including input from enrollees, to drive continual improvement in the overall program.
d. The Contractor shall comply with Department policies specifically identified as applicable to the Contractor.
e. The Contractor shall not discriminate against enrollees, providers, or employees performing under this Contract in the provision of services or administration of the program.
f. The Contractor 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)
g. The Contractor is prohibited from discriminating in enrollment, disenrollment, and re-enrollment against individuals on the basis of health status or need for health care services. 42 C.F.R. § 438.3(q)(4).
h. The Contractor is prohibited from using any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. 42 C.F.R. § 438.3(d)(4).
i. The Contractor shall develop and adhere to a written non-discrimination policy specifying the prohibition against discrimination in accordance with this Contract. The Contractor's non-discrimination language is contained within its Workplace Harassment and Discrimination Policy.
    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 Contractor's policy will apply to Care Management programs offered to enrollees;
        3. The Contractor's grievance process for enrollees and employees performing under this Contract;
        4. The investigative, and complaint process available for enrollees through the Department and for employees performing under this Contract through the U.S. Equal Employee Opportunity Commission.
        5. Instructions on how to contact the Department and the U.S. Equal Employee Opportunity Commission.
    ii. The Contractor shall submit the Workplace Harassment and Discrimination policy to the Department for review ninety (90) Calendar Days after Contract Execution. The Contractor shall make updates to its non-discrimination policy as necessary, and, at a minimum, the Contractor shall review its non-discrimination policy for updates annually.
    iii. The Contractor shall make the applicable non-discrimination policy available to its employees performing under this Contract and to enrollees.

2. Staffing and Facilities
    a. The Contractor shall have adequate staff to meet requirements and performance standards under this Contract and ensure that it is staffed with individuals trained and capable of resolving issues related to performance under this Contract.
    b. The Contactor may combine or split the listed responsibilities among the Contractor's personnel if the Contractor demonstrates that the responsibilities are being met. Similarly, the Contractor may contract with a third party to perform one or more of these responsibilities.
    c. Key PCCM Roles
        i. The Contractor shall provide the Department within thirty (30) days after execution of the Contract a list of names and contact information for the Key Roles listed below. Specific individuals in these roles may be reassigned as determined by the Contractor, and may hold titles different from these roles, without need to amend this Contract.
        ii. Key PCCM Roles include:
            1. Care Management Director
            2. Quality Management Director
            3. Chief Medical Officer
3. Conflict of Interest
   The Contractor shall have a written Conflict of Interest Policy. The Contractor shall submit its written Conflict of Interest Policy to the Department for review ninety (90) Calendar Days after execution of the Contract.
4. Implementation and Readiness
    a. Implementation
        i. The Contractor and Department mutually agree to implement the requirements of the Contract by July 1, 2021 unless otherwise listed in Attached X: PCCM Implementation Schedule.
        ii. For any requirement not included in this Contract, the Department maintains the discretion to require the Contractor to establish implementation plans and testing requirements on an ongoing basis as new program requirements are implemented or prior to the Contractor effectuating, for example, a material program, operational or technical change. The Department will provide thirty (30) days' notice to provide an implementation plan or testing requirements based on a mutually agreed upon new program requirements.
    b. Readiness review
        i. The Department and its partners will conduct a readiness review to verify the Contractor, its staff, subcontractors and other individuals and organizations are prepared to PCCM services on behalf of the Department prior to opening new lines of business, accepting new eligibility populations or at the Department's discretion as defined and as applicable in 42 C.F.R. 438.66.
            1. The requirements covered within the Readiness Review shall be determined by the Department and communicated to the Contractor at least thirty (30) Calendar Days prior to the Readiness Review.
            2. The Contractor must meet these Readiness Review requirements and contract requirements in the time frame specified by the Department.

3. Readiness Reviews shall include, but are not limited to, onsite reviews, desktop reviews, policy reviews, system demonstrations, and staff interviews.

ii. Based upon results of the readiness review(s), the Department reserves the right to:
1. Offer acceptance to allow the Contractor to commence full operations of these new activities;
2. Offer conditional acceptance to allow the Contractor to commence operations if the Contractor is found not to meet certain requirements of the readiness review(s) upon receipt of a corrective action plan from the Contractor which demonstrates how it will meet readiness review criteria within the timeframe specified by the Department; or
3. Not allow the Contractor to offer PCCM services to the new eligibility population or new PCCM services to the current eligibility population.

H. Compliance

1. Disclosures
   a. The Contractor shall provide to the Department written disclosures of any prohibited affiliation under 42 C.F.R. § 438.610.
   b. The Contractor shall report to the Department within sixty (60) Calendar Days when it has identified payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).
   c. PCCM Staffing
      i. The Contractor shall be responsible for screening its employees to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
      ii. The Contractor shall not employ or contract directly for services under this Contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal health care programs, procurement activities under the Federal Acquisition Regulation and/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)].
2. Program Integrity
   a. To promote Program Integrity, the Contractor shall adhere to the following program standards:
      i. Validation of Exclusion List Status
         1. The Contractor shall, prior to contracting, check the exclusion status of all vendors against the following lists (collectively, these lists are referred to as the "Exclusion Lists") to ensure that the Contractor does not pay federal funds to excluded persons or entities:
            a. The State Exclusion List found at https://medicaid.ncdhhs.gov/providers/excluded-providers;
            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) list of excluded parties;
d. Office of Foreign Assets Control (OFAC) Specially Designated Nationals and Blocked Persons List.

2. To the extent applicable, the Contractor shall check, at least monthly, the exclusion status of persons with an Ownership or Control Interest in the PCCM entity, managing employees of the Contractor, against the Exclusion Lists. The Contractor shall not be controlled by a sanctioned individual as that term is described in section 1128(b)(8) of the Social Security Act. 42 C.F.R. § 438.808(a).
3. The Contractor shall remove from performance under this Contract any managing employee, found on one or more of the Exclusion Lists (each an "Excluded Person")
4. The Contractor shall report to the Department within ten (10) business days of identification of an Excluded Person.

ii. Prohibited Relationships

1. In accordance with 42 C.F.R. § 438.610, the Contractor 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 Federal Acquisition Regulations (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 or entity described in the preceding paragraph.
   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.
   d. For the purposes of this Section, a "relationship" means any of the following:
      i. A director, officer, or partner of the PCCM entity;
      ii. A subcontractor of the PCCM entity, as governed by 42 C.F.R. § 438.230;
      iii. A person with beneficial Ownership of five percent (5%) or more of the PCCM entity's equity; or
      iv. A network provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract.
   e. If the Department learns that the Contractor 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 Contractor has a relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the Contractor 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 Contractor 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. The Contractor shall not be located outside of the United States in accordance with 42 C.F.R. § 438.602(i).

3. Fraud, Waste, and Abuse Prevention
   a. To promote integrity in all PCCM entity activities and combat fraud, waste, and abuse, the Contractor shall:
      i. Investigate credible allegations of Medicaid fraud, waste, or abuse involving its staff.
      ii. Notify the Department in a timely manner regarding all credible allegations of Medicaid fraud, waste, or abuse by participating providers or enrollees, received by the Contractor.
      iii. Notify the Department promptly of any substantiated allegations of Medicaid fraud, waste, or abuse by staff.
      iv. Develop and implement a fraud, waste, and abuse policy for its staff.
      v. Provide the Department the Contractor's fraud, waste, and abuse policy within one hundred twenty (120) days of the execution date of this Contract.
      vi. Implement regular training to inform staff about fraud, waste, or abuse, the Contractor's policy, and how they can report allegations of fraud, waste, and abuse.
      vii. Enforce the fraud, waste, and abuse policy and provide ongoing education to its staff regarding their responsibilities.
4. Investigation Coordination. Subject to any request not to divulge information made by any law enforcement agency who may be investigating or want to investigate:
   a. The Contractor shall cooperate with all appropriate state and federal agencies, including the Medicaid Investigations Division (MID) and the federal Office of Inspector General, in investigating fraud and abuse.
   b. The Contractor shall timely provide appropriate data or information requested by the Department or MID.
   c. The Contractor and the Department shall meet as needed to discuss issues related to fraud, abuse, and misuse of Medicaid funds and resources.
5. Whistleblower Protections
   The Contractor shall develop and maintain as part of its Employee Handbook a Whistleblower Policy related to whistleblower protections and submit to the Department for review within one hundred twenty (120) days after execution of the Contract.
6. Third Party Liability (TPL)
   a. The Department shall be responsible for actively seeking, identifying, vetting, and paying for any third party resources for the purposes of the following:
      i. Cost avoidance;

ii. Credit balance;
iii. Commercial health insurance;
iv. Medicare disallowance;
v. Casualty insurance;
vi. Liability insurance;
vii. Social determinants of health data collection and management, including all necessary authorizations

I. PCCM Technical Specifications

1. The Contractor will implement data exchanges as defined by the Department.
2. The Department anticipates changes to its Information Technology Systems. The Contractor will update its data exchanges to conform with any changes to data exchanges, file formats, data exchange frequencies, data exchange protocols and transports, and file size. The Department will provide test environments to allow adequate testing time.
3. The Contractor shall provide a testing point of contact to participate in test planning, discuss status of testing, attend status meetings, and escalate issues to the Department as needed.
4. Electronic Data Submission
   a. End to End Testing
      i. The Contractor shall complete as appropriate development, Unit/Assembly Testing, System Integration/Regression Testing, and Performance/Security Testing prior to the commencement of End to End testing.
      ii. The Contractor shall participate in End to End testing, including attending sessions to review End to End test cases.
      iii. The Contractor will perform end to end testing and show the Department the results. The Contractor will use the Department-defined scripts and Test Management Tool for tracking and reporting.
      iv. The Contractor shall use the Department's instance of HP Application Lifecycle Management (HPALM) to track End to End test execution and defect resolution.
   b. Electronic Data Interchange (EDI)
      i. The Contractor will create interfaces as necessary to exchange data between the Contractor and the Department or the Department's chosen vendors managing data required under this Contract. The Contractor's interfaces must be compatible with the Department's requirements for data infrastructure for data used pursuant to this Contract.
      ii. The Contractor shall transmit protected health information (PHI) in accordance with the HIPAA Privacy and Security rules for the transmission of electronic PHI (45 CFR 164.312(e).
      iii. Failures in data exchanges and interfaces that are not resolved through normal operations must be reported to the Department or the Department's vendor promptly, and not to exceed four (4) hours during normal business hours. If the failure substantially affects the Contractor's ability to deliver enrollee services, it must be reported as soon as practical. The Contractor will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than three business days after the resolution of the failure. The Department may request additional information if the initial RCA does not include adequate information.

c. Retransmissions
    i. If the Contractor receives a transmission from the Department or the Department's vendor that the Contractor cannot process correctly, the Contractor will notify the Department within 4 business hours and the Department shall ensure a corrected file is retransmitted to the Contractor within four (4) business hours.
    ii. If the Department or the Department's vendor cannot process a file received from the Contractor, due to errors on the part of Contractor, the Department will notify the Contractor and the Contractor 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 specified format for the data exchange, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.
d. Test Data Transmission
    The Contractor will test all data transmissions with all data exchange partners to validate connectivity, format, and data fields. Examples of data exchanges may include, but are not limited to, data exchanges between the Department and the Contractor, or between the Contractor and other Department vendors such as other Managed Care Entities, Fiscal Agent, or NC FAST. The Department will oversee any testing and review results. If the testing is not successful, the Department will ensure the entity causing the test failure remediates the failure.
e. Test Environments
    i. The Contractor shall have at least two (2) testing environments – one for Systems Integration Testing, and one for End to End testing. The environments shall use the appropriate data sets defined by the Department.
    ii. The Contractor shall use test environments are compliant with all security requirements defined by North Carolina State and the Department's Privacy and Security Office to support testing with production data.
    iii. The Contractor shall have test environments available prior to conducting Systems Integration Testing.
    iv. The Contractor's test environments must, as appropriate, be able to refresh test environments and ingest files the same size as would be required in a production environment and must be able to use data that would appear in a production environment.
    v. The Contractor's test environment must, as appropriate, be able to simulate date and duration dependent processes.

5. Enrollment and Reconciliation
    a. Enrollment and Reconciliation
        i. Enrollment:
            1. The Contractor shall accept an 834 or other eligibility file daily from the Department with new, modified, and terminated Member records for Members enrolled in the PCCM entity.
            2. The Contractor shall add, modify, or terminate Members daily based on 834 or other eligibility file.
            3. At the Department's request, the Contractor shall provide a full roster of Members currently enrolled in the PCCM entity in the Department's preferred format within seventy-two (72) hours. The file format of this

request must be provided to the Contractor at least thirty (30) days prior to any such request.

ii. Reconciliation:

1. The Contractor shall accept a weekly and monthly 834 or other eligibility file from the Department, with all enrollees that were added, modified, and terminated for the period.
2. The Contractor shall compare the Contractor's loaded enrollee data with the Department's monthly enrollee data sent, to ensure accuracy.
3. The Contractor will notify the Department of any differences in the comparison between the monthly enrollee records received and the monthly enrollee records loaded, on a monthly basis.
4. The Department shall determine if corrections are needed to the enrollment data to address discrepancies identified by the Contractor during reconciliation.
5. The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the Contractor.
6. The Contractor shall use corrected files sent by the Department.

6. Technology Documents
   a. The Contractor shall provide the following documents to the Department for review and approval within ninety (90) Calendar Days after execution of the Contract, unless otherwise approved by the Department. The Department may request additional information be made available or developed if the documentation is not satisfactory.
      i. System Security Plan: The Contractor shall complete the State's System Security Plan template within ninety (90) days after execution of the Contract. After approval by the Department, the Plan shall be updated annually and resubmitted to the Department for review. (Link to DHHS template: https://files.nc.gov/ncdit/documents/files/NC%20DIT%20SSP%20Template.20180112.docx)
      ii. Context Diagram. The Contractor shall update its context Diagram and provide it to the Department within ninety (90) days after execution of the Contract. The Contractor will maintain this document throughout the Term of the Contract.
      iii. Relevant summary findings of SOC 2 Type 2 Reports, to the extent the Contractor will store any Department owned-data on its servers. These findings shall be provided to the Department annually.
      iv. Summary findings of any system penetration tests performed on the Data Platform; and
      v. Business Associate Agreement between the Contractor and Subcontractors, if applicable.
7. PCCM Data Management
   a. The Contractor shall maintain a Data Platform that collects, analyzes, integrates, and provides operational reporting that satisfies the requirements detailed in this Contract. The Data Platform shall house state-owned data provided by the Department to the Contractor.
   b. To the extent the Contractor subcontracts administration and operation of the Data Platform to any third party, the Contractor shall execute with such third parties all necessary documentation to ensure the obligations in this Contract to protect State-owned data are applied to those third parties.

c. The Contractor shall require all third-party entities to execute its Participation Agreement and Business Associate Agreement before accessing the Data Platform and State-owned data.
d. The Contractor shall monitor access and use of the Data Platform and the Data at a location owned, leased, or controlled by the Contactor and through the use of equipment that is under the ownership or control of the Contractor, to ensure access and use are consistent with the permitted purposes and Applicable Law.
e. The Department has the right to request information from the Contractor.
f. All reports submitted by the Contractor shall be validated by the Contractor prior to submission.
g. The Department shall have access to the Data Platform and the data in it used to perform under this Contract.

V. Contract Performance

A. Sanctions

1. **Establishing Intermediate Sanctions**: In accordance with 42 C.F.R. § 438.700, the Department may establish and impose intermediate sanctions on the Contractor if it makes any of the applicable determinations specified in that regulation. The Department may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.
2. **False or Misleading Marketing**: If the Department determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the Department or that contain false or materially misleading information, to potential enrollees for the purpose of inducing them to leave the Tribal Option and enroll instead in the NC Medicaid Direct program administered by Contractor, it may impose the following Intermediate Sanctions:
    a. Civil monetary penalties, with the maximum civil monetary penalty the Department may impose varying depending on the nature of the Contractor's action or failure to act, in accordance with 42 C.F.R. § 438.704.
    b. Granting Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll;
    c. Suspension of all new enrollment, including default enrollment, after the date the Secretary or the Department notifies the Contractor of a determination of a violation of any requirement under Sections 1905(t) or 1932 of the SSA and any implementing regulations; or
    d. Suspension of payment for Beneficiaries enrolled after the effective date of the sanction until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
3. **Right to Impose Other Sanctions**: In accordance with 42 C.F.R. § 438.702, the Department retains authority to impose additional sanctions under North Carolina statutes or regulations that address areas of noncompliance.

B. Remedial Actions

1. **Remedial Actions**: If the Department determines that the Contractor is in violation of the Contract or in violation of Applicable Law, the Department may require the Contractor to take one or more of the following remedial actions, which are not subject to appeal:
    a. Immediate steps to cease or correct the non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the violation or noncompliance; Submission and implementation of a Corrective Action Plan; or
    b. Participation in additional education or training.
2. **Corrective Action Plans (CAPS)**
    a. Contractor shall develop and submit to the Department a CAP if the Department selects that remedial action for Contractor's violation to perform its obligations.
    b. If the Department notifies the Contractor it intends to invoke the remedial action of a CAP, the Contractor shall immediately cease the noncompliant behavior, if possible, or take steps to cease the noncompliant behavioral and take actions to mitigate the harm caused by the violation, until an approved CAP is implemented.
    c. A CAP must include:
        i. The request for corrective action by the Department;
        ii. A description of how the substantial failure to perform identified by the Department will be remediated;
        iii. The timeline for the implementation and completion of the corrective action(s); and
        iv. The name of the responsible person who will lead all corrective action activities.
    d. Any CAP submitted by the Contractor shall be subject to approval by the Department.
    e. The Contractor shall submit a CAP in a reasonable timeframe as determined by the Department based on the circumstances creating the need of the CAP.
    f. The Department may accept a CAP as submitted, request specified modifications, or reject it.
    g. If the Department requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP in a reasonable timeframe as determined by the Department to address the issues or concerns identified.
    h. The Contractor shall keep the Department reasonably updated on its progress implementing a CAP.

C. Intermediate Sanctions

1. The Department may, based on findings from onsite surveys, enrollee or participating PCP complaints, audited financial reviews of Contractor, or other relevant sources of verifiable information, and after providing Contractor timely written notice explaining the basis and nature of the sanction and all appeal rights of Contractor, impose the following intermediate sanctions:
    a. Contractor may be assessed an intermediate sanction not to exceed $25,000 for a determination that Contractor has falsified or misrepresented information it supplies to enrollees or participating PCPs (438.700(b)(5)).

b. Contractor may be assessed an intermediate sanction not to exceed $100,000 for a determination that Contractor has discriminated against enrollees based on their health status or need for healthcare services (438.700(b)(3)).
c. Contractor may be assessed an intermediate sanction not to exceed $100,000 for a determination that Contractor has falsified or misrepresented information it provided to CMS or to the Department (438.700(b)(4)).

2. **Effective Date of Intermediate Sanctions**
   a. If Contractor elects not to appeal the imposition of an intermediate sanction, the imposed sanction shall become effective the next Calendar Day following the expiration of the period to appeal included in the Notice of Deficiency.
   b. If the Contractor elects to appeal the imposition of an intermediate sanction and loses the appeal, the imposed sanction shall become effective the next Calendar Day following the date of the written final decision.

D. Liquidated Damages

1. Performance standards and the liquidated damages to be assessed should Contractor fail to meet those performance standards are identified in *Section V.H. Service Level Agreements, Performance Standards, and Liquidated Damages*.
2. The Department shall send a notice of deficiency assessing any liquidated damages within sixty (60) Calendar Days of the end of the calendar quarter in which Contractor reported the missed the performance standards identified in *Section V.H. Service Level Agreements, Performance Standards, and Liquidated Damages*.
3. Following receipt of a notice of deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract up to the specified limits provided below, until such time as the Department, determines the violation(s) has(have) been cured.

E. Payment of Liquidated Damages

1. If the Contractor elects not to appeal the assessment of liquidated damages, the assessed amounts shall be due ten (10) Calendar Days after the last date to appeal.
2. If the Contractor elects to appeal the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages will be due ten (10) Calendar Days from the date on the written notice of final decision. If Contractor fails to pay liquidated damages by the applicable due date, Contractor shall be subject to interest and a late payment penalty, in accordance with N.C. Gen. Stat. § 147-86.23, until the past due amount is paid. The Department reserves the right to recoup any monies owed to the Department from assessed liquidated damages by withholding the amount (including interest and late payment penalties) from future management fees owed to Contractor. The Department shall provide written notice to Contractor prior to withholding a portion of the management fees for assessed liquidated damages.

F. Notice of Deficiency

The Department will send a notice of deficiency to the Contract Administrator for Contractor prior to imposing any remedial action, intermediate sanction, or liquidated damage allowed under this Contract. The notice of deficiency will include the basis for the action, sanction, or

damage, the timeframe for complying with the action, sanction, or damage, and appeal rights as applicable.

G. Appeals Related to Contract Performance

1. Notwithstanding any words to the contrary anywhere else in this Contract, the Contractor retains at all times all its rights to contest the legal validity of any sanction or liquidated damage attempted to be imposed under this Contract.
2. Appeal Process
    a. Contractor shall have the right to appeal the imposition of intermediate sanctions or liquidated damages.
    b. To appeal, Contractor shall follow the procedure set forth in this Section and the Notice of Deficiency and shall submit a written request to appeal within fifteen (15) Calendar Days after of the Contractor receives the Department's Notice of Deficiency. The Department may extend the Contractor's deadline to appeal for good cause if the Contractor requests an extension within ten (10) Calendar Days after receiving the notice.
    c. The Contractor shall include in the appeal all arguments, materials, data, and information in support of its position.
    d. The Department shall review the appeal and submitted evidence and information and issue a written final decision within sixty-five (65) Calendar Days of the Contractor's request for appeal. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the Contractor of any extension and the reason for such extension.
    e. The final decision issued by the Department shall not be subject to further appeal within the Department.
3. Hearing Prior to Termination of Contract with Cause
    a. Contractor shall be entitled to a hearing prior to the Department seeking to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the **Termination for Cause** clause of the Contract. At least thirty (30) Calendar Days prior to the hearing, Contractor shall receive written notice of the hearing that includes the date, time, place and nature of the hearing.
    b. Following the hearing, Contractor shall receive a written final decision within sixty-five (65) Calendar Days after the hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, Contractor shall be notified of the extension and the reason for such extension.
    c. For a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to Contractor.
4. Legal Representation: The Department and Contractor may be represented by legal counsel throughout the appeal process.

H. Service Level Agreements, Performance Standards, and Liquidated Damages

Contractor shall comply with the following service level agreements (SLAs) and performance standards. Failure to meet the SLA and performance standards may result in the assessment of liquidated damages. Liquidated damages will be waived by the Department in the event circumstances outside of Contractor's control resulted in or significantly contributed to Contractor's failure to meet the established SLA or performance standard.

PCCM Service Level Agreements, Performance Standards and Liquidated Damages					
	Measure	**Performance Standard**	**Definition or Description of How Measured**	**Measurement Unit or Reporting Period**	**Liquidated Damage**
Care Management, and Quality					
1.	Failure to send the required Transition of Care data as specified in the Transition of Care Policy as agreed upon by the Contractor and Department.	Send within ten (10) Business Days of notification by the Department of enrollee's transition to a managed care entity. Bulk transitions are excluded from this Performance Standard.	The number of State Business Days from the first date the enrollee appears on the enrollment file with a status of being transitioned to a specified PHP or Tribal Option to the date the Contractor transmits the required data to that PHP or Tribal Option.	State Business Days Measurement must be made based on a complete and correct enrollment file being delivered to Contractor covering the time of the purported failure. Any defect in the enrollment file will void liquidated damages for records on a defective file.	For the first five (5) occurrences, no liquidated damages will be imposed, but a CAP may be required. Once more than five (5) failures occur, liquidated damages will be one hundred dollars ($100) per State Business Day. Up to a maximum of one thousand dollars ($1,000) per missed transmission of Transition of Care data per member.
2.	Failure to submit the Care Management Policy to the Department.	The Contractor shall submit to the Department no later than ninety (90) Calendar Days after contract effective date, and annually thereafter.	The number of State Business Days the Policy is submitted after ninety (90) days for the initial submission and the number of State Business Days past September 30th for future submissions	Annually	Fifty dollars ($50) per Business Day Up to a maximum of five hundred dollars ($500).
3.	Failure to complete a Comprehensive Needs Assessment (CNA), including reassessments, within the timeframes specified in *Section IV. B. Benefits and Care Management.*	The Contractor shall complete a Comprehensive Needs Assessment on high-risk enrollees within thirty (30) Calendar Days after engagement. Engagement in care management is defined as receiving patient consent for care management services. If an enrollee rescinds their consent for care management or the assessment before it is due, the Contractor will not be subject to liquidated damages.	The number of State Business Days the Comprehensive Needs Assessment is completed beyond the timeframe established within the Performance Standard.	Quarterly	For CNAs not completed in thirty (30) Calendar Days but completed in sixty (60) Calendar Days or less, there will be no liquidated damages, but there may be a CAP to improve the process. For CNAs more than sixty (60) Calendar Days late, one hundred dollars ($100) per day beyond 0 days. Up to a maximum of one thousand dollars ($1,000) per CNA.

PCCM Service Level Agreements, Performance Standards and Liquidated Damages					
	Measure	**Performance Standard**	**Definition or Description of How Measured**	**Measurement Unit or Reporting Period**	**Liquidated Damage**
4.	Failure to develop and maintain a Care Plan for an Enrollee with a Comprehensive Needs Assessment that results in a decision to create a Care Plan.	Contractor shall develop a care plan within thirty (30) Calendar Days after completion of the Comprehensive Needs Assessment for high-needs enrollees and update annually thereafter for enrollees still engaged in care management. The annual update shall occur no later than three hundred ninety-five (395) Calendar Days after the previous update. If an enrollee rescinds their consent for care management before the care plan is due, or refuses to follow their care plan, Contractor will not be subject to liquidated damages.	The number of State Business days from the date the Care Plan was due to the date the Care Plan was entered into the Data Platform, except that care plans abandoned when an enrollee revokes consent will not be counted	Monthly	For care plans not completed in thirty (30) days but completed in sixty (60) Calendar Days, there will be no liquidated damages, only a CAP to improve the process. For care plans more than sixty (60) Calendar Days late, one hundred dollars ($100) per day beyond sixty (60) days until the care plan is completed. Up to a maximum of one thousand dollars ($1,000) per care plan.
5.	Failure to submit the quarterly PIP report to the Department.	The Contractor shall submit the report no later than thirty (30) Calendar Days after the end of each State Fiscal Quarter.	The number of State Business Days the report is submitted beyond the timeframe established within the Performance Standard.	Quarterly	Two hundred dollars ($200) per State Business Day Up to a maximum of two thousand dollars ($2,000) per quarter.
6.	Failure to submit the annual Quality Assessment and Improvement Plan to the Department.	The Contractor shall submit the first plan by September 27, 2021. All other QAPIs are due by March 1st of each succeeding year.	The number of State Business Days the QAPI is submitted after the due date for that QAPI	Annually	Two hundred dollars ($200) per State Business Day Up to a maximum of two thousand dollars ($2,000) per year.
Technical Specifications					
7.	Failure by the Contractor to report Cybersecurity Incidents.	Contractor must report Cybersecurity Incidents to the Department three (3) State Business Days after confirming its existence.	The number of State Business Days from the date the Cybersecurity Incident was confirmed to the date the Cybersecurity Incident was reported to DHB, less three (3) State Business Days.	State Business Day.	Five hundred dollars ($500) for each State Business Day unreported after report is due. Up to a maximum of five thousand dollars ($5,000) per incident.

PCCM Service Level Agreements, Performance Standards and Liquidated Damages					
	Measure	**Performance Standard**	**Definition or Description of How Measured**	**Measurement Unit or Reporting Period**	**Liquidated Damage**
Directives and Deliverables					
8.	Failure to comply with a Corrective Action Plan as required by the Department.	The Contractor shall comply with the requirements of the approved Corrective Action Plan.	The number of State Business Days the Contract is found to be non-compliant with the approved Corrective Action Plan.	State Business Day	Five hundred dollars ($500) per State Business Day the Contractor fails to comply with an approved corrective action.

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VI. Execution

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

North Carolina Community Care Networks, Inc.

DocuSigned by:
Christopher Woodfin
ADA65FA6DA364B9...
Chris Woodfin, CFO and EVP

Date: 09/28/21 | 1:02 PM EDT

North Carolina Department of Health and Human Services, Division of Health Benefits

DocuSigned by:
Dave Richard
[illegible]
Dave Richard, Deputy Secretary

Date: 09/28/21 | 5:13 AM PDT

Attachment A: PCCM Fees and Provider Payments

1) PCCM Fees Paid to the Contractor

Table 1: Payment to the Contractor	
Monthly Payment	$3,873,778
Total Enrollment Assumption	418,299
Care Management Population Assumption	109,545

2) Payment for Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP)

Table 2: Payment to the Local Health Departments (LHD)	
Program	PMPM Paid to LHD
CMARC	$4.56
CMHRP	$4.96

3) Primary Care Provider Fees to be Paid by the Department

Table 3: Primary Care Provider Fees to be Paid by the Department	
Provider Type	PMPM Paid to PCP
Carolina Access: Non-ABD and Health Choice	$2.50
Carolina Access: ABD	$5.00
CIHA as of July 1, 2019	$61.65

4) Temporary Rates in Response to Public Health Emergency: Effective July 1, 2021 and until such time as the Department provides notice by publication of a Special Medicaid Bulletin of an end date for these rates, the fees set forth in the following table will be paid to participating providers in lieu of the rates specified in Table 3 of Attachment A:

Table 4: Temporary Rates to Primary Care Provider Fees to be Paid by the Department	
Provider Type	PMPM Paid to PCP
Carolina Access: Non-ABD and Health Choice	$5.00
Carolina Access: ABD	$10.00
CIHA	$67.82

Attachment B: Deliverables and Reporting Requirements

Table 1: Reports from N3CN					
Report Name	Frequency	Due Date	Initial Reporting Period	Initial Due Date	DHB Sign Off Date
1. Change in Member Circumstance (MEM009-B)	Monthly	15 Days after month end	January 2022	February 15, 2022	30 Days after Received
2. Member Grievance Log	Quarterly	15 days after quarter end	July 1, 2021 to September 30, 2021	October 15, 2021	30 Days after Received
3. Care Needs Screening Report (BCM026)	Quarterly	60 days after the end of the quarter	February & March 2022	May 1, 2022	30 Days after Received
4. Annual Quality Measures Report (QAV007)	Annual	120 days after measurement period (Calendar Year)	Calendar Year 2021	April 30, 2022	30 Days after Received
5. Care Management Interaction Beneficiary Report (BCM051)	Monthly with values on an annual rolling basis	15 days after month end	July 2021 August 2021 September 2021	October 15, 2021	30 Days after Received
6. CCNC Enrolled PCP	Monthly (changes only)	5 business day before the end of the month	July 2021	July 26, 2021	30 Days after Received
7. Cumulative Quarterly Financial Report	Quarterly	45 Calendar Days after the end of the quarter	July 2021 to September 2021	November 15, 2021	30 Days after Received
8. Quality Assurance and Performance Improvement Plan (QAPI)	Annual	90 days after contract effective date and annually thereafter on March 1	7/1/21 to 6/30/22	9/27/2021	60 days after Received
9. Performance Improvement Projects: Quarterly report	Quarterly	30 days after end of quarter	December 2021	1/30/22	30 days after Received
10. N3CN Audited Financial Statement	Annual	December 31	Fiscal Year 2021	December 31, 2021	30 Days after Received
11. State Grant Certification No Overdue Tax Debts	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
12. Federal Certifications & Disclosures	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
13. IRS Tax Exemption Verification Form	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received

Table 1: Reports from N3CN					
Report Name	Frequency	Due Date	Initial Reporting Period	Initial Due Date	DHB Sign Off Date
14. State Certifications	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received
15. Conflict of Interest Verification	Annual	January 31	Calendar Year 2021	January 31, 2022	30 Days after Received

Table 2: Deliverables from N3CN	
Deliverable Name	Delivery Time Frame
1. Business Continuity Plan	One hundred twenty-Hundred Twenty (120) days of Contract Execution
2. Care Management Policy	Ninety (90) of Contract Execution and annually thereafter
3. Conflict of Interest Policy	ninety (90) days of Contract Execution
4. Enrollee Grievance Policy	ninety (90) days of Contract Execution
5. Enrollee Handbook	One hundred five days (105) of Contract Execution
6. Enrollee Welcome Letter	Ninety (90) days prior to use with Members and annually thereafter
7. Fraud, Waste and Abuse Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
8. Key PCCM Role - Care Management Director	Thirty (30) days of Contract Execution
9. Key PCCM Role - Chief Medical Director	Thirty (30) days of Contract Execution
10. Key PCCM Role - Quality Management Director	Thirty (30) days of Contract Execution
11. Member Educational and Outreach Materials Policy	Sixty (60) of Contract Execution and annually thereafter
12. Provider Participation Agreement	Upon the effective date of the Contract
13. Service Line Operational Prior to Launch.	Ninety (90) of Contract Execution
14. Supplemented Call Scripts	Thirty (30) days prior to use with audience
15. System Security Plan	Ninety (90) days of Contract Execution and annually thereafter
16. System Context Diagram	Ninety (90) days of Contract Execution
17. Summary SOC 2, Type 2	Ninety (90) days of Contract Execution and annually thereafter
18. Whistleblower Policy	One hundred twenty-Hundred Twenty (120) days of Contract Execution
19. Workplace Harassment and Discrimination Policy	Ninety (90) days of Contract Execution

Table 3: Deliverables from DHB	
Deliverable Name	Delivery Time Frame
1. Call Scripts (at least six)	Within thirty (30) days of Contract Execution
2. Enrollee Handbook	Within forty-five (45) days of Contract Execution
3. Approve PCP Participation Agreement	Within thirty (30) days of Contract Execution

Attachment C: Managed Care Terminology Provided to PCCM

1. Appeal: The process to seek review of an Adverse Determination for services provided under Medicaid Direct or an Adverse Benefit Determination for services covered under Medicaid Managed Care.
2. Co-Payment: Also known as a “Copay” is a fixed amount paid by the Member for certain covered health care services. The copay amount may vary by service or Provider. Co-pays are not required for IHS eligible individuals. Example: A Member cost of one dollar ($1) for a generic prescription.
3. Durable Medical Equipment (DME): Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is appropriate for home use and is not useful to a person without illness or injury. For devices classified as DME after January 1, 2012, has an expected life of three (3) years.
4. Emergency Medical Condition: A medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.
5. Emergency Medical Transportation: Medically Necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.
6. Emergency Room Care: Care given for a medical emergency, in a part of the hospital where emergency diagnosis and treatment of illness or injury is provided, when it is believed that one’s health is in danger and every second counts.
7. Emergency Services: Inpatient and outpatient services by a qualified Provider needed to evaluate or stabilize an emergency medical condition
8. Excluded Services: Services that are not available under Medicaid FFS.
9. Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member’s rights regardless of whether remedial action is requested.
10. Habilitation Services and Devices: Health care and support services that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services and supports for people with disabilities in a variety of inpatient, outpatient or home and community settings.
11. Home Health Care: Certain Medically Necessary services provided to Members in any setting in which normal life activities take place other than a hospital, nursing facility, or intermediate care facility. Services include skilled nursing, physical therapy, speech-language pathology, and occupational therapy, home health aide services, and medical supplies.
12. Hospitalization: Care in a hospital that requires admission as an inpatient for a duration lasting more than twenty-four (24) hours. An overnight stay for observation could be outpatient care.
13. Medically Necessary: Those covered services that are within generally accepted standards of medical care in the community or defined by rule or policy and not typically experimental unless allowed by federal law or rule.
14. PCP Network: A group of Primary Care Providers contracted by the PCCM entity to provide health care services.
15. Non-participating Provider: Non-Par or non-participating Providers are Primary Care Providers that have not entered into an agreement with PCCM entity and are not part of the PCP Network, unlike participating Providers
16. Participating Provider: Par or participating Providers are Primary Care Providers that have an agreement with the PCCM entity and are part of its PCP Network

17. Physician Services: Health care services a licensed medical physician, or physician extender such as a nurse practitioner or physician assistant, provides, orders, or coordinates.
18. Plan: The health Benefit option in which a Member has enrolled.
19. Premium: The amount paid for health insurance monthly. In addition to a premium, other costs for health care, including a deductible, copayments, and coinsurance may also be required.
20. Prescription Drug Coverage: Refers to how Members' prescription drugs and medications are covered under the NC Medicaid and Health Choice State Plan.
21. Prescription Drugs: Also known as prescription medication or prescription medicine, is a pharmaceutical drug that legally requires a medical prescription to be dispensed.
22. Primary Care Physician: A licensed medical doctor (MD) or doctor of osteopathy (DO) that provides and coordinates patient needs and initiates and monitors referrals for specialized services when required. See *Primary Care Provider*, below.
23. Primary Care Provider (PCP): The participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.
24. Provider: Any individual or entity that is engaged in the delivery of health care services, or ordering or referring for those services, and is legally authorized to do so by the state in which services are delivered.
25. Rehabilitation Services and Devices: Health care services and equipment that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to sickness, injury, or disablement. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.
26. Skilled Nursing Care: Care that requires the skill of a licensed nurse.
27. Specialist: A Provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
28. Urgent Care: Medical care provided at a walk-in clinic for illnesses or injury that require prompt attention but do not rise to the level of an Emergency Medical Condition.

Attachment D: Business Associate Agreement

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH BENEFITS

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made effective upon the later of the execution datesof this Agreement ("Effective Date") by and between North Carolina Department of Health and Human Services, Division of Health Benefits ("Covered Entity") and North Carolina Community Care Networks, Inc. ("Business Associate") (collectively the"Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are Parties to a contract entitled: (Placeholder for ContractTitle) (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the "Department") that has been designated in whole or in part by the Department as ahealth care component for purposes of the HIPAA Privacy Rule.

c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d. The Parties enter into this Agreement with the intention of complying with the HIPAA Privacy Ruleprovision that a Covered Entity may disclose protected health information to a business associateand may allow a business associate to create or receive protected heath information on its behalf,if the covered entity obtains satisfactory assurances that the business associate will appropriatelysafeguard the information.

2. DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have thefollowing meaning in this Agreement:

a. "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

b. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

c. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shallinclude a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

d. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Informationat 45 C.F.R. Part 160 and Part 164.

e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.

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

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to preventuse or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is knownto Business Associate of a use or disclosure of Protected Health Information by Business Associatein violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.

e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and § 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.

f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.

g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.

h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received, by Business Associate on behalf of, Covered Entity available to the Secretaryfor purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform

functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract,provided that such use or disclosure:

1) would not violate the Privacy Rule if done by Covered Entity; or

2) would not violate the minimum necessary policies and procedures of the Covered Entity.

b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilitiesof the Business Associate, provided that:

1) the disclosures are Required by Law; or

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

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

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

5. TERM AND TERMINATION

a. **Term**. This Agreement shall be effective as of the Effective Date stated above and shall terminatewhen the Contract terminates.

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

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

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

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

c. **Effect of Termination**.

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

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

6. GENERAL TERMS AND CONDITIONS

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

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

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

IN WITNESS WHEREOF, the Parties, through their authorized representatives, execute this Agreement as ofthe Effective Date.

BUSINESS ASSOCIATE

DocuSigned by:
Tom Wroth
FC93C1B47D124EF...

09/29/21 | 9:58 AM EDT

Tom Wroth, MD
President & CEO

Date

COVERED ENTITY

DocuSigned by:
Dave Richard
11395D232A054A2...

09/28/21 | 5:13 AM PDT

Dave Richard
Deputy Secretary

Date

Attachment E: State Certifications

State Certifications

Contractor Certifications Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of theExecutive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 133-32: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): http://www.ethicscommission.nc.gov/library/pdfs/Laws/EO24.pdf
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
- G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

Certifications

(1) **Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009)**, the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.

(2) **Pursuant to G.S. 143-48.5 and G.S. 143-133.3**, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E- Verify system." E-Verify System Link: www.uscis.gov

(3) **Pursuant to G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:

(a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**

(b) [check **one** of the following boxes]

☒ Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143- 59.1(c)(2) after December 31, 2001; **or**

☐ The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock ofthe corporation incorporated in the tax haven country.

(4) **Pursuant to G.S. 143-59.2(b)**, the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.

(5) **Pursuant to G.S. 143B-139.6C**, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the NorthCarolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.

(6) The undersigned hereby certifies further that:

(a) He or she is a duly authorized representative of the Contractor named below;

(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and

(c) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1and -59.2 shall be guilty of a Class I felony.

Contractor's Name: North Carolina Community Care Networks, Inc.

Contractor's Authorized Agent:

Signature: DocuSigned by: Tom Wroth FC93C1B47D124EF... Date: 09/29/21 | 9:58 AM EDT

Printed Name: Tom Wroth, MD Title: President & CEO

Attachment F: Federal Certifications and Disclosures

The undersigned states that:

1. He or she is the duly authorized representative of the Contractor named below;
2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as setout herein:
   a. The Certification Regarding Nondiscrimination;
   b. The Certification Regarding Drug-Free Workplace Requirements;
   c. The Certification Regarding Environmental Tobacco Smoke;
   d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
   e. The Certification Regarding Lobbying;
3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
4. [Check the applicable statement]

   ☐ He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

   OR

   ☒ He or she **has not completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has not made**, and **has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.
5. The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

DocuSigned by:
Tom Wroth
FC93C1B47D124EF...

Signature

President & CEO

Title

North Carolina Community Care Networks, Inc.

Contractor Name

09/29/21 | 9:58 AM EDT

Date

[This Certification Must be Signed by the Same Individual Who Signed the Proposal Execution Page]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686),which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C.§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92- 255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religionand political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Contractor certifies that it will provide a drug-free workplace by:

   a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

   b. Establishing a drug-free awareness program to inform employees about:

      i. The dangers of drug abuse in the workplace;

      ii. The Contractor's policy of maintaining a drug-free workplace;

      iii. Any available drug counseling, rehabilitation, and employee assistance programs; and

      iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

   d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

      i. Abide by the terms of the statement; and

      ii. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

   e. Notifying the Department within ten days after receiving notice under subparagraph (d)(ii) from an employee or otherwise receiving actual notice of such conviction;

   f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(ii), with respect to any employee who is so convicted:

      i. Taking appropriate personnel action against such an employee, up to and including termination; or

      ii. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs(a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):

   Address:

Street:	1000 Centre Green Way, Suite 300
City, State, Zip Code:	Cary, NC, 27513

3. Contractor will inform the Department of any additional sites for performance of work under this agreement.

4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which

is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies,** by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

VI. Disclosure Of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(a) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Disclosure of Lobbying Activities

(Approved by OMB 0344-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action	2. Status of Federal Action	3. Report Type
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	☐ a. initial filing ☐ b. material change **For Material Change Only:** Year: Enter Year Quarter: Enter Qtr Date of Last Report: Enter a date.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:	
☐ Prime	Name:	Click or tap here to enter text.
☐ Subawardee Tier (if known): Enter Text	Street Address:	Click or tap here to enter text.
Congressional District (if known): Enter Text	City, State, Zip:	Click or tap here to enter text.
	Congressional District (if known):	Click or tap here to enter text.

6. Federal Department/Agency:	7. Federal Program Name/Description:	Click or tap here to enter text.
Click or tap here to enter text.	CFDA Number (if applicable):	Click here to enter text.

8. Federal Action Number (if known):	Click or tap here to enter text.	9. Award Amount (if known)	$Click here to enter text.

10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*)	b. Individuals Performing Services (*last name, first name, MI*): (including address if different from No.10a.)
Click or tap here to enter text.	Click or tap here to enter text.

(*attach Continuation Sheet(s) SF-LLL-A, if necessary*)

11. Amount of Payment (*check all that apply*):	$Click or tap here to enter text.			13. Type of Payment (*check all that apply*):
	☐ Actual	☐ Planned		☐ a. retainer
12. Form of Payment (*check all that apply*):	☐ a. cash	☐ b. In-kind (specify below):		☐ b. one-time fee ☐ c. commission d. contingent fee e. deferred f. other; specify: Click or tap here to enter text.
	Nature:	Click to enter text.		
	Value:	$Click to enter text.		

14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11(*attach Continuation Sheet(s) SF-LLL-A, if necessary*):

Click or tap here to enter text.

15. Continuation Sheet(s) SF-LLL-A attached:	☐ Yes	☐ No

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for eachsuch failure.	Signature:		
	Print Name:	Click or tap here to enter text.	
	Title:	Click or tap here to enter text.	
	Telephone No.	Enter text.	Date:

Federal Use Only	Authorized for Local Reproduction Standard Form - LLL

Attachment G: Location of Workers Utilized by the Contractor

In accordance with NC General Statute 143-59.4, the Contractor shall detail the location(s) at which performance will occur, as well as the manner in which it intends to utilize resources or workers outside of the United States in the performance of this Contract. The Department will evaluate the additional risks, costs, and other factors associated withsuch utilization prior to making an award. Complete items a, b, and c below**.**

a) Will any work under this Contract be performed outside the United States? ☐YES ☒NO

If yes, list the location(s) outside the United States where work under this Contract will be performed by the Contractor.

Click or tap here to enter text.

b) The Contractor agrees to provide notice, in writing to the Department, of the relocation of the Contractor will performing the services under the Contract outside of the United States.
☐ YES ☒NO

c) Identify all U.S. locations at which performance will occur: North Carolina

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Attachment H: Program Performance Metrics Reporting Requirements

Table 1: Program Performance Metrics and Targets

More information on the program performance metrics definitions and the Department's targeting methodology can be obtained in North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual which can be found on this page - https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

A. Care Management Penetration Rates	**Target (FY22)**
1. Overall annual penetration rate Defined as unique members with a completed care management encounter during the contract year.	109,545 members[1]
2. Foster Children receiving complex care management during the year Defined as unique foster care members with a completed care management encounter and care plan during the contract year.	10% of Foster Care Population
3. Dual eligible receiving complex care management during the year Defined as unique dual eligible members with a completed care management encounter and care plan during the contract year.	3% of Duals Population
B. Child Preventive/Primary Care	**Target (CY21)**
1. Well Child Visits: 0-30 Months of Life	56%
2. Child and Adolescent Well Visits	32.5%
3. Childhood Immunization Status: Combination 10	35.5%
4. Immunizations for Adolescents: Combination 2	31%
5. Cervical Cancer Screening (CCS)	36.5%
6. Chlamydia Screening in Women (CHL)	57.5%
7. Controlling High Blood Pressure (CBP)	Observational - No Target
8. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9%) (HPC)	Observational - No Target
9. Plan All Cause Readmissions (PCR) [Observed versus expected ratio]	0.88
10. Total Cost of Care[2]	Observational - No Target

[1] If total Medicaid Direct population changes by more than 10%, Department and Contractor will mutually agree to adjustment of the overall annual penetration rate target and fixed monthly payment.

[2] Department will be responsible for reporting this measure to the Contractor.

Attachment I: Implementation Timelines

a. The Parties acknowledge the following performance obligations will not begin upon execution of the Contract.

b. **Call Center**. Contractor will not have a call center capable of receiving inbound calls and incorporating the automated processes described in the Contract in place as of the date of execution of the Contract. After the Department has provided the final scripts and routing information for inbound call activities, the Department and Contractor will set a timeline for implementation of the inbound call center functionality. The Parties anticipate the inbound call center functionality will begin to be used on November 1, 2021 or other mutually agreed upon date.

c. **Care Needs Screenings**. Contractor will not have the Care Needs Screening tool or process in place as of the date of execution of the Contract. The Parties anticipate Care Needs Screenings will begin on February 1, 2022, or other mutually agreed upon date.

d. **Enrollee Handbook**. Contractor will not have its version of the Enrollee Handbook finalized as of the date of execution of the Contract. After the Department has approved the final wording for Contractor's version of the Enrollee Handbook, the Department and Contractor will set a timeline for publication and potential delivery of the Enrollee Handbook. The Parties anticipate Contractor's version of the Enrollee Handbook will begin to be used on January 4, 2022, or other mutually agreed upon date.

e. **Foster Care Exit Outreach**. Contractor will not have in place as of the date of execution of the Contract the programming necessary to identify enrollees in Foster Care who are within six months of turning twenty-six years of age. The Parties anticipate Contractor will implement this functionality on January 4, 2022, or other mutually agreed upon date.

f. **Participation Agreements**. After the Department has reviewed and accepted Contractor's new participation agreement, the Department and Contractor will prioritize PCCM participating entities for receipt and execution of the new participation agreement and will set a timeline for delivery and receipt of executed participation agreements. Entities with existing participation agreements in place as of the date of execution of the Contract will be allowed to access the Data Platform under that participation agreement for up to one hundred thirty-five (135) days. Entities that do not execute a new participation agreement on the established timeline will not have access to the Data Platform until they do. Contractor will notify the Department of all PCCM participating entities that do not execute a participation agreement as of the timeline established by the Department and Contractor.

g. **Revised Risk Stratification Algorithm**. Contractor will not have a revised risk stratification algorithm incorporating new parameters from the Department in place as of the date of execution of the Contract. The Parties anticipate the revised risk stratification algorithm will begin to be used on January 4, 2022, or other mutually agreed upon date.

h. **Revised Risk Stratification Algorithm for Foster Children**. Contractor will not have a revised risk stratification algorithm incorporating new parameters from the Department in place as of the date of execution of the Contract. The Parties anticipate the revised risk stratification algorithm will begin to be used on January 4, 2022, or other mutually agreed upon date.

i. **Subcontractors**. Contractor will not have executed Subcontractor agreements in place with all approved Subcontractors as of the date of execution of the Contract. After the Department has reviewed and accepted Contractor's new Subcontractor agreement, the Department and Contractor

will set a timeline for delivery and receipt of executed Subcontractor agreements. Contractor will notify the Department of all Subcontractors that do not execute a Subcontractor agreement as of the timeline established by the Department and Contractor. Contractor may choose not to use any Subcontractor that does not sign the Subcontractor agreement. Contractor will use a Memorandum of Agreement or similar document with the approved Subcontractors to enable Subcontractors to perform under the Contract until the Subcontractor agreements are executed.

j. **Welcome Letters**. Contractor will not have Welcome letters in place as of the date of execution of the Contract. After the Department has approved the final wording for the Welcome letters, the Department and Contractor will set a timeline for delivery of those letters. The Parties anticipate Welcome letters will begin to be sent on January 4, 2022, on or other mutually agreed upon date.

k. **Transition of Care Prioritization Logic.** Contractor will not have a technical solution in place for automatically triggering priority logic in VirtualHealth for members disenrolling into Medicaid Direct from Standard Plans or Tribal Option as of the date of execution of the Contract. The Parties anticipate Transition of Care Prioritization Logic will be in place on January 4, 2022 or other mutually agreed upon date. Contractor will be able to receive all warm handoffs and outreach to members identified via warm handoff by date of execution of the Contract.