Amendment Number 3/4
Prepaid Health Plan Services
#30-190029-DHB – PHP Name

THIS Amendment to the Prepaid Health Plan Services Contract #30-190029-DHB – PHP Name (Contract) awarded February 4, 2019 and subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and PHP Name (Contractor), each, a Party and collectively, the Parties.

Background:
The purpose of this Amendment is to make clarifications, technical corrections and updates to reflect legislative changes enacted by the General Assembly and other program changes in the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

1. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
2. Section V. Scope of Services;
3. Section VI. Contract Performance; and
4. Section VII. Attachments A – N

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

a. Section III.A. Definitions, is revised to restate the identified definitions and add newly defined terms. Section III.A. Definitions shall be renumbered accordingly within the Contract.

(1) Definitions for 18, 87, 106, and 107, are revised and restated as follows:

18. Care Management Fees: Non-visit based payments to AMH Tier 3 practices made in addition to NC Medicaid Direct and Medical Home Fees, providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.

87. Objective Quality Standard: Means, as defined in Section 5.(6) d. of Session Law 2015-245, the objective quality standard the Department applies during the Provider Enrollment Process.

106. Provider Contracting: The process by which the PHP negotiates and secures a contractual agreement with providers who are active, Medicaid Enrolled providers and are to be included in the PHP's Provider Network.

107. Provider Enrollment: The process by which a provider is enrolled in North Carolina's Medicaid or NC Health Choice programs, with credentialing as a component of enrollment. A provider who has enrolled in North Carolina's Medicaid or NC Health Choice programs (or both) shall be referred to as a "Medicaid Enrolled provider" or an "Enrolled Medicaid provider".

(2) The following defined terms are added to Section III.A. Definitions:

(i) PHP Contract Data Utility (PCDU): A secure file transfer platform to allow for posting of Department guidance to the PHPs and submission of key contract deliverable and reports by the PHPs for review and approval by the Department.

(ii) Remote Patient Monitoring: The use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient

monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring.

a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation.
b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.

(iii) Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Telehealth may be referred to as "telemedicine" within this Contract.

(iv) Transition Entity: Department-designated entity responsible for coordinating transition of care activities and supporting members through the transition between service delivery systems. Transition entities include other PHPs, LME/MCOs, CCNC, Tribal Option and other designated entities.

(v) Transition Notice Date: The date a transitioning member's anticipated enrollment change is reflected on a PHP's eligibility file (834).**(vi) Virtual Patient Communications:** Virtual patient communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

b. Section III.C. Contract Term is revised and restated as follows:

1. The initial Contract Term will be from the Contract Effective Date through June 30, 2025 and shall include an implementation period and Contract Years 1 through 4 as follows:

First Revised and Restated Section III. C. Table 1: Contract Term	
Contract Period	**Effective Dates**
Implementation Period	Contract Award through June 30, 2021
Contract Year 1	July 1, 2021 through June 30, 2022
Contract Year 2	July 1, 2022 through June 30, 2023
Contract Year 3	July 1, 2023 through June 30, 2024
Contract Year 4	July 1, 2024 through June 30, 2025

2. The Department reserves the option, at its sole discretion, to extend the Contract for one (1) additional Contract Year or a shorter period as required by the Department. The Department shall notify a PHP in writing if it is exercising its option to renew at least ninety (90) days prior to the expected renewal date.

3. The Contractor shall notify the Department in writing at least nine (9) months prior to the renewal date if Contractor does not wish to renew. The Contractor may be responsible for damages for failure to notify the Department of the intent not to renew within this timeframe.

c. Section III.D. Terms and Conditions revised to add a new term titled <u>CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY</u> between 13. <u>COPYRIGHT</u> and 14. <u>DISCLOSURE OF CONFLICTS OF INTEREST</u> as follows and to renumber Section III.D accordingly:

<u>CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY</u>: Contractor shall make a good faith effort to recruit, train, promote, and retain a culturally and linguistically diverse governance,

leadership, and workforce, who are responsive to the population in the service area, in accordance with applicable Federal and State law.

d. Section III.D. Terms and Conditions revised to add a new term titled HISTORICALLY UNDERUTILIZED BUSINESS (HUBs) between 22. GOVERNMENTAL RESTRICTIONS and 23. INDEPENDENT CONTRACTOR as follows and to renumber Section III.D accordingly:

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, including via the use of subcontractors owned by HUBs.

e. Section III.D. Terms and Conditions 30. NOTICES is revised and restated as follows:

NOTICES: Any notices permitted or required under the Contract must be delivered to the appropriate Contract Administrator for each Party. Unless otherwise specified in the Contract, any notices shall be in writing and **delivered by email**. In addition, notices may be delivered by first class U.S. Mail, commercial courier (e.g. FedEx, UPS, DHL), or personally delivered provided the notice is also emailed to the Contract Administrator at approximately the same time.

f. Section III.D. Terms and Conditions 32. PAYMENTS AND REIMBURSEMENT, a. Managed Care Payments, is revised and restated as follows:

a. **Managed Care Payments**: The Department will make the following Managed Care payments to the Contractor, as applicable:
   i. Risk-adjusted Monthly Per Member Per Month (PMPM) capitated payments;
   ii. Maternity event payments;
   iii. Additional directed payments to certain providers, and
   iv. COVID-19 vaccine administration and testing reimbursements under non-risk arrangement; and
   v. Enhanced case management pilot payments.

g. Section III.D. Terms and Conditions 32. PAYMENTS AND REIMBURSEMENT, c. Maternity Event Payments, and d. Additional Directed Payments for Certain Providers are revised and restated as follows:

c. **Maternity Event Payments:** As provided in *Section V.I.1. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required documentation of an eligible delivery event to the Department. The Contractor must accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.

d. **Additional Directed Payments for Certain Providers:** The Department will make payments to the Contractor to support additional, utilization-based, directed payments to certain providers as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) and in accordance with *Section V.D.4. Provider Payments.*

h. Section III.D. Terms and Conditions 32. PAYMENTS AND REIMBURSEMENT, is revised to add the following:

k. COVID-19 Vaccine Administration and Testing reimbursements under non-risk arrangement: The Contractor will receive reimbursement for COVID-19 vaccine administration and testing reimbursement outside of standard Capitation PMPM Rates.

i. Section III.E. Confidentiality, Privacy and Security Protections. 2. Confidential Information is revised to add the following:

f. The PHP shall adhere to the Department's data suppression criteria and consent protocols when transferring member information under the scope of 42 C.F.R. Part 2.

2. Modifications to Section V. Scope of Services of the Contract

Specific subsections are modified as stated herein.

a. Section V.A. Administration and Management, 4. PHPs and Related Providers is revised to add the following:

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

b. Section V.A. Administration and Management, 9. Staffing and Facilities, g. is revised and restated as follows:

g. The PHP shall provide, upon request, an updated Business Continuity Plan with a detailed Staffing Contingency Plan, in the event of public health emergencies, natural disasters, or sudden and unexpected increases in enrollment, with a description on how the plan shall be implemented and coordinated with the Department.

c. Section V.A. Administration and Management, 9. Staffing and Facilities is revised to add the following:

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

i. Identify and analyze health disparities through review of utilization and quality data,
ii. Address stakeholder representation and engagement improvements,
iii. Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid members,
iv. Develop new initiatives that would address health disparities, and
v. Examine existing policies that can be amended to improve health equity and reduce health disparities.

d. Section V.B. Members, 1. Eligibility for Medicaid Managed Care, d. Medicaid Managed Care eligibility iv. is revised and restated as follows:

iv. The following populations shall be exempt from Medicaid Managed Care:

a) Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).

e. Section V.B. Members, 3. Member Engagement, h. Written and Oral Member Materials, ii. d) is revised and restated as follows:

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

1. Taglines are required on materials that are critical for potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment

forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d).

f. Section V.B. Members, 3. Member Engagement, k. Member Welcome Packet, i. is revised and restated as follows:

k. Member Welcome Packet

i. The PHP shall send a Welcome Packet to the Member within six (6) Calendar 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 with confirmation of the Member's PCP assignment.

a) For Members who select a PHP during the Open Enrollment period through May 31, 2021, the PHP shall send the Welcome Packet no earlier than May 16, 2021 and no later than June 5, 2021. If the Member does not select a PCP, the PHP shall not send the Welcome Packet until the PHP receives confirmation of the Member's PCP selection from the Department on the 834 enrollment file or other standard eligibility and enrollment file. The PHP shall ensure a Member does not receive two welcome packets.

b) For all new Members enrolled after May 31, 2021, the PHP shall send the Welcome Packet within six (6) Calendar Days of receipt of a Member enrollment information with confirmation of the Member's PCP assignment.

g. Section V.B. Members, 3. Member Engagement, l. Member Identification Cards, ii. – iii. is revised and restated as follows:

ii. The PHP shall provide the Member identification card with the Welcome Packet. A replacement identification card shall be provided at least once every twelve (12) months, upon request by the Member or the Member's authorized representative, or upon AMH/PCP change, at no charge to the Member.

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

h. Section V.B. Members, 3. Member Engagement, m. Member Handbook, i. is revised and restated as follows:

i. The PHP shall ensure that each Member receives a Member Handbook, which serves as a summary of benefits and coverage, within eight (8) Calendar Days after the PHP receives notice of the Member's enrollment in the PHP. 42 C.F.R. § 438.10(g)(1).

i. Section V.B. Members, 3. Member Engagement, n. Member Education and Outreach is revised to add the following:

v. In support of the Department's Health Equity goals, the PHP shall develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the PHP's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. The plan shall be submitted no later than August 31, 2021 and annually thereafter to the Department.

j. Section V.B. Members, 3. Member Engagement, o. Engagement with Consumers is revised to add the following:

iv. The PHP shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by PHP.

k. Section V.B. Members, 3. Member Engagement, p. Engagement with Beneficiaries Utilizing Long Term Services and Supports is revised to add the following:

iv. The PHP shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by PHP.

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

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

vii. The PHP shall help coordinate resolution of concerns within 30 days related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's authorized family member(s), the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or Member Advisory Committee as appropriate.

l. Section V.B. Members, 6. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements, v. a) is revised and restated as follows:

v. The PHP shall ensure that the individuals making decisions on grievances and appeals:

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

m. Section V.B. Members, 6. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements, xi.) is revised to add the following:

xi. The PHP shall adhere to the NC DHHS Transition of Care Policy's guidance for managing appeals in effect during the Member's transition.

n. Section V.B. Members, 6. Member Grievances and Appeals, c. Member Grievance Process, iv. is revised and restated as follows:

iv. Reserved.

o. Section V.B. Members, 6. Member Grievances and Appeals d. Notice of Adverse Benefit Determination, vi. Internal Plan Appeals, h) Request for Plan Appeals, 2. is revised and restated as follows:

2. Reserved.

p. Section V.B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vii. Expedited Resolution of Plan Appeals, c) is revised and restated as follows:

c) Reserved.

q. Section V.B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vii. Expedited Resolution of Plan Appeals, e) is revised and restated as follows:

e) Reserved.

r. Section V.B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vii. Expedited Resolution of Plan Appeals, f) is revised and restated as follows:

f) Reserved.

s. Section V.B. Members, 6. Member Grievances and Appeals, d. Notice of Adverse Benefit Determination, vii. Expedited Resolution of Plan Appeals, g) is revised and restated as follows:

g) If the PHP denies the request for an expedited plan appeal, it shall do the following:
   i. Immediately transfer the appeal to the timeframes for standard resolution; and
   ii. Make reasonable efforts to give the Member or an authorized representative oral notice of the denial and follow up with a written notice of the denial of the expedited resolution request within seventy-two (72) hours of receipt of the request. 42 C.F.R. 438.410(c) and N.C. Gen. Stat. § 108D-14(b).

t. Section V.B. Members, 6. Member Grievances and Appeals, e. Continuation of Benefits, i. is revised and restated as follows:

i. Timely Request for Continuation of Benefits: The PHP shall continue and pay for the Member's benefits during the pendency of the plan appeal and State Fair Hearing if all of the following occur:
   a) The Member, or the Member's authorized representative, files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
   b) The plan appeal involves the termination, suspension, or a reduction of previously authorized services;
   c) The services were ordered by an authorized provider;
   d) The period covered by the original authorization has not expired; and
   e) The Member timely files for continuation of benefits within ten (10) Calendar Days of the PHP sending the notice of the adverse benefit determination (or before), or on the intended effective date of the PHP's proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(b).

u. Section V.B. Members, 6. Member Grievances and Appeals, e. Continuation of Benefits, iv. is revised and restated as follows:

iv. Reserved.

v. Section V.B. Members, 6. Member Grievances and Appeals, e. Continuation of Benefits, v.a) is revised and restated as follows:

v. Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
   a) The PHP shall be permitted to recover the cost of services furnished to the Member during the pendency of the plan appeal and the State Fair Hearing if:
      i. The PHP notified the Member of the potential for recovery;
      ii. The PHP furnished benefits to the Member solely because of the requirement for continuation of benefits; and
      iii. The final resolution of the plan appeal or the State Fair Hearing is adverse to the Member (i.e., upholds the PHP's adverse benefit determination). 42 C.F.R. § 438.420(d). For purposes of recovering cost of services furnished during the pendency of the appeal, the

PHP shall consider a final resolution to be adverse to the Member when all the following occur:

a. The Member timely requests benefits to continue during the plan appeal or the State Fair Hearing;
b. The PHP fully upholds its initial decision in its notice of resolution to the Member following the plan appeal; and
c. The Office of Administrative Hearings issues a final decision in accordance with N.C. Gen. Stat. § 150B-34 that fully upholds the PHP's Adverse Benefit Determination that gave rise to the appeal.

w. Section V.C. Benefits and Care Management 1. Medical and Behavioral Health Benefits Package, c. Covered Services, First Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services is revised and restated as set forth in Attachment 1, *Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services*, to this Amendment.

x. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, d. Medical Necessity is revised to add the following:

vi. The PHP shall cover COVID-19 testing according to guidance issued by the Department.
vii. During the COVID-19 Public Health Emergency, the PHP shall cover the testing, treatment, and vaccine administration for COVID-19 and comply with cost-sharing requirements as defined in the Department's approved CMS waivers, state plan amendments, and concurrence letters related to COVID-19.
viii. After the end of the COVID-19 Public Health Emergency, the Department reserves the right to require PHPs to cover the testing, treatment, and vaccine administration for COVID-19 without cost-sharing for members.

y. Section V.C. Benefits and Management 1. Medical and Behavioral Health Benefits Package e. Utilization Management iv. is revised and restated as follows:

iv. The Utilization Management (UM) Program,
consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
a) Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
b) Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
c) Authorize LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
d) Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
e) Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
f) Protecting Members from discouragement, coercion, or misinformation about the amounts of Services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a Service.
g) Mechanisms for detecting instances of overutilization, underutilization, and misutilization;
h) Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the PHP;
i) Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act.

j) Dissemination of guidelines to all affected providers and, upon request, to Members and potential Members; and

k) Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member.

l) The PHP shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the PHP shall submit the attestation required by this Section annually, by June 30th, unless otherwise directed by the Department.

m) Nothing in this Section shall be construed to limit or interfere with the Department's right to individually review and approve any PHP UM or clinical coverage policy to ensure compliance with the Contract.

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z. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, Section V.C. Table 4: Required Clinical Coverage Policies is revised and restated as follows:

First Revised and Restated Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	**SCOPE**
Behavioral Health and Intellectual/ Developmental Disability *Note: For these policies, PHPs shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): i. Mobile Crisis Management ii. Diagnostic Assessment iii. Partial Hospitalization iv. Professional Treatment Services in Facility-based Crisis v. Ambulatory Detoxification vi. Non-hospital Medical Detoxification vii. Medically Supervised or ADATC Detox Crisis Stabilization viii. Outpatient Opioid Treatment 8A-2: Facility-based Crisis Services for Children and Adolescents 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers 8F: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder
Obstetrics and Gynecology	1E-7: Family Planning Services
Physician	1A-23: Physician Fluoride Varnish Services 1A-36: Implantable Bone Conduction Hearing Aids (BAHA) 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair 13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	As defined in *Section V.C.3. Pharmacy Benefits*

aa. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, xiii.d) is revised and restated as follows:

d) The PHP must honor existing and active medical prior authorizations on file with the North Carolina Medicaid or NC Health Choice program minimally for the first ninety (90) days after implementation (Medicaid Managed Care Launch) or until the end of the authorization period, whichever occurs first to ensure continuity of care for Members. For service authorizations managed by an LME-MCO and impacted by 42 C.F.R. Part 2, the PHP shall deem authorizations submitted directly by impacted providers as covered under this requirement. For the first sixty (60) days after Medicaid Managed Care launch, the PHP shall pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers until end of episode of care or the sixty (60) days, whichever is less.

bb. Section V.C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, f. Telemedicine is revised and restated as follows:

f. Telehealth, Virtual Patient Communications and Remote Patient Monitoring

i. The PHP shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid and NC Health Choice beneficiaries as an alternative service delivery model, where clinically appropriate, in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. The services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).

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

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

iv. As part of the UM Program Policy, the PHP shall develop and submit a Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department.

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

1. Eligible providers who may perform Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
2. Modalities covered by the PHP;
3. Modalities not covered by the PHP;
4. Requirements for and limitations on coverage;
5. Description of each covered modality, including:
    i. Reserved;
    ii. Compliance with local, state and federal laws, including HIPAA; and
    iii. Process to ensure security of protected health information.
6. Reimbursement mechanism (i.e. flow of funds from PHP to all relevant providers and facilities) for each covered modality; and
7. Billing guidance for providers.

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

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

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

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

cc. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services is revised and restated as follows:

g. In Lieu of Services

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

ii. The PHP shall submit the ILOS Service Request Form, in a format to be defined by the Department, prior to implementation to the Department for approval.

a) In no instance shall the PHP reduce or remove ILOS service without approval by the Department concurrent within a contract year.

b) If changes, reduction, or removal of ILOS services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

c) The PHP shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.

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

iv. The PHP shall monitor the cost-effectiveness of each approved In Lieu of Service by tracking utilization and expenditures on an annual basis or more frequently upon request of the Department (see *Attachment J. First Revised and Restated Reporting Requirements* for more detailed requirements).

v. The PHP may offer the following In Lieu Of Service:

a) Institute for Mental Disease (IMD): The PHP may contract and pay for services for members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered setting for no more than fifteen (15) Calendar Days within a Calendar Month. 42 CFR 438.6(e).

1. To provide the service, the PHP must submit an ILOS request form, as defined by the Contract.
2. If the PHP does not provide the ILOS request form for review and approval, capitation payments may be adjusted accordingly.
3. If the PHP provided the ILOS, the PHP shall provide the Department with a weekly report on members utilizing IMD services as defined in *Section VII. Attachment J. First Revised and Restated Reporting Requirements*. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

vi. The PHP shall not require the Member to utilize an ILOS.

vii. If the PHP wishes to offer an ILOS previously approved by the Department as outlined in *Attachment C. approved Behavioral Health In Lieu of Services,* the PHP is still required to submit the Department's standardized ILOS Service Request Form for approval.

dd. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, k. Electronic Verification System revised to add the following:

v. The PHP shall deliver the EVV data elements to the Encounter Processing System (EPS) for Personal Care Services or services that provide support with activities of daily living in a member's home that are not daily rate services.

vi. The PHP shall permit providers to continue using their existing EVV system for visit data aggregation to the PHP's selected EVV vendor provided the system is compliant with state and federal regulations.

ee. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package is revised to add the following:

m. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements
   i. The PHP shall work with the Department and the Member's nursing facility to coordinate Specialized Services, as defined in the federal PASRR regulations at 42 C.F.R. § 483.120, for members admitted to nursing facilities.
   ii. The PHP shall ensure the provision of Specialized Services identified by the PASRR process for Members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under the Contract.
   iii. The PHP shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the Member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such Specialized Services are delivered.

ff. Section V.C. Benefits and Management, 3. Pharmacy Benefits, a. is revised to add the following:

i. The PHP shall administer both point of sale (POS) and Physician's Drug Program (PDP) as a part of the pharmacy benefit. The PHP shall cover prescription drugs in the same program as the Medicaid FFS pharmacy benefit. The PHP may, at its discretion cover, the drug under the other program (i.e., POS drugs may be covered by the PDP), unless otherwise prohibited by the Department in the Medication Coverage Restriction List.

gg. Section V.C. Benefits and Management, 3. Pharmacy Benefits, d. Utilization Management, ii. is revised and restated as follows:

ii. For pharmacy services, the PHP shall follow the existing Medicaid and NC Health Choice Fee-for-Service clinical coverage policies, prior authorization (PA) criteria, and clinical criteria into the UM Program as described in:
   a. Clinical Coverage Policies: *Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies* below. The PHP shall not implement any clinical or prior authorization criteria beyond those included in the policies.
   b. PA Criteria: Drugs and/or drug classes requiring prior approval are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.
   c. Clinical Criteria: Drugs and/or drug classes subject to clinical criteria are available at https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.

hh. Section V.C. Benefits and Management, 4. Transition of Care, c. is revised and restated as follows:

c. The PHP shall follow the Department's Transition of Care Policy and, at a minimum, carry out the following responsibilities when supporting members transitioning between PHPs or between the PHP and NC Medicaid Direct, LME/MCOs or the Tribal Option:
   i. The PHP shall identify enrolling or disenrolling Members, as defined in the Managed Care Enrollment Policy, who are transitioning from or to another PHP, NC Medicaid Direct/LME-MCO or the Tribal Option.
   ii. Provide for the transfer of relevant Member information, including PHP care management records, open service authorizations, prescheduled appointments (including NEMT), historic claims and encounter data, and other pertinent materials, to another PHP, LME/MCO, Tribal Option or NC Medicaid Direct program upon notification of establishment of care such that the transition of care shall be with minimal disruption to Members' established relationships with providers and existing care treatment plans.
      a) Within five (5) Business Days of the PHP receiving notice that a member will disenroll, the PHP shall transfer transition data files and the member's transition file to the applicable PHP

or receiving entity. To ensure transition file information is current to maintain continuity of care through the transition, the PHP shall have the authority to extend transition file transfer date to occur no later than the Member's disenrollment date.

b) If a PHP receives notice of a transitioning member's enrollment and has not received the applicable transition data file or the member's transition file within five (5) Business Days of the Transition Notice Date, the PHP shall contact the applicable entity on the following business day to request transition information, as needed.

ii. Section V.C. Benefits and Management, 4. Transition of Care, c.vi. is revised and restated as follows:

vi. Allow pregnant Members to continue to receive services from their behavioral health treatment provider, with treatment provider without any form of prior authorization until the birth of the child, the end of the pregnancy, or loss of the pregnancy.

jj. Section V.C. Benefits and Management, 4. Transition of Care, c.vii. is revised and restated as follows:

vii. The PHP shall bear the financial responsibility for diagnosis-related group based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the PHP (or prior in the case of a beneficiary who is inpatient on their first day of enrollment in the PHP if there is no prior Medicaid managed care or NC Medicaid Direct coverage for inpatient) through the date of discharge from such facility. Post discharge care may be coordinated prior to discharge.

kk. Section V.C. Benefits and Management, 4. Transition of Care, c. is revised to add the following:

ix. Upon receipt of the relevant Member information, the PHP shall ensure that all data received, including medical records, care management records, historic claims and encounter data, the Patient Risk List, and other pertinent materials are transferred to the Member's AMH Tier 3 or CIN up to thirty (30) Calendar Days prior to the effective date and no later than seven (7) Business Days of the effective date of the PHP's assignment of the Member to an AMH Tier 3.

x. The PHP shall facilitate the transfer of a Member's claims/encounter history and Prior Authorization data between PHPs and other authorized Transition Entities and Department Business Associates following requirements established and published by the Department.

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

xii. Upon receipt of the relevant Member information, the PHP shall ensure that all data, as defined by the Department, once received, are transferred to the Member's AMH Tier 3 or CIN up to thirty (30) Calendar Days prior to the effective date and no later than seven (7) Business Days of the effective date of the PHP's assignment of the Member to an AMH Tier 3.

ll. Section V.C. Benefits and Management, 4. Transition of Care, d. Transition of Care with Change of Providers, ii. Member Notification of Provider Termination, a) – b) is revised and restated as follows:

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

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

mm. Section V.C. Benefits and Management, 6. Care Management, a. Care Management and Care Coordination, iv. Identification of High-Need Members Needing Care Management, a) 3. is revised and restated as follows:

3. The PHP shall include the Department's standardized Healthy Opportunities screening questions provided in *Attachment M. 9. Healthy Opportunities Screening Questions* in all Care Needs Screenings, covering four (4) priority domains:

i. Housing;
ii. Food;
iii. Transportation; and
iv. Interpersonal Safety.

nn. Section V.C. Benefits and Management, 6. Care Management, a. Care Management and Care Coordination, iv. Identification of High-Need Members Needing Care Management, c) Comprehensive Assessment to Identify High-Need Members, 11 -12. is revised and restated as follows:

11. Reserved.

oo. Section V.C. Benefits and Management, 6. Care Management, a. Care Management and Care Coordination, v. Provision of Care Management for High-Need Members, b) Care Management Services, 5. – 10. is revised and restated as follows:

5. The PHP shall establish a multi-disciplinary care team for each high-need Member that consists of, where applicable depending on Member needs:
   i. The Member;
   ii. Caretaker(s)/legal guardians;
   iii. AMH/PCP;
   iv. Behavioral health provider(s);
   v. Specialists;
   vi. Nutritionists;
   vii. Pharmacists and Pharmacy Techs; and
   viii. Community Health Workers.
6. The PHP shall ensure timely communication across the care team.
7. The PHP shall ensure that each high-need Member is informed of:
   i. The nature of the care management relationship;
   ii. Circumstances under which information will be disclosed to third parties;
   iii. The availability of the grievance and appeals process as described in *Section V.B.6. Member Grievances and Appeals*; and
   iv. The rationale for implementing care management services.
8. The PHP shall ensure that care managers assist in coordinating access to naloxone for members with an opioid use disorder (e.g., referrals to pharmacy or community organization).
9. The PHP shall provide the Department with a weekly report on members utilizing IMD-SUD services as defined in *Section VII. Attachment J. First Revised and Restated Reporting Requirements*. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.
10. The PHP shall develop policies and procedures to close out the Care Plan process, should the care team determine that the Member no longer requires an ongoing Care Plan. Policies and procedures for closeout shall include Member notification processes.
    i. Upon termination of an LTSS service that results in the member no longer meeting the LTSS definition, a PHP shall continue to provide care management to the member for a time

determined by individual circumstance and documented in the care plan to minimize disruption and ensure continuity of care after the service termination.

pp. Section V.C. Benefits and Management, 6. Care Management, a. Care Management and Care Coordination, v. Provision of Care Management for High-Need Members, d) HIV Case Management Providers is revised and restated as follows:

d) HIV Case Management Providers

1. The PHP may contract with existing HIV Case Management providers, at their discretion.

qq. Section V.C. Benefits and Management, 6. Care Management, a. Care Management and Care Coordination, vi. Care Manager Qualifications and Training, e) is revised and restated as follows:

e) The PHP shall ensure that care manager training include at a minimum:

1. Self-management, including medication adherence strategies;
2. Motivational interviewing or comparable training;
3. Person-centered needs assessments and care planning;
4. Integrated and coordinated physical and behavioral health care;
5. Execution of Comprehensive Assessments of Members;
6. Services available only through BH I/DD TPs, BH I/DD TP eligibility criteria, and the process for a Member who needs a service that is available only through BH/IDD Tailored Plans to transfer to a BH I/DD Tailored Plans;
7. BH crisis response (for care managers with assigned Members with BH needs);
8. Transitional care management;
9. Cultural competency, including considerations for Tribal population for PHPs that enroll Tribal members;
10. Understanding and addressing ACEs, Trauma, and Trauma Informed Care; ~~and~~
11. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level;
12. Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children;
13. Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications) and
14. The State "System of Care" training curriculum (for care managers with assigned Members age three (3) up to age eighteen (18) with BH needs). Request any newly added training requirements identified in amendment 3 be completed within the first year of operation.

rr. Section V.C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Care Manager Qualifications and Training, f) is revised to add the following:

7. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment, and training Members on proper practices, particularly for Members receiving care in the home or community-based settings, or as Members transition across care settings.
8. General understanding of virtual (e.g., Telehealth) applications in order to assist Members in using the tools.

ss. Section V.C. Benefits and Management, 6. Care Management, b. Local Care Management and Related Programs, i. is revised and restated as follows:

i. The Department seeks a Contractor that has the ability to provide a robust system of local care management—care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible. Local care management is the preferred approach to care management. The PHP shall have an established system of care management through Advanced Medical Home (AMH) and defined in *Attachment M. 2. First Revised and Restated Advanced Medical Home Program Policy*, and Local Health Departments that will provide high quality care to Members.

tt. Section V.C. Benefits and Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, a) General Requirements, 2. is revised and restated as follows:

2. Reserved.

uu. Section V.C. Benefits and Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, b) Advanced Medical Home Quality Metrics 3. is revised and restated as follows:

3. The PHP shall develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics. Performance Incentive Payments must be accounted for and reported to the Department separately from Medical Home Fees and Care Management Fees.

vv. Section V.C. Benefits and Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, c) Advanced Medical Home Data and Information Sharing is revised and restated as follows:

c) Required Data and Information Sharing to Support Care Management

1. In cases where the Department establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department.

2. In order to support care management activities, the PHP shall provide the following data to AMH practices (or their designated CINs or other technology partners):

i. Member Assignment Files:

a) For AMH Tier 3 practices or their designated CINs or other technology partners, Member assignment and pharmacy lock-in data applicable to their populations using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department and published on the Department's website.

b) For AMH Tier 1 and 2 practices and other PCPs (using a format of the PHP's choosing):

1. Point in time assignment, on a least a monthly basis;
2. Projected assignment information by the following month (to the extent information is available);
3. Information about newly-assigned Members to the PHP, within seven (7) Business Days of enrollment (more rapid notification may be required for assignment of newborns); and
4. Notifications of any ad-hoc changes in assignment as they occur, within seven (7) Business Days of each change.

ii. Claims and Encounter data (applicable to AMH Tier 3 practices or their designated CINs or other technology partners): Current and historical Medical and Pharmacy claims and encounter data applicable to their populations, using the standard format, frequency, file

layout, transmission type and transmission method, and with supporting notifications, as specified by the Department.

iii. Initial Care Needs Screening Information (applicable to all AMH practices).

a) Results of all available Initial Care Needs Screenings, within seven (7) Business Days of the end of the screening window or seven (7) Business Days of assignment of a new PCP or AMH, whichever is earlier.

iv. Risk Stratification information (applicable to all AMH practices).

a) PHP-furnished risk scoring results

b) Notification when Members fall into required Department priority population categories.

c) The PHP is encouraged to explain the types or categories of inputs to its risk stratification model with AMH practices (e.g. frequent hospital utilization) that can inform specific actions by the AMH.

v. Quality measure performance information at the practice level (applicable to all AMH practices).

a) The PHP shall provide feedback on quality scoring results to each AMH practice on both an annual and an interim basis as specified by the Department.

3. The PHP shall successfully implement all mandatory AMH program integrations with all its contracted AMH Tier 3 practices (or their designated CINs/other technology partners) prior to Medicaid Managed Care launch, or for any new AMH Tier 3 practice, within one hundred twenty (120) Calendar Days of provider contract execution with the PHP. Successful integration completion requires both the PHP and its contracted AMH Tier 3 practices (or their designated CINs/ other technology partners) to fully complete design, development, testing and deployment activities aligned with all the requirements and respective interface specifications specified by the Department and published on the Department's website.

i. The PHP shall complete testing and implementation of the interface and integration for required data sharing with each AMH Tier 3 practice (or its designated CIN or other technology partners), in accordance with the Department's published AMH Tier 3 data specifications and within thirty (30) Calendar Days, for any provider contracts signed less than one hundred twenty (120) Calendar Days prior to Medicaid Managed Care launch.

ii. At a frequency and in a format determined by the Department, the PHP shall transmit integration status reports that include information on the PHP's testing and implementation of the interface and integration for required data sharing with each AMH Tier 3 practice (or designated CIN/ other technology partners), including identification of at-risk file transmissions and reasons for any non-completion of activities within the required timeframes.

4. The PHP shall participate in the Data Subcommittee of the AMH Technical Advisory Group to contribute to data sharing planning and improvements to support AMHs.

5. In order to support care management activities, the PHP shall provide the following data to CMARC/CMHRP technology vendor for Local Health Departments (LHDs) providing care management of high risk pregnancy and at-risk children:

i. Member assignment data applicable to their populations using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department and published on the Department's website.

ii. Claims and Encounter data: current and historical Medical and Pharmacy claims and encounter data applicable to their populations, using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department.

iii. Risk Stratification information:

a) PHP-furnished risk scoring results,

b) Notification when Members fall into required Department priority population categories.

c) The PHP is encouraged to explain the types or categories of inputs to its risk stratification model with LHDs (e.g. frequent hospital utilization) that can inform specific actions by the LHD.

d) Quality measure performance information at the LHD level. The PHP shall provide feedback on quality scoring results to each LHD on both an annual and an interim basis as specified by the Department.

6. The PHP shall successfully implement all mandatory LHD program integrations with state selected CMARC/CMHRP technology vendor. Successful integration completion requires both the PHP and LHD platform vendor to fully complete design, development, testing and deployment activities aligned with all the requirements and respective interface specifications specified by the Department and published on the Department's website.

7. The PHP shall develop a strategy to share data with Members, in a format that is secure, takes into account varying levels of health literacy, and promotes member engagement in care.

ww. Section V.C. Benefits and Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting d) Advanced Medical Home Oversight is revised and restated as follows:

d) Advanced Medical Home Oversight

1. The PHP shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms.
2. During Contract Year 1, PHPs shall not monitor or audit AMHs against compliance standards that are beyond the scope of the AMH program requirements, including but not limited to requirements imposed as part of National Committee for Quality Assurance (NCQA) pre-delegation auditing.
3. In the event of underperformance by an AMH practice or CIN/other technology partner, the PHP shall send a notice of underperformance to the AMH practice/CIN/other technology partner and copy the Department.
4. The PHP shall provide the AMH practice/CIN/other technology partner a minimum of thirty (30) Calendar Days to remediate noncompliance with Tier-specific AMH requirements and any other mutually agreed upon contract terms prior to the PHP moving to downgrade a Tier status (for AMH practices) or cease to make payments (AMH practices or CINs/other technology partners).
5. The PHP shall not automatically change the Tier of any affiliated AMH Tier 3 practices as a result of a Corrective Action Plan or other compliance action imposed at the CIN/other partner level.
6. In the event of continued underperformance (i.e. non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the PHP to stop paying the Care Management Fee and/or Medical Home Fee (as applicable based on Tier status) and downgrade the Tier status of the AMH for that PHP, only.
7. In the event that the PHP notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Fee that would otherwise be required by the Department, the PHP shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification.
8. In the event a practice is downgraded from Tier 3 to Tier 2, the PHP shall ensure that there are no gaps in care management functions for Members assigned to the practice.

9. Within ninety (90) Calendar Days of contract execution with the provider, the PHP shall share with each AMH practice a description of the oversight process it will use to monitor practices' performance against Tier-specific AMH requirements. The oversight process shall contain a process for Corrective Action Plans, or equivalent, as a mechanism to allow practices to remediate compliance problems. For AMH practices affiliated with a CIN/other partner, the description shall include the process that the PHP will employ to monitor performance at the CIN/other partner level, including how Corrective Action Plans will apply at the CIN/other partner level and how the PHP will keep AMH practices informed in the event that a Corrective Action Plan is imposed at the CIN/other partner level.
10. In the case of any corrective actions imposed at the CIN/other technology partner level, the PHP shall provide notice to each AMH practice affiliated with that CIN/other technology partner within sixty (60) Calendar Days that the corrective action has been imposed. The PHP shall provide individual AMH practices affiliated with the CIN/other technology partner notice of their options, which shall include contracting directly with the PHP as an AMH Tier 3, contracting with another CIN/other technology partner as an AMH Tier 3, or reverting to AMH Tier 2.

xx. Section V.C. Benefits and Management, 6. Care Management, d.i.k)4. is revised and restated as follows:

4. Contracting with all Tier 3 AMH practices at a Tier 3 level in the Regions the PHP offers services in, unless the practice declines to contract with the PHP or chooses to contract at a lower Tier level; and

yy. Section V.C. Benefits and Management, 7. Prevention and Population Health Management Programs b. is revised to add the following:

b. The PHP shall establish prevention and population health programs aligned with the Department's larger public health goals and Quality Strategy. The Department will provide population-level measures to the PHP, such as measures related to infant and maternal mortality, that are intended to inform the PHP about regional trends and assist the PHP in performance improvement efforts.

i. The PHP shall implement initiatives to increase access to medication-assisted treatment, including initiatives to increase the number of providers offering this treatment.

zz. Section V.C. Benefits and Management, 7. Prevention and Population Health Management Programs, g. Tobacco Cessation Services, iv. is revised and restated as follows:

iv. The PHP shall develop a comprehensive Tobacco Cessation Plan which, at a minimum, includes the following strategies to reduce tobacco use across members:

a) Promote and educate on the Department's QuitLine benefit;
b) Promote tobacco free campuses at contracted facilities;
c) Ensure tobacco screening and treatment, including nicotine replacement and other appropriate medications, are provided to all relevant members in both inpatient, other facility-based, and outpatient/community settings;
d) Ensure tobacco use (including e-cigarettes) and exposure needs are assessed and addressed in all relevant Care Needs Screening, Comprehensive Assessment and Care Plan;
e) Increase use of 99406 and 99407 CPT codes in all appropriate settings;
f) Use incentives for members and providers;
g) Provider training; and
h) A yearly report on efforts and outcomes.

aaa. Section V.C. Benefits and Management, 8. Opportunities for Health, e. is revised and restated as follows:

e. The PHP shall use North Carolina-developed tools to address the four priority domains for Opportunities for Health including:

i. **Standardized Screening Questions**: As part of care management, the PHP shall undertake best efforts to conduct a Care Needs Screening of every Member as defined in the Contract. The Screening shall include standardized screening questions, ~~to be~~ developed by the Department, to identify Members with unmet health-related resource needs who required a Comprehensive Assessment for care management.

ii. **NCCARE360:**

a) The PHP shall use NCCARE360 beginning at Medicaid Managed Care launch to:
   1. Act as its community-based organization and social service agency resource repository to identify local community-based resources.
   2. Identify community-based resources available on NCCARE360 and connect Members to such resources; and
   3. Track the outcome of referrals to ensure that Members are connected to needed resources.

b) The Department will ensure that the PHP gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support to use NCCARE360 for its Medicaid Members at no cost to the PHP. All PHP requirements outlined in this Subsection are available through the NCCARE360 Base Package and Base Support.
   1. NCCARE360 Base Package includes:
      i. Unlimited NCCARE360 licenses for PHP users to assist Medicaid Members;
      ii. Unite Us standard reporting package; and
      iii. Unite Us pre-launch workflow consultation and planning.
   2. NCCARE360 Base Support includes:
      i. One-time in-person training;
      ii. Self-guided e-learning training;
      iii. Recurring Unite Us training webinars;
      iv. License maintenance and updates; and
      v. Technical support ticketing.
   3. The PHP may, at its discretion, add additional NCCARE360 product offerings or services other than the Base Package and Base Support, such as interoperability or integration capabilities, payment interfaces or software, or solutions engineering. The PHP shall pay for any additional offerings or services above the Base Package and Base Support functionality described in *Section V.C.8.e.ii.b.1.* and *Section V.C.8.e.ii.b.2.*

c) The PHP shall work directly with Unite USA, Inc. to:
   1. Execute necessary agreements with Unite USA, Inc. to access the NCCARE360 licenses and training purchased by the Department.
   2. Ensure that care management staff who will use NCCARE360 receive NCCARE360 training.

d) Delegated care management entities:
   1. Delegated care management entities, including but not limited to Tier 3 AMHs and LHDs, are encouraged, but not required, to use NCCARE360 for the functions outlined in *Section V.C.8.e.ii.a*.
   2. The Department intends to work with Unite USA, Inc. to facilitate NCCARE360 licensing and training for delegated care management entities.
   3. The Department will ensure that any delegated care management entity that chooses to use NCCARE360 for the functions outlined in V.C.8.e.ii.a for Medicaid

Members gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support, as outlined in *Section V.C.8.e.ii.b.1* and *Section V.C.8.e.ii.b.2*, to use NCCARE360 for Medicaid Members at no cost to the delegated care management entity. All PHP requirements outlined in *Section V.C.8.e.ii.a* are available through the NCCARE360 Base Package and Base Support.

iii. **North Carolina "Hot Spot" Map**: The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. PHPs are encouraged to use this tool to strategically guide contributions to health-related resources in the regions and communities it serves (Available at: http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b)

bbb. Section V.C. Benefits and Management, 8. Opportunities for Health, f. PHP Contributions to Health-Related Resources is revised and restated as follows:

f. PHP Contributions to Health-Related Resources

i. The PHP is encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves.

ii. The PHP that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V. I. 2. Medical Loss Ratio*, subject to Department review and approval.

iii. A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a Region to health-related resources may be awarded a preference in auto-assignment to promote enrollment in each Region in which the PHP contributes, subject to Department review and approval and contingent on the Department determining that the contribution meets the Department's Quality Strategy standards. The auto-assignment increase will take effect the next Contract Year, or at a date determined by the Department, after the contribution is made.

iv. The PHP is encouraged to identify opportunities to contribute to health-related resources in the Quality Assurance and Performance Improvement (QAPI) plan. See *Section V. E. 1. Quality Management and Quality Improvement.*

ccc. Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs is revised and restated as follows:

g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilots

i. Through Enhanced Case Management Pilots, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) priority domains (housing, food, transportation, and interpersonal safety) can be delivered effectively to Medicaid Members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the pilots is to learn which evidence based interventions and processes are best matched for a specific population to improve health, lower health care costs, and to inform health care delivery statewide.

ii. Through a competitive procurement process, the Department will establish Enhanced Case Management pilots in up to four (4) areas of the State to provide a subset of high-need, high-risk, and emerging-risk Medicaid Members with information, services and benefits targeted to measurably improve health and lower costs. The pilots will employ evidence-

based interventions addressing Members' needs in housing, food, transportation, and interpersonal safety. The PHP shall play a key role in executing the pilots in accordance with the roles and responsibilities enumerated below.

iii. A pilot Region:
   a) Must cover no less than three (3) contiguous North Carolina counties;
   b) Shall cover the entirety of any county included in the Local Pilot Region;
   c) May cross Standard Plan and BH I/DD Tailored Plan PHP Region boundaries;
   d) Will promote cross-county collaboration since Medicaid Members seek services across county lines; and
   e) May include a subset of counties from within the PHP regions.

iv. Each pilot will have a Lead Pilot Entity (LPE). The LPE's role is to develop, contract with and manage a network of pilot service providers (e.g., community based organizations) that can deliver the evidence-based interventions across each of the four (4) priority domains.

v. The PHP shall contract with any LPE operating within the PHP's Region(s) using a Department-developed model contract within one hundred fifty (150) Calendar Days of LPE Contract award.

vi. The PHP shall utilize care managers—employed by or under contract with the PHP or in a Tier 3 Advanced Medical Home (AMH) or Local Health Department —to execute key pilot functions.

vii. The PHP shall ensure that the care manager screens Members using a forthcoming Department-developed "Pilot Qualification Screening Tool" to assess whether they meet pilot eligibility criteria.

viii. The PHP shall ensure that the care manager, in consultation with the LPE, develops a care plan and identifies the pilot services that a Member is eligible to receive based on Member need, the pilot services available in the Member's pilot region, and forthcoming DHHS-developed guidance.

ix. The PHP shall ensure that the care manager obtains Members' consent to enroll in the pilot based on forthcoming DHHS-developed guidance.

x. The PHP shall authorize enrollment into the pilot and the delivery of pilot services based on forthcoming Department guidelines, to be developed in collaboration with PHPs and LPEs prior to launching the pilots.

xi. The PHP shall ensure that the care managers communicate approved pilot service authorization to pilot enrolled Members

xii. The PHP shall ensure that the care manager connects Members approved for pilot enrollment to pilot providers in the LPE's network for approved pilot services, in partnership with the LPE.

xiii. The PHP shall ensure that the care manager conducts a reassessment for the mix of pilot services no less frequently than every three (3) months and for the eligibility for services no less frequently than every six (6) months.

xiv. The PHP shall ensure that the care manager is responsible for identifying information and data on pilot Members in accordance with forthcoming Department guidelines that support the State's oversight and evaluation efforts, including:
   a) Pilot enrollment and referral source;
   b) The identified needed pilot services in an individual's care plan;
   c) Approved pilot services;
   d) Denied pilot services; and
   e) Number of reassessments and associated findings.

xv. The PHP will receive payments from the Department up to a PHP-specific capped allotment to fund pilot services based on the cost and volume of specified services authorized for the PHP's Members.

xvi. The PHP shall make payments to the LPE for administrative funding and value-based payments, subject to Department guidance, and to Human Service Organizations for the delivery of pilot services.

xvii. The PHP shall manage total pilot funding against allocations for eligible populations, covered services, and Opportunities for Health domains, as developed by the LPE and approved by the Department.

a) Eligible populations include those that qualify for pilot services under Department determined health and resource need based risk eligibility criteria.

b) Covered services include those authorized by the PHP and that follow Department guidelines.

xviii. The PHP shall support the Department's efforts to evaluate the effectiveness of the pilots by reporting quarterly on a range of metrics, including:

a) Pilot enrollment;

b) Pilot service utilization;

c) Pilot expenditures;

d) Member health outcomes; and

e) Member cost and utilization metrics.

ddd. Section V.D. Providers, 1. Provider Network, c. Availability of Services (42 C.F.R. § 438.206), v. Telemedicine Services is revised and restated as follows:

v. Telehealth, Virtual Patient Communications or Remote Patient Monitoring Services:

a) The PHP may use Telehealth, Virtual Patient Communications or Remote Patient Monitoring in order to provide access to needed services in a clinically appropriate manner that are not available within the PHP's network and in accordance with the NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring.

b) PHPs shall be permitted to include Telehealth in their Request for Exception to the Department's network adequacy standards, as appropriate.

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

d) Access Telehealth providers does not count toward meeting network adequacy standards, unless approved as part of an exception to Network requirements.

eee. Section V.D. Providers, 1. Provider Network, g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207), i.c) is revised and restated as follows:

c. The demonstration that the PHP has the capacity to serve the expected enrollment shall be on a county basis for every county in the PHP's service area. For a statewide PHP, this means demonstration shall be for every county in each Region 1 through 6.

fff. Section V.D. Providers, 1. Provider Network, g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207), i.d) is revised and restated as follows:

d) The Department will supply Member eligibility information that includes county of residence and residence zip code for each Medicaid and NC Health Choice beneficiary that is in the mandatory enrollment population as of the date of the report. The information will be provided to the Contractor

after Contract Award, at a date to be defined by the Department for purposes of demonstrating compliance with the time and distance standards found in *Attachment F. First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards* during the Readiness Review, and at other times as needed as part of the network adequacy oversight.

ggg. Section V.D. Providers, 2. Provider Network Management, b. is revised and restated as follows:

b. To help recognize the Department's aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency. The period before the PDM/CVO has achieved full Implementation will be considered the Provider Credentialing Transition Period. The Medicaid Enrolled provider information gathered by the Department or Department's vendors will be shared with the PHP who will use that information for network contracting.

hhh. Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, ii.a. is revised and restated as follows:

a. The PHP may utilize proposed contract templates submitted to the Department for review, prior to approval, with notification to the provider that the contract is subject to amendment based upon Department review and approval.

iii. Section V.D. Providers, 2. Provider Network Management, c. Provider Contracting, v. is revised as follows:

v. In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the PHP shall not exclude eligible providers from its network except under the following circumstances:

a. When a provider fails to appear in the Department's daily Provider Enrollment File, meaning the provider has not met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled provider; or

b. When a provider refuses to accept network rates (which shall not be less than any applicable rate floors).

jjj. Section V.D. Providers 2. Provider Network Management c. Provider Contracting vi. is revised as follows:

vi. The PHP shall not deny a pharmacy the opportunity to participate in its network as required by N.C. Gen. Stat. § 58-51-37(c)(2). Nothing in this subsection shall require the PHP to contract with a pharmacy when the pharmacy fails to appear in the Department's daily Provider Enrollment File, meaning the pharmacy has not met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled provider.

kkk. Section V.D. Providers, 2. Provider Network Management, f. Program Integrity, iv. is revised and restated as follows:

iv. The PHP shall prohibit providers and referral providers from billing Members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. § 438.106.

lll. Section V.D. Providers, 2. Provider Network Management, g. Credentialing and Re-credentialing Process is revised and restated as follows:

g. Credentialing and Re-credentialing Process

i. The PHP shall develop a Credentialing and Re-credentialing Policy consistent with the Department requirements and its associated policies and subject to Department approval.
   a. The PHP shall develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.

ii. The PHP shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval. PHP is not prohibited from collecting other information from providers necessary for the PHP's contracting process.
   a. The PHP shall make timely network contracting decisions using the process outlined in the PHP's Credentialing and Re-credentialing Policy.

iii. The PHP shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.D. Providers*.

iv. The PHP is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.

v. Re-credentialing:
   a. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment process, the PHP shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. The PHP's process shall occur no less frequently than every five (5) years consistent with the Department policy and procedure.
   b. After the Provider Credentialing Transition Period, the PHP shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. The PHP's process shall occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.

vi. Reserved.

vii. Through the uniform credentialing process, the Department will apply Objective Quality Standards and screen and enroll, and periodically revalidate all PHP network providers as Medicaid Enrolled providers. 42 C.F.R. § 438.602(b)(1).
   a. The PHP may execute network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected Members. 42 C.F.R. § 438.602(b)(2).

vii. The PHP shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

viii. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to Section III.D.5. Availability of Funds, DHHS shall indemnify, defend, and hold harmless the PHP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to

any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the PHP by the Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the PHP and relied upon by the PHP in credentialing a provider for participation in the PHP's network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The PHP shall have the option to participate at its own expense in the defense of such claims or actions filed and the PHP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the PHP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The PHP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PHP's use of and reliance on such credentialing information.

mmm. Section V.D. Providers, 2. Provider Network Management, i. Network Provider Credentialing and Re-credentialing Policy iii. is revised and restated as follows:

iii. The PHP shall submit any significant changes to the PHP's Credentialing and Re-credentialing Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.

nnn. Section V.D. Providers, 2. Provider Network Management, i. Network Provider Credentialing and Re-credentialing Policy, iv. is revised and restated as follows:

iv. Network Contracting Decisions
   a. PHP shall establish and maintain a process to make Quality Determinations in accordance with PHP's Credentialing and Re-credentialing Policy.
   b. Reserved.
   c. Reserved.
   d. The PHP shall provide written notice of network contracting decisions to providers within five (5) business days of determination of the provider's status as an active Medicaid Enrolled provider.

ooo. Section V.D. Providers, 2. Provider Network Management, l. Provider Directory, i. is revised and restated as follows:

i. The PHP shall develop a consumer-facing provider directory of all Network providers including the required information for all contracted providers.
   a. Notwithstanding *Section V.D.2.l.i.*, the PHP may use best practices to exclude a Network Provider from the consumer-facing directories if the PHP includes in a Provider Directory Policy, or other policy as appropriate, an explanation of the process and rules used by the PHP when deciding whether to include a provider in a consumer-facing directory.
   b. The PHP shall provide the Provider Directory Policy, or other policy as appropriate, to the Department for review at the request of the Department.
   c. As used in this section, best practices specifically include, but are not limited to:
      1. A provider opts out of being in the directory, such as when the provider is not open to the general public (e.g., a student health center open only to students of the educational organization).
      2. A provider cannot traditionally be contacted directly for making appointments, such as facility-based providers like anesthesiologists or radiologists.

3. Provider is otherwise outside the scope of what would normally be included in a provider directory, such as a Value-added service.

ppp. Section V.D. Providers, 2. Provider Network Management, l. Provider Directory, iv. is revised and restated as follows:

iv. In accordance with 42 C.F.R. § 438.10(h)(3):

a. The PHP shall update the paper directory at least quarterly, if the PHP has a mobile-enabled, electronic provider directory, or monthly, if the PHP does not have a mobile-enabled, electronic provider directory. The paper directory shall clearly identify the date of the update.

b. The PHP shall update the electronic version of the consumer-facing directory no later than thirty (30) Calendar Days after the PHP receives updated provider information and clearly identify the date of the update.

qqq. Section V.D. Providers. 2. Provider Network Management. l. Provider Directory, vi.r. is revised and restated as follows:

r. Whether provider has completed cultural competency training, including description of training.

rrr. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, i. is revised to add the following:

w) Disaster and emergency relief planning and response in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease.

sss. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, v. is revised and restated as follows:

v. The PHP shall review and update the provider manual annually, with submission due on July 1st, or upon request of the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or PHP policies, procedures, bulletins, guidelines or manuals, or PHP business processes as necessary. Within the provider manual, the PHP shall track and maintain a list of revisions made to manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.

ttt. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, vi. is revised and restated as follows:

vi. If there are substantive updates or revisions that impact provider or PHP business, as determined by the Department or PHP, the PHP may update the provider manual once per quarter in addition to the annual update. Unless directed by the Department, the PHP shall not update the provider manual more than once per quarter during the Contract Year. Submissions by the PHP of its provider manual during the Contract Year to the Department, as allowed in this section, shall not be construed by the PHP to replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

uuu. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, vii. is revised and restated as follows:

vii. When seeking review and approval of the provider manual, the PHP shall submit the provider manual to Department for approval within fifteen (15) Calendar Days of making substantive updates. The PHP shall not post, print or enforce the updates until the PHP has received approval from the Department.

vvv. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, viii. is revised and restated as follows:

viii. The PHP shall have ten (10) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process.

www. Section V.D. Providers, 3. Provider Relations and Engagement, d. Provider Manual is revised to add the following:

ix. The PHP shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) Calendar Days of notification or request by Department. Corrections or revisions to the printed version shall be included in the next printing.

x. The PHP shall make the provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

xi. The PHP shall make the redline provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal only.

xxx. Section V.D. Providers, 4. Provider Payments, h. Indian Health Care Provider (IHCP) Payments, i. is revised to add the following:

c) The PHP shall reimburse IHCPs for Pharmacy Claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan.

yyy. Section V.D. Providers, 4. Provider Payments, j. Public Ambulance Provider Payments is revised and restated as follows:

i. The PHP shall reimburse in-network public ambulance providers no less than 100% of base rates specified in the North Carolina Medicaid Managed Care Public Ambulance Provider Cost-Based Fee Schedule for Medicaid and NC Health Choice members (as allowed under 42 C.F.R. § 438.6(c)(iii)(B)), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

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

v. The PHP shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) business days of receiving the payment from the State.

a) The PHP is not in violation of this Section, or required to pay interest or penalties, if the PHP's failure to comply with this Section is caused in material part by either of the following:

1. the person submitting the claim; or
2. by matters beyond the PHP's reasonable control, including an act of God, insurrection, strike, fire, or power outages.

b) The PHP is not in violation of this section, or required to pay interest or penalties, to the Provider under this section, if the PHP has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

aaaa. Section V.D. Providers, 4. Provider Payments, l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)) is revised to add the following:

ix. Interest and Penalties

a.) The PHP shall pay interest on late directed payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid as specified in the Contract.

b.) In addition to the interest on late directed payments required by this Section, the PHP shall pay the provider a penalty equal to one percent (1%) of the directed payment for each Calendar Day following the date that the directed payment should have been paid as specified in the Contract.

bbbb. Section V.D. Providers, 4. Provider Payments, p. Advanced Medical Home Payments is revised and restated as follows:

p. Advanced Medical Home Payments

i. In addition to the payment for services provided, the PHP shall pay AMH practices each of the following components:

a) Medical Home Fee (all Tiers);

b) Care Management Fee (Tier 3 only) and

c) Performance Incentive Payments (required only for Tier 3 until such time the Department expands the required payment to other tiers).

ii. The PHP shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the Member is assigned to that AMH practice. Medical Home Fees for AMH Tiers 1 – 3 practices may be prorated for partial months and shall be no less than the following amounts for the first two contract years:

a) $1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the NC Medicaid Direct program);

b) $2.50 PMPM for Members not in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the NC Medicaid Direct program); and

c) $5.00 PMPM for Members in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the NC Medicaid Direct program).

d) $61.65 PMPM for Members assigned to CIHA as AMH/PCP (consistent with Carolina ACCESS II in the NC Medicaid Direct program).

iii. The PHP shall pay Care Management Fees to Tier 3 practices that are negotiated between the PHP and Tier 3 practice and that adequately compensate Tier 3 practices for the additional care management responsibility assumed. Care Management Fees must be a per member per month payment that is a minimum guaranteed revenue to the practice and must not be placed at risk based on measures of utilization, cost, or quality. Care Management Fees must be accounted for and reported to the Department separately from Medical Home Fees and Performance Incentive Payments.

iv. In Contract Years 1 and 2, the PHP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:

a) The PHP shall design Tier 3 Performance Incentive Payments to be in addition to Medical Home Fees and Care Management Fees (i.e., the PHP shall not place all or part of the Medical Home Fees or Care Management Fees at risk based on performance).

B) The PHP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMH Tier 3.

c) The PHP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set, once finalized.

v. The PHP shall have flexibility to develop its own payment model(s) that increase the level of prospective, non-NC Medicaid Direct payment and/or incorporate increased accountability for total cost of care, beyond the Tier 3 payment model. The PHP shall obtain the approval of the Department before entering agreements with AMH providers under any such model(s).

cccc. Section V.D. Providers, 4. Provider Payments is revised to add the following:

x. Payments for Durable Medical Equipment

i. Consistent with Section 11 of Session Law 2020-88, for Contract Years 1 – 3, the PHP shall reimburse durable medical equipment and supplies and orthotics and prosthetics consistent with the NC Medicaid Direct reimbursement based on the lesser of the supplier's usual and customary rates up to one hundred percent (100%) of the maximum allowable NC Medicaid Direct rates for durable medical equipment and supplies and orthotics and prosthetics.

y. Payment for Crisis Providers

i. The PHP shall reimburse in-network providers for mobile crisis services and facility based crisis services no less than the Department's Enhanced Behavioral Health Fee Schedule unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

z. Payments for COVID Vaccines Administration and Testing

i. The PHP shall reimburse providers based on Department's NC Medicaid Direct rates for COVID-19 Vaccine Administration and COVID-19 testing.

dddd. Section V.E. Quality and Value 1. Quality Management and Quality Improvement i. Quality Measures is revised and restated as follows:

i. Quality Measures

i. The PHP shall report, and will be held accountable for performance against, measures aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence.

ii. The PHP shall report a set of quality and administrative measures listed in *Attachment E. Required PHP Quality Metrics* that are meant to provide the Department with a complete picture of the PHP's processes and performance

a) Detailed specifications around measure reporting, stratification, and data submission will be supplied to the PHPs prior to launch and annually thereafter.

iii. The PHP shall incorporate Department identified measures into the PHP's QAPI and quality improvement activities. Department identified measures are indicated in *Attachment E. First Revised and Restated Required PHP Quality Metrics*. The Department reserves the right to change the quality measures identified for PHP's QAPI and quality improvement activities.

iv. Beginning in Contract Year 3, the Department may implement withhold measures based on quality measures used to administer a PHP quality withhold/incentive program. A subset of measures may be included in the Withhold/Incentive Program. Measures that may be subject to future withholds are indicated for reference only in Attachment E. Required PHP Quality Metrics. The Department reserves the right to change measures that may be subject to future withholds.

v. The Department shall monitor for CMS development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.

eeee. Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, j. Disparities Reporting and Tracking, i is revised and restated as follows:

i. The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.

a) Detailed specifications around measure reporting, stratification, and data submission will be supplied to the PHP after Contract Award and annually thereafter.

ffff. Section V.E. Quality and Value 1. Quality Management and Quality Improvement l. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330 i. is revised and restated as follows:

i. The PHP shall include no less than three (3) performance improvement projects as part of the annual Quality Assessment and Performance Improvement program and may be required to develop additional performance improvement projects for specific focus areas and/or clinical measures as directed by the Department. The PHP's PIPs must be approved by the Department annually as part of the PHP's QAPI program"

gggg. Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, l. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330), v. is revised and restated as follows:

v. The PHP shall be required to develop and execute at least two (2) clinical performance improvement projects annually that must be related to the following areas:

hhhh. Section V.E. Quality and Value, 1. Quality Management and Quality Improvement, n. Quality Improvement - Provider Supports, viii. is revised and restated as follows:

viii. The PHP shall provide quality improvement support to network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:

a) The opioid strategy interventions;
b) The Healthy Opportunity interventions;
c) The Advanced Medical Home program;
d) Behavioral Health integration;
e) Value-Based Payment;
f) Pregnancy management/Pregnancy Management Program;
g) Activities to support at-risk children;
h) The CDC 6|18 initiative; and
i) Support for other activities such as response to or recovery from COVID-19, or future epidemic or pandemic preparedness and response, as indicated by the Department.

iiii. Section V.F. Stakeholder Engagement, 2. Engagement with Community and County Organizations, a. is revised and restated as follows:

a) The PHP must have a strong understanding of and capability to meet the needs of North Carolina's local communities, including County Agencies (e.g., local health departments, local Department of Social Services, Area Agency on Aging, Local Education Agencies children's developmental services agencies, local systems of care programs, law enforcement, justice and judicial agencies such as sheriff departments, police departments, pre and post-trial release programs, reentry councils, county magistrates, housing authorities, county commissioners, county managers, etc.) and County and Community Based Organizations (e.g. faith-based organizations, food pantries, domestic violence agencies) to help guide and support the delivery of services to members and their families in in the Regions that it serves.

jjjj. Section V.F. Stakeholder Engagement, 2. Engagement with Community and County Organizations, is revised to add the following:

i. The PHP shall support local collaboratives that are focused on addressing the unique needs of the populations they serve.

i. The PHP shall participate in city or county "System of Care" Community Collaboratives, and work with the Collaboratives to address service barriers, identify system gaps, and develop cross-system provider training plans for Members age three (3) up to eighteen (18) receiving BH services.

kkkk. Section V.F. Stakeholder Engagement, 4. Local Area Crisis Services Plan, b. is revised and restated as follows:

b. The PHP shall develop Comprehensive Local Crisis Management Plan that outlines the following:

i. Contracting status with each provider identified in each local area crisis services plan and other key crisis providers identified by the Department within their regions.

ii. Approach to integrate with each LME/MCO and local communities in the development and implementation of each local area crisis service plan,

iii. Planned activities for the upcoming year to support the development, implementation and ongoing operations of all plans in each Region covered by this Contract,

iv. Progress on planned activities for the prior year to support the development, implementation and ongoing operations of all plans in each Region covered by this Contract, and

v. Barriers to accomplishing the planned activities for the prior year.

llll. Section V.G. Program Operations, 1. Service Lines Section, f. is revised and restated as follows:

f. The PHP shall be permitted to use overflow or secondary call centers to meet capacity requirements as defined in this Section. All call centers shall be held to the same service line performance standards as defined within the Contract, unless the Department has approved an exception as provided in this Section.

mmmm. Section V.G. Program Operations, 1. Service Lines is revised to add the following:

u. The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers. The PHP is required to submit a request to the Department for review and approval for a call center used by the PHP, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract. The PHP shall not be allowed to request, for Department review and approval, any exceptions for overflow call centers.

i. Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the five (5) service lines specified in the Contract.

nnnn. Section V.G. Program Operations, 2. Staff Training, e. is revised and restated as follows:

xix. Unique needs, experiences of members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:

a) The significance of extended families including an understanding that the definition of extended families is different than non-native families;

b) The different service eligibility for non-enrolled family members of enrolled members in EBCI or other federally recognized tribes;

c) Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish); Respect for traditions where gender and age may play an important role:

1. Elders have a highly respected status due to their life experiences;
2. Elders tend to be non-verbal;
3. Pregnant individuals; and
4. Veterans.

d) The different service types and benefit plans available through the Tribal Option;

xx. HIPAA and the Department's Privacy and Security requirements; and

xxi. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.

oooo. Section V.G. Program Operations, 2. Staff Training, f. xi. – xiii. is revised and restated as follows:

xi. Unique needs and requirements of Indian Health Care Providers;
xii. HIPAA and the Department's Privacy and Security requirements; and
xiii. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.

pppp. Section V.G. Program Operations, 2. Staff Training, g. vi. – viii. is revised and restated as follows:

vi. Fraud, waste, and abuse detection, investigation, and prevention;
vii. HIPAA and the Department's Privacy and Security requirements; and
viii. Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.

qqqq. Section V.G. Program Operations, 2. Staff Training, is revised to add the following:

k. The PHP shall require all staff to complete implicit bias training, inclusive of race, ethnicity, and religion in health care, gender and class bias.

rrrr. Section V.G. Program Operations, 4. PHP Policies is revised to add the following:

e. In support of the Department's Health Equity goals, the PHP shall revise and resubmit for approval the follow policies to the Department for review and approval to specifically acknowledge how the PHP is addressing health disparities and incorporating health equity into their internal and external policies, and procedures. The PHP shall submit no later than August 31, 2021:

i. Network Access Plan,
ii. VBP/APM Strategy,
iii. Care Management Policy,
iv. Provider Support Plan,
v. Provider Training Plans,
vi. Opioid Misuse Prevention Program, and
viii. Local Community Collaboration Plan.

ssss. Section V.G. Program Operations, 5. Business Continuity is revised and restated as follows:

a. The PHP shall develop and maintain a Business Continuity Plan this is acceptable to the Department and demonstrate the adequacy of the Plan at the Department's request. The PHP shall adhere to all applicable published Department Privacy and Security policies, (located at https://it.nc.gov/documents/statewide-information-security-manual and https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/) and all other requirements set forth in the Contract.
b. Within thirty (30) Calendar Days of the Contract Award, the PHP shall submit a detailed description of its Business Continuity Plan for all requirements specified in the Contract. See *Attachment N. Business Continuity Management Program.* The PHP shall update the Business Continuity Plan every six (6) months. The PHP shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following a natural or manmade disaster or state of emergency. The Plan shall meet recognized industry standards for security and disaster recovery requirements. The Plan shall identify disaster or emergency situations (e.g., fire, flood,

terrorist event, hurricanes/tornadoes, epidemic or pandemic), which could result in a major failure or disruption in care. As part of the PHP's business continuity planning, the PHP shall identify and review all federal or state disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Award to inform future disaster or emergency planning. For each identified disaster or emergency situation, the PHP shall explain in detail:

i. The preventive measures that would be instituted to minimize the impact;
ii. The back-up, off-site storage, and other pre-disaster or emergency safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
    a) Descriptions of the controls for back-up processing, including how frequently back-ups occur;
    b) Documented back-up procedures;
    c) The location of data that has been backed up (off-site and on-site, as applicable);
    d) Identification and description of what is being backed up as part of the back-up plan;
    e) Any change in back-up procedures in relation to the PHP's technology changes;
    f) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and
iii. Reserved.
iv. The tasks that would be involved, and identify by job description or title the PHP's staff and the Department's staff involvement;
v. Current contact information for all critical staff and relevant personnel and notification procedures (i.e. call tree);
vi. Approach for providing care coordination activities to high risk Medicaid members;
vii. Approach for supporting the Department's priorities for statewide and local disaster or emergency planning;
viii. Process to provide information and resources to Medicaid members on how to protect themselves during a disaster or emergency and assist members with understanding how and when to access Medicaid benefits;
ix. Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a member;
x. Processes to ensure that providers deliver all necessary care to members during a disaster or emergency;
xi. Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
xii. Approach to supporting providers in the event of provider revenue disruptions;
xiii. Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
ix. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternative worksite locations;
xv. The time-frame required to accomplish full recovery from the point of interruption;
xvi. A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
xvii. The procedures for coordinating with the Department in the event of a disaster or emergency;
xviii. Employee training and awareness detailing activation process;
xix. Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results;

xx. The procedures for notifying the Department, Enrollment Broker, Members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.

xxi. Approach to incorporating the Department best-practices from disaster or emergency response including:

a) Increasing care management for medically fragile enrollees to include high risk enrollees (e.g., high risk pregnant women, dialysis patients, medically frail, hemophiliacs, long term care population) during a disaster or emergency:

1. Pre-Emergency:
   i. Incorporate disaster or emergency planning in the care planning process; and
   ii. Increase member outreach to ensure that adequate shelter, access to support to address their Unmet Health-Related Resource Needs, access to back-up equipment and/or caretaker training if equipment fails or arrange NEMT for evacuation if the member is unable to safely shelter in place.
2. During an Emergency:
   i. Continue to check-in on high risk members to ensure safety~~;~~, and access to supports to address their Unmet Health-Related Resource Needs;
   ii. Arrange for NEMT to evacuate if needed;
   iii. Offer extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries; and
   iv. Ensure continuity of care, as directed by the Department, to:
      a. Remove and/or reduce required prior authorizations and concurrent review,
      b. Ensure all Members have access to out-of-network and telehealth providers, and
      c. Increase member access to medications by removing maximum dosage limits for required medication including medication assisted treatment (MAT), anti-psychotics, and insulin.
3. Post-Emergency:
   i. Follow up with high risk members to ensure safety and identify additional behavioral or medical needs, or Unmet Health-Related Resource Needs; and
   ii. Offer extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries.

b) Supporting the Department's priorities for state-wide and local disaster or emergency planning, including:

1. Participation in the development of community disaster or emergency response plans as needed;
2. Collaboration with ~~the~~ other Department vendors to align efforts, as needed;
3. Appointment of at least one representative to the statewide disaster or emergency response panel;
4. Recruitment and training for in-network behavioral health providers to staff local disaster shelters; and
5. Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.

c. The PHP shall comply with any additional guidance released by the Department during any type of disaster or emergency, including guidance on provider payments.

d. As part of the Business Continuity Plan, the PHP shall submit Business Continuity Plan(s) for any/all call center(s) for the Department's review and approval within thirty (30) Calendar Days of the Contract Award and be updated at least every six (6) months thereafter.
e. The PHP shall notify the Department each time the Business Continuity Plan is activated within two (2) hours of an event.
f. The Plan shall, at a minimum, include an overflow telephone system to operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.
    i. The overflow system must interface with the call tracking and recording standards and technology required in the Contract.
    ii. All quality and performance standards required in this Contract shall apply to the overflow call center.

tttt. Section V.H. Claims and Encounter Management, 1. Claims, c. Claims Processing and Reprocessing Standards, iv. is revised and restated as follows:

iv. The PHP shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:

a) The PHP shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.
b) The PHP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes.
c) The PHP shall capture and retain the IP address and the user login/user name for all claims submitted via the PHP on-line portal.

uuuu. Section V.H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, ii. is revised and restated as follows:

ii. The PHP shall reprocess medical and pharmacy claims, including resubmitted and corrected claims, in a timely and accurate manner as described in this Section (including interest and penalties if applicable).

vvvv. Section V.H. Claims and Encounter Management, 1. Claims d. Prompt Payment Standards iv. Interest and Penalties is revised to add the following:

d) The PHP shall implement fee schedule changes and reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section beginning on the forty-sixth (46th) Calendar Day after the PHP received notification from the Department.

wwww. Section V.I. Financial Requirements, 1. Capitation Payments, g.is revised and restated as follows:

g. The Department has established a separate maternity event payment. This payment will be made to the PHP after the PHP submits required documentation of a successful delivery event, defined as a qualifying birth, to the Department.
    i. The PHP shall follow with the Department's Maternity Event Payment Billing Guide.
    ii. The PHP shall void the claim within thirty (30) Calendar Days after notice from the Department that valid documentation is not found during the Maternity Event Reconciliation with Encounters as part of the Maternity Event Payment Billing Guidance.

xxxx. Section V.I. Financial Requirements, 2. Medical Loss Ratio, b.iv.a)1. is revised and restated as follows:

1. The PHP is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:
   i. Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual Members and North Carolina geographic regions, including rural areas.
   ii. Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

yyyy. Section V.I. Financial Requirements 2. Medical Loss Ratio, c.i. is revised and restated as follows:

c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
   i. The PHP's classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.

zzzz. Section V.I. Financial Requirements 2. Medical Loss Ratio d. is revised and restated as follows:

d. If the PHP's Department-defined MLR is less than the minimum MLR threshold, the PHP shall do one of the following:
   i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
   ii. Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in Section V. D. 9. Opportunities for Health; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
   iii. Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy, subject to approval by the Department;
   iv. Allocate a portion of the total obligation to a mix of Department-approved contributions to health-related resources and/or Department-approved public health and Health Equity investments and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

aaaaa. Section V.I. Financial Requirements is revised to add the following follows:

4. Risk Corridor:

a. A risk corridor arrangement between the PHP and the Department will apply to share in gains and losses of the PHP as defined in this section. The Risk Corridor payments to and recoupments from the PHP will be based on a comparison of the PHP's reported Risk Corridor Services Ratio ("Reported Serves Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Standard Plan Rate Book ("Target Services Ratio").
   i. The Risk Corridor Measurement Period is defined as July 1, 2021 to June 30, 2022.
   ii. The risk corridor payments and recoupments will be based on a comparison of the PHP's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the Standard Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

iii. The PHP Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments).

iv. The Reported Services Ratio numerator shall be the PHP's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid and NC Health Choice managed care programs. The numerator shall be defined as the sum of:

a) Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments and COVID-19 vaccine and testing costs.

b) Advanced Medical Home Fees as defined in Section 4. Provider Payments including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department

c) Performance Incentive Payments to Advanced Medical Homes as defined in Section 4. Provider Payments

d) Other quality-related incentive payments to NC Medicaid providers

e) Non-claims based provider stabilization payments to support provider sustainability and beneficiary access.

f) Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.

g) The final Risk Corridor Services Ratio report should also include any payments required by the Minimum Primary Care Provider Expenditure requirement.

v. The PHP is prohibited from including in the Reported Services Ratio numerator the following expenditures:

a) Payments to providers for delegated Care Management.

b) Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department

c) Interest or penalty payments to providers for failure to meet prompt payment standards.

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

e) COVID-19 vaccine administration and testing costs included in a non-risk arrangement.

f) Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

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

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

viii. The PHP must provide an attestation of the accuracy of the Information provided in its submitted risk corridor calculations, including minimum PCP Expenditure requirement calculation, as specified in 42 C.F.R. § 438.606.

ix. Terms of the Risk Corridor

a) If the Reported Services Ratio is less than the Target Services Ratio minus 3%, the PHP shall pay the Department 50% of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus 3% and the Reported Services Ratio.

b) If the Reported Services Ratio is greater than the Target Services Ratio plus 3%, the Department shall pay the PHP 50% of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus 3%.

x. Risk Corridor Settlement and Payments

a) The Department will complete a settlement determination for the Risk Corridor Measurement Period.

b) The PHP shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

c) The PHP shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department. The risk corridor settlement will consider the outcome of the Minimum Primary Care Expenditure requirement evaluation. As such, the final Risk Corridor settlement will include the following two iterations of the Risk Corridor Services Ratio report.

1. Preliminary Risk Corridor Services Ratio report will exclude from the numerator any payments required from the Minimum Primary Care Provider Expenditure requirement.
2. Final Risk Corridor Services Ratio report will consider the final outcome and any payments required from the Minimum Primary Care Provider Expenditure requirement.

d) The PHP shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.

e) The Department may choose to review or audit any information submitted by the PHP.

f) The Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.

g) The Department will provide the PHP with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to Section VI.A.e.vii. of the Contract within fifteen (15) Calendar Days of the notice by the Department to the PHP.

h) If the final Risk Corridor Settlement requires the PHP to remit funds to the Department, the PHP must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.

i) At the sole discretion of the Department, the Department may allow the PHP to contribute all or a part of the amount otherwise to be remitted to:

1. Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
2. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.

j) To be considered for the in lieu of remittance option, the PHP must submit a proposal to the Department for review and approval concurrent with or prior to submission of the PHP's interim Risk Corridor Services Ratio report.

k) If the PHP has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the PHP by offsetting a subsequent monthly capitation payment.

l) If the final Risk Corridor Settlement requires the Department to make additional payment to the PHP, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the PHP initiates a dispute as described in Section VI.A.e.vii. the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

bbbbb. Section V.I. Financial Requirements is revised to add the following follows:

5. Minimum Primary Care Provider (PCP) Expenditure Requirement:

a. The PHP shall spend a minimum percentage of its capitation revenue on services and quality payments to primary care providers as outlined in this section.

b. The PHP shall calculate and report the Reported PCP Expenditure Percentage as the ratio of the Reported PCP Expenditures to the Department-defined MLR denominator for the Risk Corridor Measurement Period as part of the interim and final Risk Corridor Service Ratio reports.

c. Reported PCP Expenditures shall include the portion of the Reported Services Ratio numerator attributable to the following Categories of Service as defined in Appendix D of the Standard Plan Capitation Rate Book.
   i. Physician – Primary Care
   ii. FQHC/RHC
   iii. Other Clinic
   iv. Family Planning Services
   v. Medical Home Payments

d. The PHP shall not report expenditures excluded from the Reported Services Ratio numerator in the Reported PCP Expenditures.

e. The Minimum PCP Expenditure Percentage shall be calculated as ninety percent (90%) of the PCP Target Expenditure Percentage for each rate cell documented in the Standard Plan Rate Book and weighted by the PHP's capitation revenue for each rate cell (excluding revenue associated with additional utilization based payments).

f. The PCP Target Expenditure Percentage shall be calculated for each rate cell as the sum of the expected per member per month expenditures for the Rating Period as defined in the Standard Plan Rate Book divided by the capitation rate for each rate cell net of the premium tax and regulatory surcharge component.

g. If, in either the interim or preliminary Risk Corridor Services Ratio Report the PHP's Reported PCP Expenditure Percentage is greater than or equal to the Minimum PCP Expenditure Percentage, or the PHP's Reported Services Ratio is greater than the Target Services Ratio as defined in the Risk Corridor Section less 0.5% margin, no further action is needed by the PHP.

h. If, in either the interim or preliminary Risk Corridor Services Ratio Report the PHP's Reported PCP Expenditure Percentage is below the Minimum PCP Expenditure Percentage, the PHP shall calculate the amount of required additional PCP payments needed as the denominator of the Department-defined MLR multiplied by the minimum of the following:
    i. The Minimum PCP Expenditure Percentage less the Reported PCP Expenditure Percentage.
    ii. The Target Services Ratio less the Reported Services Ratio as defined in the Risk Corridor Section less 0.5% margin.

i. If either the interim or preliminary Risk Corridor Report indicates additional PCP payments are needed, the PHP shall submit to the Department for review and approval a proposal for corrective action to make additional payments to applicable providers to meet the Minimum PCP Expenditure Percentage. The corrective action proposal may include one or a combination of the following actions for consideration:
    i. Retroactive, uniform percentage increase to per member per month Advanced Medical Home Fees as defined in Section 4. Provider Payments.
    ii. Uniform percentage increase in quality-related payments to providers included in the definition of PCP Expenditures.
    iii. Alternative primary care provider payment approach that promotes Health Equity or otherwise aligns with the Department's Quality Strategy.

j. The PHP shall make payments in alignment with the approved corrective action proposal no later than sixty (60) Calendar Days following approval by the Department.

k. Provider payments required by this section shall be reported as incurred claims attributable to the Risk Corridor Measurement Period for purposes of Risk Corridor Service Ratio reporting and the associated rating year for purposes of MLR reporting.

ccccc. Section V.J. Compliance, 4. Third Party Liability (TPL), k.i. is revised and restated as follows:

k. The PHP shall develop and maintain a TPL Policy for review and approval by the Department.

i. The TPL Policy shall include the following:

a) Cost avoidance activities;

b) Payment recovery activities;

c) Identification of other forms of insurance processes and procedures; and

d) Subrogation, including:

1. Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'

ddddd. Section V.K. Technical Specifications, 6. Technology Documents, b. vi. – viii. is revised and restated as follows:

vi. Processes and plans for vulnerability and breach management including response processes;

vii. Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software); and

viii. Process and procedures necessary to comply with 42 C.F.R. Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:

a) Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 C.F.R. Part 2;

b) Where appropriate, secure Member consent prior disclosing member protected health information covered under 42 C.F.R. Part 2 requirements and;
c) Establish functionality or procedures to remove or redact information protected by 42 C.F.R. Part 2 prior to disclosure of the information.

3. Modifications to Section VI. Contract Performance of the Contract.

Specific subsections are modified as stated herein.

a. Section VI.A. Contract Violations and Noncompliance e. Remedial Actions, Intermediate Sanctions, and Liquidated Damages v. Liquidated Damages, *Section VI.A. Table 1: First Revised and Restated PHP Liquidated Damages* is revised and restated as follows:

Second Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
1.	Failure to meet plan readiness review deadlines as set by the Department.	$5,000 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section V.A.9. Staffing and Facilities and Attachment O. 10. Disclosure of Conflicts of Interest.*	$10,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by At*tachment O.9. Disclosure of Litigation and Criminal Conviction.*	$1,000 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Attachment O.9. Disclosure of Ownership Interest*.	$2,500 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section V.B.4. Marketing*	$5,000 per occurrence
6.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section V.B.2. Medicaid Managed Care Enrolment and Disenrollment.*	$500 per occurrence per Member
7.	Failure to comply with timeframes for providing Member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section V.B.3. Member Engagement.*	$250 per occurrence per Member
8.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.6. Member Grievances and Appeals.*	$500 per occurrence
9.	Reserved.	Reserved.
10.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$5,000 per occurrence
11.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.6. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND $500 per Calendar Day for each day the PHP fails to provide continuation or restoration as required by the Department.
12.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.6. Member Grievances and Appeals.*	$1,000 for each mediation or hearing that the PHP fails to attend as required
13.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	$5,000 per occurrence per Member

Second Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
14.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.C.1. Medical and Behavioral Health Benefits Package and Section V.C.3. Pharmacy Benefits.*	$5,000 per standard authorization request $7,500 per expedited authorization request
15.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section V.D.1. Provider Network.*	$1,000 per occurrence
16.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Medical and Behavioral Health Benefits Package.*	$2,500 per occurrence
17.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.C.3. Pharmacy Benefits.*	$2,500 per Calendar Day per occurrence
18.	Failure to comply with Transition of Care requirements as specified *Section V.C.4. Transition of Care.*	$100 per Calendar Day, per Member AND The value of the services the PHP failed to cover during the applicable transition of care period, as determined by the Department.
19.	Failure to ensure that a Member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified *Section V.C.5. Non-Emergency Transportation.*	$500 per occurrence per Member
20.	Failure to comply with driver requirements as defined in the PHP NEMT Policy.	$1,500 per occurrence per driver
21.	Failure to comply with the assessment and scheduling requirements as defined in the PHP NEMT Policy.	$250 per occurrence per Member
22.	Failure to comply with vehicle requirements as defined in the PHP NEMT Policy.	$1,500 per Calendar Day per vehicle
23.	Failure to timely develop and furnish to the Department PHP the Care Management Policy.	$250 per Calendar Day
24.	Reserved.	Reserved.
25.	Reserved.	Reserved. Reserved. Reserved.
26.	Reserved.	Reserved.
27.	Reserved.	Reserved.
28.	Reserved.	Reserved.
29.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with a LHD.	$500 per Calendar Day
30.	Failure to implement and maintain an Opioid Misuse Prevention Program and Member Lock-In Program as described in *Section V.C.7. Prevention and Population Health Management Program.*	$2,000 per Calendar Day for each day the Department determines the PHP is not in compliance
31.	Failure to update online and printed provider directory as required by *Section V.D.2. Provider Network Management.*	$1,000 per occurrence
32.	Failure to report notice of provider termination from participation in the PHP's provider network (includes terminations initiated by the provider or by the PHP) to the Department or to the affected Members within the timeframes required by *Section V.D.2. Provider Network Management.*	$100 per Calendar Day per Member for failure to timely notify the affected Member
33.	Reserved.	Reserved.
34.	Failure to notify a provider of the network contracting decision within five (5) Business Days of verification of the provider's status as a Medicaid Enrolled provider.	$50 per Calendar Day per provider
35.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in *Section V.D.1. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$2,500 per month for failure to meet any of the listed standards, either individually or in combination
36.	Failure to timely submit a PHP Network Data File that meets the Department's specifications.	$250 per Calendar Day

Second Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
37.	Failure to maintain accurate provider directory information as required by *Section V.D.2. Provider Network Management.*	$100 per confirmed incident
38.	Failure to timely provide notice to the Department of capacity to serve the PHP's expected enrollment as described in *Section V.D.1. Provider Network.*	$2,500 per Calendar Day
39.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.E.1. Quality Management and Quality Improvement.*	$5,000 per Calendar Day
40.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per Calendar Day
41.	Failure to timely submit QAPI to the Department as described in *Section V.E.1. Quality Management and Quality Improvement.*	$1,000 per Calendar Day
42.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.3. National Committee for Quality Assurance (NCQA) Association.*	$100,000 per month for every month beyond the month NCQA accreditation must be obtained
43.	Failure to timely submit monthly encounter data set certification.	$1,000 per Calendar Day
44.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Attachment J: Reporting Requirements.*	$2,000 per Calendar Day
45.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section V.I.2 Medical Loss Ratio* and *Attachment and Attachment J. Reporting Requirements.*	$2,000 per Calendar Day
46.	Failure to timely and accurately submit financial reports in accordance with *Attachment J: Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per Calendar Day
47.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.J.3. Fraud, Waste and Abuse Prevention.*	$5,000 per Calendar Day that the Department determines the PHP is not in compliance
48.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.J.1. Compliance Program* and *Attachment J: Reporting Requirements.*	$1,000 per Calendar Day
49.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.J.4. Third Party Liability* and *Attachment J: Reporting Requirements*	$250 per Calendar Day
50.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$2,500 per incident for failure to fully cooperate during an investigation
51.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the PHP's own conduct, a provider, or a Member.	$250 per Calendar Day
52.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.J.3. Fraud, Waste and Abuse Prevention* and *Attachment J: Reporting Requirements.*	$2,000 per Calendar Day
53.	Failure by the PHP to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$500 per Member per occurrence per AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the PHP's failure to comply with the terms of this Contract, the PHP shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.

Second Revised and Restated Section VI.A. Table 1: PHP Liquidated Damages		
No.	**PROGRAM ISSUES**	**DAMAGES**
54.	Failure by the PHP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$500 per Member per occurrence
55.	Failure by the PHP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500 per Member per occurrence, not to exceed $10,000,000
56.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$500 per Calendar Day that the Department determines the PHP is not in compliance
57.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$1,000 per occurrence per committee that the Department determines the PHP is not in compliance
58.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$500 per Calendar Day the unapproved agreement or materials are in use
59.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$1,500 per occurrence per plan/program that the Department determines the PHP is not in compliance
60.	Failure to provide a timely and acceptable corrective action plan or comply with a corrective action plan as required by the Department.	$500 per Calendar Day for each day the corrective action plan is late, or for each day the PHP fails to comply with an approved corrective action
61.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$500 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
62.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$1,000 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)

b. Section VI.B. Service Level Agreements, Section VI.A. Table 2: First Revised and Restated PHP Service Level Agreement is revised and restated as follows:

Second Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Member Enrollment Processing	The PHP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the PHP to its system to trigger enrollment and disenrollment processes.	Daily	$1,000 per occurrence
2.	Member Appeals Resolution -Standard	The PHP shall resolve at least ninety-eight percent (98%) of PHP internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month

Second Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Member Appeals Resolution -Expedited	The PHP shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the PHP within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$10,000 per month
4.	Member Grievance Resolution	The PHP shall resolve at least ninety-eight percent (98%) of Member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the PHP within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$5,000 per month
5.	Adherence to the Preferred Drug List	The PHP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
6.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
7.	Call Response Time/Call Answer Timeliness -Member Services line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
8.	Call Wait/Hold Times - Member Services line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
9.	Call Abandonment Rate – Member Services line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month

Second Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
10.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month
11.	Call Wait Time/Hold Times - Behavioral Health Crisis Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-eight percent (98%) of all incoming calls.	The time after the initial answer to an incoming call and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$15,000 per month
12.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
13.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$10,000 per month
14.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
15.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
16.	Call Response Time/Call Answer Timeliness -Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
17.	Call Wait/Hold Times - Provider Support Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$5,000 per month

Second Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
18.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month
19.	Call Response Time/Call Answer Timeliness -Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
20.	Call Wait/Hold Times - Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
21.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
22.	Encounter Data Timeliness/ Completeness – Medical	The PHP shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per claim per Calendar Day
23.	Encounter Data Timeliness/ Completeness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	$100 per claim per Calendar Day
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$25,000 per month
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$50,000 per week

Second Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
26.	Encounter Data Reconciliation - Pharmacy	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within thirty (30) Calendar Days or at least ninety-nine point eight (99.8%) of paid claim amounts reported on financial reports within sixty (60) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$100,000 per month
27.	Website User Accessibility	The PHP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.		Daily	$2,500 per occurrence
28.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month
29.	Timely response to electronic inquiries	The PHP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) business days of receipt.	Electronic inquires includes communications received via email, fax, web or other communications received electronically by the PHP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence (each communication outside of the standard for the month)
30.	Encounter Data Reconciliation - Medical	The encounters submitted by the PHP shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine point eight (99.8%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the PHP.	Monthly	$10,000 per month

4. Modifications to Section VII. Attachments A-N of the Contract.

Specific attachments and subsections are modified as stated herein.

a. **Attachment 2: Section VII. Attachment B. Clinical Coverage Policy List is revised and restated in its entirety as set forth in** Attachment 2, *Attachment B. First Revised and Restated Clinical Coverage Policy List,* to this Amendment.

b. **Attachment 3: Section VII. Attachment E. Required PHP Quality Metrics is revised and restated in its entirety as set forth in** Attachment 3, *Attachment E. First Revised and Restated Required PHP Quality Metrics*, to this Amendment.

c. **Attachment 4: Section VII. Attachment F. First Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards is revised and restated in its entirety as set forth in** Attachment 4, *Attachment F. Second Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards,* to this Amendment.

d. **Attachment 5: Section VII. Attachment G. First Revised and Restated Required Standard Provisions for PHP and Provider Contracts is revised and restated in its entirety as set forth in** Attachment 5, *Attachment G. Second Revised and Restated Required Standard Provisions for PHP and Provider Contracts*, to this Amendment.

e. **Attachment 6: Section VII. Attachment J. Reporting Requirements is revised and restated in its entirety as set forth in** Attachment 6, *Attachment J. First Revised and Restated Reporting Requirements*, to this Amendment.

f. **Attachment 7: Section VII. Attachment M.1. North Carolina Medicaid Managed Care Enrollment Policy is revised and restated in its entirety as set forth in** Attachment 7, *Attachment M.1. North Carolina Medicaid Managed Care Enrollment Policy*, to this Amendment.

g. **Attachment 8: Section VII. Attachment M.2. Advanced Medical Home Program Policy is revised and restated in its entirety as set forth in** Attachment 8, *Attachment M.2. First Revised and Restated Advanced Medical Home Program Policy*, to this Amendment.

h. **Attachment 9: Section VII. Attachment M.6. Uniform Credentialing and Re-credentialing Policy is revised and restated in its entirety as set forth in** Attachment 9, *Attachment M.6. First Revised and Restated Uniform Credentialing and Re-credentialing Policy*, to this Amendment.

i. **Attachment 10: Section VII. Attachment M.7. Management of Inborn Errors of Metabolism Policy is revised and restated in its entirety as set forth in** Attachment 10, *Attachment M.7. First Revised and Restated Management of Inborn Errors of Metabolism Policy*, to this Amendment.

j. **Attachment 11: Section VII. Attachment A – N is modified to add** *Attachment M. 9. Healthy Opportunities Screening Questions* as set forth in in Attachment 11 to this Amendment.

5. **Effective Date:** This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

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

Execution:

By signing below, the Parties execute this Amendment in their official capacities and agree to the amended terms and conditions outlined herein as of the Effective Date.

PHP Name

_____ Date: _____

PHP Signature

Department of Health and Human Services

_____ Date: _____

Dave Richard
Deputy Secretary
NC Medicaid

Attachments to the Amendment

Attachment 1: *Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services*

Attachment 2: *Attachment B. First Revised and Restated Clinical Coverage Policy List*

Attachment 3: *Attachment E. First Revised and Restated Required PHP Quality Metrics*

Attachment 4: *Attachment F. Second Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards*

Attachment 5: *Attachment G. Second Revised and Restated Required Standard Provisions for PHP and Provider Contracts*

Attachment 6: *Attachment J. First Revised and Restated Reporting Requirements*

Attachment 7: *Attachment M.1. First Revised and Restated North Carolina Medicaid Managed Care Enrollment Policy*

Attachment 8: *Attachment M.2. First Revised and Restated Advanced Medical Home Program Policy*

Attachment 9: *Attachment M.6. First Revised and Restated Uniform Credentialing and Re-credentialing Policy*

Attachment 10: *Attachment M.7. First Revised and Restated Management of Inborn Errors of Metabolism Policy*

Attachment 11: *Attachment M. 9. Healthy Opportunities Screening Questions*

Attachment 1: Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
Inpatient hospital services	Services that – Are ordinarily furnished in a hospital for the care and treatment of inpatients; Are furnished under the direction of a physician or dentist; and Are furnished in an institution that - (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66. Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to Subsection 1.1.1, above)	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. § 440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Health Choice State Plan, Section 6.2.1 NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY MEDICAID	COVERED BY NCHC
	may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a). Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid and NCHC beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven (7)-consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS.			

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program			
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that— Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Health Choice State Plan, Section 6.2.2	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program			
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions *Section V.C.2.: Early and periodic screening, diagnostic and treatment services (EPSDT)* of the Contract	YES	NO
Nursing facility services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. § 440.40 42 C.F.R. § 440.140 42 C.F.R. § 440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 3A	YES	YES
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h NC Health Choice State Plan, Section 6.2.3 NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
	common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.	NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia		

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation		

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial		

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) NC Clinical Coverage Policy 1B-2, Rituximab (Rituxan) NC Clinical Coverage Policy 1B-3, Intravenous Iron Therapy		
Rural health clinic services	Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for "physician services" and "physician-directed services" whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. Child health assistance in RHCs is authorized for NC	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	Health Choice beneficiaries in 42 U.S.C. 1397jj(a)(5). The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	NC Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics		
Federally qualified health center services	Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program. Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in U.S.C. 1397jj(a)(5). The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee	YES	YES

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics		
Telemedicine	The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telemedicine and Telepsychiatry	YES	YES
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Health Choice State Plan, Section 6.2.8	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services		
Family planning services	Regular Medicaid Family Planning (Medicaid FP) and NCHC services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Health Choice State Plan Section 6.2.9	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	medically approved methods, supplies, and devices to prevent conception.	NC Clinical Coverage Policy 1E-7, Family Planning Services		
Certified pediatric and family nurse practitioner services	(a) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section. If the State specifies qualifications for pediatric nurse practitioners, the practitioner must - i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. If the State specifies qualifications for family nurse practitioners, the practitioner must -	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a	YES	YES

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	Be currently licensed to practice in the State as a registered professional nurse; and Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and Have a family nurse practice limited to providing primary health care to individuals and families.			
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11	YES	NO
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 NC NEMT Policy	YES	NO
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program or NC Health Choice beneficiaries. Transport is provided only	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18	YES	YES

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary. Ambulance services include only emergency transport via ground and air medical ambulance for a NCHC beneficiary.	NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15		
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2	YES	NO
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Health Choice State Plan, Sections 6.2.6, 6.2.7 NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters *Section V.C.3. Pharmacy Benefits* of the Contract		
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist. (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Health Choice State Plan Section 6.2.5	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program			
Physical therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages7c, 7c.15 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks,	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
	including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)		
Speech, hearing and language disorder services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
Limited inpatient and outpatient behavioral health services defined in	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
required clinical coverage policy	Please refer to NC Clinical Coverage Policies and services listed.	NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): Mobile Crisis Management Diagnostic Assessment Partial Hospitalization Professional Treatment Services in Facility-based Crisis Ambulatory Detoxification Non-hospital Medical Detoxification Medically Supervised or ADATC Detox Crisis Stabilization Outpatient Opioid Treatment NC Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers		
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	SSA, Title XIX, Section 1905(a)(28) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A,	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services		
Other diagnostic, screening, preventive and rehabilitative services	(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5	YES	NO

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level			
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, "is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less."	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care	YES	YES
Optometry services	Medicaid and NCHC shall cover the following optical services when provided by ophthalmologists and optometrists: a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids. Opticians may dispense approved visual aids.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a NC Health Choice State Plan Section 6.2.12	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21		
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services	YES	YES
Private duty nursing services	Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. § 440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age	YES	NO

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing and employed by a licensed home care agency. A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.			
Personal care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)	YES	NO

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			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
	(IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c. In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.			
Hospice services	The North Carolina Medicaid (Medicaid) and NC Health Choice (NCHC) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3D, Hospice Services	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.			
Durable medical equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: 1. Inexpensive or routinely purchased items 2. Capped rental/purchased equipment 3. Equipment requiring frequent and substantial servicing 4. Oxygen and oxygen equipment 5. Related medical supplies 6. Service and repair 7. Other individually priced items 8. Enteral nutrition equipment	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Health Choice State Plan Section 6.2.12, 6.2.13 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies	YES	YES

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		NC Clinical Coverage Policy 5B, Orthotics & Prosthetics		
Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics	YES	YES
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) or NC Health Choice (NCHC) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES	YES
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b	YES	NO

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services		
Inpatient psychiatric services for individuals under age 21	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Health Choice State Plan Section 6.2.10 NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services	YES	YES
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma		

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	DESCRIPTION	KEY REFERENCES	MEDICAID	NCHC
		NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation		

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multi-visceral Transplants		
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device	YES	YES
Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy	YES	YES
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services	YES	YES

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

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
			COVERED BY	
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**MEDICAID**	**NCHC**
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES	YES
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES	YES
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit	YES	NO
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)	YES	NO

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
		NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home		
Ophthalmological Services	General ophthalmologic services include a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	services or in which special treatment is given.			
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administration Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older	YES	YES
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**COVERED BY NCHC**
		NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision		
Vision Services	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21	YES	YES
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual patient communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring	YES	YES

Second Revised and Restated Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	**DESCRIPTION**	**KEY REFERENCES**	**COVERED BY MEDICAID**	**NCHC**
	remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.			

Attachment B. First Revised and Restated Clinical Coverage Policy List

The *First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List* below documents the complete list of Clinical Coverage Policies the Department maintains currently for its Fee-for-Service program. Full detail on the policies is available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
Allergies	1N-1: Allergy Testing 1N-2: Allergy Immunotherapy
Ambulance Services	15: Ambulance Services
Anesthesia	1L-1: Anesthesia Services 1L-2: Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Burn Treatment and Skin Substitutes	1G-1: Burn Treatment 1G-2: Skin Substitutes
Chiropractic Services	1F: Chiropractic Services
Cardiac	1R-1: Phase II Outpatient Cardiac Rehabilitation Programs 1R-4: Electrocardiography, Echocardiography, and Intravascular Ultrasound
Community Based Services	3A: Home Health Services 3D: Hospice Services 3G-1: Private Duty Nursing for Beneficiaries Age 21 and Older 3G-2: Private Duty Nursing for Beneficiaries Under 21 years of Age 3H-1: Home Infusion Therapy 3L: State Plan Personal Care Services (PCS)
Dietary Evaluation and Counseling and Medical Lactation Services	1-I: Dietary Evaluation and Counseling and Medical Lactation Services
Facility Services	2A-1: Acute Inpatient Hospital Services 2A-2: Long Term Care Hospital Services 2A-3: Out-of-State Services 2B-2: Geropsychiatric Units in Nursing Facilities

First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
Hearing Aid Services	7: Hearing Aid Services
Laboratory Services	1S-1: Genotyping and Phenotyping for HIV Drug Resistance Testing 1S-2: HIV Tropism Assay 1S-3: Laboratory Services 1S-4: Genetic Testing 1S-8: Drug Testing for Opioid Treatment and Controlled Substance Monitoring
Maternal Support Services (Baby Love)	1M-2: Childbirth Education 1M-3: Health and Behavior Intervention 1M-4: Home Visit for Newborn Care and Assessment 1M:5, Home Visit for Postnatal Assessment and Follow-up Care 1M-6: Maternal Care Skilled Nurse Home Visit
Medical Equipment	5A-1: Physical Rehabilitation Equipment and Supplies 5A-2: Respiratory Equipment and Supplies 5A-3: Nursing Equipment and Supplies 5B: Orthotics & Prosthetics
Obstetrics and Gynecology	1E-1: Hysterectomy 1E-2: Therapeutic and Non-Therapeutic Abortions 1E-3: Sterilization Procedures 1E-4: Fetal Surveillance 1E-5: Obstetrics 1E-6: Pregnancy Medical Home
Ophthalmological Services	1T-1: General Ophthalmological Services 1T-2: Special Ophthalmological Services
Physician	1A-2: Preventive Medicine Annual Health Assessment 1A-3: Noninvasive Pulse Oximetry 1A-6: Invasive Electrical Bone Growth Stimulation 1A-7: Neonatal and Pediatric Critical and Intensive Care Services 1A-8: Hyperbaric Oxygenation Therapy 1A-9: Blepharoplasty/Blepharoptosis (Eyelid Repair) 1A-11: Extracorporeal Shock Wave Lithotripsy 1A-12: Breast Surgeries 1A-13: Ocular Photodynamic Therapy

First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
	1A-14: Surgery for Ambiguous Genitalia 1A-15: Surgery for Clinically Severe or Morbid Obesity 1A-16: Surgery of the Lingual Frenulum 1A-17: Stereotactic Pallidotomy 1A-19: Transcranial Doppler Studies 1A-20: Sleep Studies and Polysomnography Services 1A-21: Endovascular Repair of Aortic Aneurysm 1A-22: Medically Necessary Circumcision 1A-24: Diabetes Outpatient Self-Management Education 1A-25: Spinal Cord Stimulation 1A-26: Deep Brain Stimulation 1A-27: Electrodiagnostic Studies 1A-28: Visual Evoked Potential (VEP) 1A-30: Spinal Surgeries 1A-31: Wireless Capsule Endoscopy 1A-32: Tympanometry and Acoustic Reflex Testing 1A-33: Vagus Nerve Stimulation for the Treatment of Seizures 1A-34: End Stage Renal Disease (ESRD) Services 1A-38: Special Services: After Hours 1A-40: Fecal Microbiota Transplantation 1A-41: Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone 1A-42: Balloon Osital Dilation
Podiatry	1C-1: Podiatry Services 1C-2: Medically Necessary Routine Foot Care
Radiology	1K-1: Breast Imaging 1K-2: Bone Mass Measurement 1K-6: Radiation Oncology 1K-7: Prior Approval for Imaging Services
Reconstructive Surgery	1-O-1: Reconstructive and Cosmetic Surgery 1-O-2: Craniofacial Surgery 1-O-3: Keloid Excision and Scar Revision 1-O-5: Rhinoplasty and/or Septorhinoplasty
Rural Health Clinics, FQHCs and Health Departments	1D-1: Refugee Health Assessments Provided in Health Departments 1D-2: Sexually Transmitted Disease Treatment Provided in Health Departments 1D-3: Tuberculosis Control and Treatment Provided in Health Departments

First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
	1D-4: Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Solid Organ Transplants	11B-1: Lung Transplantation 11B-2: Heart Transplantation 11B-3: Islet Cell Transplantation 11B-4: Kidney (Renal) Transplantation 11B-5: Liver Transplantation 11B-6: Heart/Lung Transplantation 11B-7: Pancreas Transplant 11B-8: Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Specialized Therapies	10A: Outpatient Specialized Therapies 10B: Independent Practitioners (IP) 10D: Independent Practitioners Respiratory Therapy Services
Stem Cell or Bone Marrow Transplants	11A-1: Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) 11A-2: Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia) 11A-3: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Chronic Myelogenous Leukemia 11A-5: Allogeneic Hematopoietic & Bone Marrow Transplant for Genetic Diseases and Acquired Anemias 11A-6: Hematopoietic Stem-Cell & Bone Marrow Transplantation in the Treatment of Germ Cell Tumors 11A-7: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Hodgkin Lymphoma 11A-8: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Multiple Myeloma and Primary Amyloidosis 11A-9: Allogeneic Stem-Cell & Bone Marrow Transplantation for Myelodysplastic Syndromes & Myeloproliferative Neoplasms 11A-10: Hematopoietic Stem-Cell & Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors & Ependymoma 11A-11: Hematopoietic Stem-Cell & Bone Marrow Transplant for Non-Hodgkin's Lymphoma 11A-14: Placental and Umbilical Cord Blood as a Source of Stem Cells

First Revised and Restated Section VII. Attachment B. Table 1: Clinical Coverage Policy List	
CLINICAL SUBJECT	**SCOPE**
	11A-15: Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood 11A-16: Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring
Ventricular Assist Device	11C: Ventricular Assist Device
Vision Services	6A: Routine Eye Exam and Visual Aids for Recipients Under Age 21

Attachment E. First Revised and Restated Required PHP Quality Metrics

The Section VII. Attachment E. Table 1: Survey Measures and General Measures list the Department's quality and administrative measures that are meant to provide the Department with a complete picture of PHP's processes and performance as described in Section V.E. Quality and Value. These Measures include a select set of Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

The PHP shall track all measures listed below. The Department will review and update the quality measures annually and reflect any updates in the Technical Specifications. The Department will monitor other measures that are not included in the table below and may engage with PHPs around these performance measures. An asterisk (*) indicates that the measure is calculated by the Department.

First Revised and Restated Section VII. Attachment E. Table 1. Survey and General Measures			
Reference #	*NQF #*	*Measure Name*	*AMH Measure*
1.	N/A	Child and Adolescent Well-Care Visit (WCV)	x
2.	1516	Well-Child Visits in the First 30 Months of Life (W30)	x
3.	N/A	Total Eligibles Receiving at least One Initial or Periodic Screen (EPSDT)	
4.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
5.	0032	Cervical Cancer Screening (CSC)	x
6.	0038	Childhood Immunization Status (Combination 10) (CIS)	x
7.	0033	Chlamydia Screening in Women (Total Rate) (CHL)	x
8.	0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC).	x
9.	0018	Controlling High Blood Pressure (CBP)	x
10.	0039	Flu Vaccinations for Adults (FVA, FVO)*	
11.	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	
		7- Day Follow-up	
		30-Day Follow-up	
12.	1517	Prenatal and Postpartum Care (Both Rates) (PPC)	
		Timeliness of Prenatal Care	
		Postpartum Care	

13.	1407	Immunizations for Adolescents (Combination 2) (IMA)	x
14.	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	
15.	N/A	Low Birthweight[1]	
16.	2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	
17.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	
18.	N/A	Rate of Screening for Pregnancy Risk	
19.	N/A	Rate of Screening for Unmet Resource Needs	
20.	0418/04118e	Screening for Depression and Follow-Up Plan (DSF)	x
21.	2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	
22.	1768	Plan All-Cause Readmissions	x
23.	N/A	Total Cost of Care*	x

[1] The Department will work jointly with the plans to report this measure.

Attachment G. Second Revised and Restated Required Standard Provisions for PHP and Provider Contracts

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

1. **Contracts between the PHP and Providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices, that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the PHP utilizes the definition as found in Section III.A. of the PHP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the PHP capitated contract with the Department.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. PHP shall specifically include a provision permitting the PHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.
    e. Survival. The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the PHP's insolvency the contract mustaddress:
            1. Transition of administrative duties and records;and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the PHP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the PHP's network participation requirements as outlined in the PHP's Credentialing and Re-credentialing Policy and to notify the PHP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 45 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
            1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
            2. During Provider Credentialing under Full Implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
    g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the PHP and to notify the PHP of subsequent changes in status of professional liability insurance on a timely basis.
    h. Member Billing: The contract must address the following:
        i. That the provider shall not bill any Medicaid Managed Care Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the

Member's own expense, as long as the provider has notified the Member in advance that the PHP may not cover or continue to cover specific services and the Member to receive the service; and

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

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

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

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

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

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

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

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

m. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5).

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

i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.

ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.

iii. Notification of changes in these requirements shall also be provided by the PHP, allowing providers time to comply with such changes.

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

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

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

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

i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the PHP.

ii. The PHP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

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

t. Interpreting and Translation Services: The contract must have provisions that indicate:

i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
ii. The provider must ensure the provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
iii. The provider shall report to the PHP, in a format and frequency to be determined by the PHP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

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

v. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH care management model and requirements consistent with the Department's Advanced Medical Home Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's Advanced Medical Home Program.

w. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with a LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

x. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
i. G. S. 58-3-200(c).
ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
iii. G.S. 58-50-270(1), (2), and (3a).
iv. G.S. 58-50-275 (a) and (b).
v. G.S. 58-50-280 (a) through (d).
vi. G.S. 58-50-285 (a) and (b).
vii. G.S. 58-51-37 (d) and (e).

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

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

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

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

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

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

a. Attachment M. 2. Advanced Medical Home Program Policy
b. Attachment M. 3. Pregnancy Management Program Policy
c. Attachment M. 4. Care Management for High-Risk Pregnancy Policy
d. Attachment M. 5. Care Management for At-Risk Children Policy

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

a. Compliance with State and Federal Laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination

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

e. Department authority related to the Medicaid program

The [Provider] agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance

under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

f. Access to provider records

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

i. The United States Department of Health and Human Services or its designee;
ii. The Comptroller General of the United States or its designee;
iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee
iv. The Office of Inspector General
v. North Carolina Department of Justice Medicaid Investigations Division
vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
vii. The North Carolina Office of State Auditor, or its designee
viii. A state or federal law enforcement agency.
ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

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

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

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

The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

x. For Medical claims (including behavioral health):
    1. The [Company] shall within eighteen (18) calendar days of receiving a Medical Claim notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to process the claim.
    2. The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

3. *A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.*

xi. *For Pharmacy Claims:*

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

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

1. *The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties ifapplicable).*

xiii. *If the [Company]fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.*

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

xv. *The [Company] shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require the [Provider] to requests the interest or thepenalty.*

h. Contract Effective Date.

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

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

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

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

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

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

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

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

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

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

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

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

Section VII. Attachment F. Second Revised and Restated. Table 1: PHP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
12	All State Plan LTSS (except nursing facilities)*	PHP must have at least 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
13	Nursing Facilities*	PHP must have at least 1 nursing facility accepting new patients in every county.	PHP must have at least 1 nursing facility accepting new patients in every county.

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

Section VII. Attachment F. Second Revised and Restated. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient Behavioral Health Services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (OTP) (adult)

Section VII. Attachment F. Second Revised and Restated. Table 2: Definition of Service Category for Behavioral Health Time and Distance Standards		
Reference Number	**Service Type**	**Definition**
3.	Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult • Facility-based crisis services for children and adolescents • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center(ADATC) detoxification crisis stabilization (adult)
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

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

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

Section VII. Attachment F. Second Revised and Restated. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar days
Specialty Care			
6	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar days
8	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Behavioral Health Care			
9	Mobile Crisis Management Services	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within two (2) hours
10	Urgent Care Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours

Section VII. Attachment F. Second Revised and Restated. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
11	Urgent Care Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
13	Routine Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Within fourteen (14) calendar days
14	Emergency Services for Mental Health	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
15	Emergency Services for SUDs	Refer to *Attachment M. 8.: Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

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

Section VII. Attachment F. Second Revised and Restated. Table 4: Specialty Care Providers	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery

Section VII. Attachment F. Second Revised and Restated. Table 4: Specialty Care Providers	
Reference Number	**Service Type**
8a.	Gynecology[1]
9.	Infectious Disease
10.	Hematology
11.	Nephrology
12.	Neurology
13.	Oncology
14.	Ophthalmology
15.	Optometry
16.	Orthopedic Surgery
17.	Pain Management (Board Certified)
18.	Psychiatry
19.	Pulmonology
20.	Radiology
21.	Rheumatology
22.	Urology

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

Attachment M. POLICIES

7. First Revised and Restated Management of Inborn Errors of Metabolism Policy

1. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.
2. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.
3. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that PHP cover the full cost of therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized care plan.
4. Once a client is established with a specialized treatment facility a nutrition care plan is developed and products prescribed. The current system of product coverage is four pronged:

    a. Clients with health insurance coverage fill their metabolic formula prescriptions through pharmacies or Durable Medical Equipment (DME) suppliers.

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

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

    d. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

5. The PHP will need to establish working relationships with the NSB, Specialty Treatment Centers, and metabolic formula suppliers/manufacturers.

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

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

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

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

Attachment J. First Revised and Restated Reporting Requirements

The following table details the Medicaid Managed Care Program reports that the PHP must submit to the Department. The PHP shall submit reports in the format, frequency and method that is defined in the NC PHP Report Guide. The NC PHP Report Guide provides guidance specific to each report. The Department shall maintain the NC PHP Report Guide, along with all applicable report templates, and publish to the PHP via the PHP Contract Data Utility (PCDU) with effective date. If a technical change is made to a template before the next NC PHP Report Guide version is published, a revised template will be posted to the PCDU with its new effective date. Each of the report templates contain specific data elements required, data definitions, and required formats.

Although the State has indicated the reports that are required, the PHP may suggest additional reports.

1. As part of Readiness Activities, the PHP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
2. The Department reserves the right to require additional reports beyond what is included in this Attachment, which shall be added by Amendment. The PHP shall submit all report formats to the Department for approval. Reports require approval by the Department before being considered final.

First Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
1. ***Administration and Management***	
a. PHP Operating Report	Annual report of each entity identified under the PHP Operating Report, providing evidence of PHP oversight activities and entity performance (i.e. metrics, CAPs, sanctions)
2. ***Members***	
a. PHP Enrollment Extract	Weekly detail and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
b. Member Services Quality Assurance Report	Quarterly report of survey results which measures member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
c. Member Marketing and Educational Activities Report	Quarterly summary of Member marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.

d. Planned Marketing Procedures, Activities, and Methods	Annual report of planned marketing activities including number/types of events, locations, description of materials distributed, and number of Members reached.
e. Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs
g. Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PHP including the total number of appeal and grievance requests filed with the PHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.
h. PHP Enrollment Summary Report	Monthly summary report, and underlying data, highlighting key Member enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.
i. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).
j. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report of non-verifiable Member addresses and returned mail.
k. Nursing Facility Admission Disenrollment Report	Ad hoc report on Member disenrollment from a PHP due to a Nursing Facility stay longer than 90 days.
l. Clearinghouse Daily Uploads Extract	Tracking file submitted for each daily or monthly upload to the PCG Clearinghouse of each initial Notice of Adverse Benefit Determination (NABD) and Resolution Notice of Adverse Benefit Determination sent to members.
m. Monthly PHP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems.
3. ***Benefits and Care Management***	
a. Institute of Mental Disease (IMD) Report	Alternate-week report providing the prior two calendar weeks' summary of members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provide NPI, facility admission date and facility discharge date.
b. Pharmacy Benefit Determination/Prior Authorization Report	Monthly report provides summary information on pharmacy prior approval requests.
c. ProDUR Alert Report	Quarterly report highlighting prospective alerts and responses for pharmacy claims.
d. Top GSNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.
e. Ad Hoc and Trigger Report	Quarterly report containing activities and adhoc report, summary of total paid claims, and trigger report with comparison of top 200 GC3s by claim count.
f. EPSDT Report	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.

g. Non-Emergency Medical Transportation (NEMT) Report	Monthly report highlighting the NEMT utilization, monthly requests received, processed, denied and open where the date of service falls within the reporting range.
h. Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.
i. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Programs.
j. Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots.
k. CMARC and CMHRP Corrective Action Plan Report	Quarterly report on Care Management for At-Risk Children & and Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.
l. Care Needs Screening Report	Quarterly report of beneficiary screening results including SDOH and Care Needs Screening.
m. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management payments.
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. AMH Integration Contracting Report	Monthly AMH Tier 3 practices contracting and integration status report
p. Nursing Facility Transitions Report	Quarterly report tracking the number and disposition of Members discharged from a nursing facility.
q. Ongoing Transitions of Care Status Report	Monthly report to provide a status update of PHP's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFP and the Department's Transitions of Care policy.
r. High Needs Members Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members.
s. Crossover-Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.
t. Quarterly Admission and Readmission Report	Quarterly summary report of admission and readmission trends.
u. Service Line Issue Summary Report	Quarterly report to identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.
v. Medical Prior Authorization Extract	Weekly detail data extract of medical prior authorizations.
w. Pharmacy Prior Authorization Extract	Weekly detail data extract of pharmacy prior authorizations.
x. Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.

c. Network Adequacy Exceptions Narrative Report	Quarterly narrative report of active granted network adequacy exceptions, including date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with PRV001-J Network Adequacy Exceptions Report
d. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy.
e. Provider Contracting Determinations and Activities Report	Quarterly and ad hoc report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Provider Contracting Determinations and Activities Narrative Report	Quarterly and ad hoc narrative report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with PRV005-J: Provider Contracting Determinations and Activities Narrative Report.
g. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.
h. Network Adequacy Annual Submission Report	Annual and Ad hoc report demonstrating the geographical location of providers in the Provider Network in relationship to where Medicaid Members live.
i. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.
j. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. To be submitted with the Timely Access Physical Health Provider Appointment Wait Times Report.
k. Essential Provider Alternate Arrangements Narrative Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how Members needs are being met, the PHPs work to alleviate the inadequacy. To be submitted with the Essential Alternate Arrangements Report.
l. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. To be

	submitted with the Timely Access Behavioral Health Provider Appointment Wait Times Report.
m. Rate Ceiling Necessity Report	Ad hoc report to identify provider types for which the PHP recommends an establishment of a rate ceiling, to include information supporting the recommendation.
n. Provider Grievances, Appeals, and Litigated Appeals Report	Monthly report on log of all provider appeals and grievances and key provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, average time to resolution. 42 C.F.R. § 438.66(c)(3).
o. FQHC RHC Summary Remittance Advice Report	Quarterly report for FQHC/RHC claims data used to enable wrap payments.
p. Local Health Department Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.
q. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to capture claims data, calculations, and summary report for Public Ambulance Provider directed payments.
r. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.
s. Out of Network (OON) Service Requests Report	Monthly report on all requests for out-of-network services including status or requests, number of approval or denial, and the decision reasoning
t. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).
u. Summary UNC_ECU Physician Claims Report	Quarterly report to capture claims data to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.
v. NEMT Provider Contracting Report	Quarterly report to capture non-emergency provider contracting report at a detailed and summary level from the PHP's.
w. Capitation Reconciliation Report	Monthly report that PHPs will leverage the to inform the State of any capitation related payment discrepancies observed. PHPs will include records of beneficiaries where no payment was received from the State or payment received differed from the amount expected. PHPs will only include beneficiary records with discrepancies on this report to the State. The PHP Capitation Reconciliation Report will be submitted on a monthly cadence. PHPs will indicate expected values and values observed on ASC x12 834 monthly file for beneficiaries.
x. Suspended and Terminated Providers Report	Monthly report showing suspended claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department

	or otherwise fail to meet Department requirements. PHP shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Referenced in V.D.2.j.i.a / V.D.2.j.i.b.
5. ***Quality and Value***	
a. QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. VBP Assessment	Annual retrospective report documenting VBP contracts in place and payments made under VBP arrangements.
d. VBP Strategy Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming Contract Year. These templates should be included in PHPs' VBP Strategies submitted to the Department annually.
e. VBP Strategy Narrative Report	Annual report projecting VBP contracts and payments expected to be made under VBP arrangements in the coming year. These templates should be included in PHPs' VBP Strategies submitted to the Department annually. To be submitted with VBP Strategy Templates.
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
6. ***Stakeholder engagement***	
a. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes incl. number served.
b. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by PHP to collaborate with county organizations to address issues by county/region.
7. ***Program Administration***	
a. Service Line Report	Quarterly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.
b. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, electronic communication response rate.
c. Training Evaluation Outcome Report	Annual report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).
8. ***Compliance***	
a. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.

b. Third Party Liability Report	Quarterly claim level detail of third party or cost avoidance activities by the PHP, including type of service, provider rendering services, and total amount paid and recovered/avoided.
c. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by provider including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
d. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.
e. Overpayment Recoveries Report	Annual report of overpayment recoveries. 42 C.F.R. § 438.604(a)(7).
f. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
g. Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.
h. Identification of Other Forms of Insurance and Report Start Date of Insurance Coverage Added for Cost Avoidance Report	Quarterly report to record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP. IV.4.d.
9. ***Financial Requirements***	
a. NC PHP Financial Report	A consolidated reporting packet of all finance related reporting requirements. Specific submission instructions and details are located in the associated companion guide with the report template.
b. Financial Arrangements with Drug Companies Report	Bi-annual report that describes all financial terms and arrangements between the PHP and any pharmaceutical drug manufacturer or distributor.
c. Risk Corridor Service Ratio Report	Interim, Preliminary and Final Risk Corridor Service Ratio reports providing information on the components of the Risk Corridor Service Ratio and Primary Care Expenditure Percentage requirements.

Attachment M. POLICIES

1. First Revised and Restated North Carolina Medicaid Managed Care Enrollment Policy

a) **Background**

The Department will ensure that Medicaid[1] and NC Health Choice beneficiaries, their families and caregivers are supported in the transition to Medicaid Managed Care throughout the enrollment process, including selecting a Prepaid Health Plan (PHP) and an advanced medical home (AMH) and/or primary care provider (PCP). The Department will ensure beneficiaries and their families have the tools and resources to access care and experience a smooth transition from Medicaid Fee-For-Service to Medicaid Managed Care, and throughout Medicaid Managed Care implementation.

The Department is planning to implement Medicaid Managed Care in two (2) phases based on Regions, with distinct open enrollment periods for each phase, for the initial transition of beneficiaries from Medicaid Fee-for-Service to Medicaid Managed Care to ensure successful implementation.

b) **Scope**

The North Carolina Medicaid Managed Care Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the PHPs in the enrollment of beneficiaries into Medicaid Managed Care. The intent of this Policy is not to replace any existing enrollment processes related to Medicaid Fee-For-Service and/or Local Management Entities/Managed Care Organizations (LME/MCOs).

c) **Populations Eligible for Medicaid Managed Care**

The Department is responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt, or mandatory at any point in time. The PHP must adhere to Medicaid Managed Care eligibility determinations made by the Department and enroll or disenroll beneficiaries in accordance with those determinations and this Policy. Populations to be excluded, exempt or mandatory in Medicaid Managed Care are defined in the Contract.

d) **Medicaid Managed Care Eligibility Determinations**

The Department is responsible for performing, managing and maintaining all Medicaid Managed Care enrollment and cost sharing eligibility determinations. It is the responsibility of the Enrollment Broker, the PHP and other partners of the Department operating within Medicaid Managed Care to adhere to the determinations made by the Department.

e) **Prepaid Health Plan Enrollment**

i. Consistent with 42 C.F.R. § 438.810, the Department will contract with an Enrollment Broker to provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives, who want to select a PHP and an AMH/PCP or have questions about Medicaid Managed Care.

ii. Crossover populations

1. Open enrollment

a. To support beneficiary choice, the Department will offer the crossover population a sixty (60) calendar day open enrollment period to select a PHP prior to the scheduled transition date from Medicaid Fee-for-Service to Medicaid Managed Care.

[1] "Medicaid" includes both Medicaid and NC Health Choice programs within this Policy unless noted otherwise.

b. During the open enrollment period, the Enrollment Broker will engage in proactive outreach that explains the Enrollment Broker's services, provides managed care education, and supports PHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care.
c. If a beneficiary selects a PHP during the open enrollment period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.
d. If a beneficiary does not select a PHP during the open enrollment period, the Department will auto-assign the beneficiary to a PHP based on the Department's defined auto-assignment algorithm. The Department will transmit PHP assignment to the PHP through an 834 eligibility file.
e. For a beneficiary in a crossover population who selects a PHP, or who is auto-assigned into a PHP, coverage by the PHP begins on the first day of the scheduled transition date to Medicaid Managed Care for the specific crossover population. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.

2. Choice period
a. After coverage by a PHP begins, the Member will have ninety (90) calendar days to change his or her PHP without cause.
b. During the choice period, the Enrollment Broker will continue to provide choice counseling and support the Member with PHP and AMH/PCP selection.
c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the member selected the PHP.
d. If a Member does not select a different PHP during the choice period, the Member will remain in his or her PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

iii. Ongoing enrollment (post Medicaid Managed Care implementation)

1. New Medicaid applicants eligible for Medicaid Managed Care
a. New Medicaid applicants will have an opportunity to select a PHP and AMH/PCP as part of the eligibility application process.
b. If an applicant selects a PHP during the eligibility application process, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.
c. If an applicant does not select a PHP as part of the eligibility application process, the applicant will be auto-assigned to a PHP based on the Department-defined auto-assignment algorithm described in Section 6.f.vi. The Department will transmit the auto-assignment to the assigned PHP through an 834 eligibility file, if the applicant is determined eligible for Medicaid and is also determined eligible for Medicaid Managed Care.
d. For applicants determined Medicaid Managed Care eligible who select a PHP or who are auto-assigned into a PHP, coverage by the PHP begins on the first day of the month in which Medicaid eligibility is determined. However, the new Medicaid beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
e. Choice period
i. After coverage by the PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.

iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.

iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her previously selected or auto-assigned PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section 7.

2. New beneficiaries eligible for Medicaid Managed Care
   a. For a beneficiary determined eligible for Medicaid Managed Care after implementation, the beneficiary will be auto-assigned into a PHP based on the Department-defined auto-assignment algorithm.
   b. The Department will transmit the auto-assignment to the assigned PHP through an 834 eligibility file. Coverage by the assigned PHP will begin on the first day of the month in which the beneficiary is determined eligible for Medicaid Managed Care. However, the beneficiary will have an additional opportunity to select a different PHP during his or her choice period.
   c. Choice period
      i. After coverage by a PHP begins, a Member will have ninety (90) calendar days to change his or her PHP without cause.
      ii. During the choice period, the Enrollment Broker will provide choice counseling and support the Member with PHP and AMH/PCP selection.
      iii. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the new PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.
      iv. If a Member does not select a different PHP during the choice period, the Member will remain in his or her auto-assigned PHP until the Member's annual redetermination date, unless otherwise disenrolled from the PHP for reasons specified in Section f.

iv. Medicaid eligibility redetermination
1. Upon receiving a notice from the Department of the Member's upcoming annual redetermination, the Member may contact the Enrollment Broker prior to the redetermination decision to select a different PHP for his or her upcoming eligibility year.
2. If a Member is redetermined eligible for Medicaid and has not selected a different PHP prior to the redetermination decision, the Department will auto-assign the Member into the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care. However, the Member will have an additional opportunity to select a different PHP during his or her annual choice period.
3. Annual choice period
   a. If a Member is redetermined eligible for Medicaid, the Member will receive a notice from the Department and will be offered ninety (90) calendar days to select a different PHP.
   b. During the choice period, the Enrollment Broker will provide choice counseling and support the Member in PHP and AMH/PCP selection.
   c. If a Member selects a different PHP during the choice period, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file. Coverage of the Member by the new PHP will begin on the first day of the next month in which the Member selected the PHP.

d. If a Member is redetermined eligible and has not selected a different PHP during the choice period, the Member will remain in the same PHP from the prior eligibility year, provided that the PHP continues to participate in Medicaid Managed Care.
e. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, the Member will receive his or her choice period, plus additional time added to the choice period equal to the number of calendar days the redetermination decision was delayed.

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

v. Special cases

1. Exempt populations
   a. The Enrollment Broker will provide choice counseling to exempt populations and support PHP/Medicaid Fee-For-Service/Tribal Option (as applicable) and AMH/PCP selection throughout the beneficiary's eligibility year.
   b. If a beneficiary in an exempt population selects a PHP, the Enrollment Broker will transmit the PHP selection to the Department. The Department will transmit PHP selection to the PHP through an 834 eligibility file.
   c. If a beneficiary in an exempt population selects a different PHP, or delivery system (such as Medicaid Fee-For-Service or Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by the new PHP or delivery system begins on the first day of the next month in which the beneficiary selected the new PHP or delivery system.[2]
2. Deemed newborns
   a. If a Member is known to be pregnant, the PHP shall validate that the Member selects an AMH/PCP for the child prior to the birth.
   b. Upon delivery, a deemed newborn will be assigned to the mother's PHP, and the PHP will begin providing coverage to the newborn immediately. The PHP is responsible for the provision and payment of services for the deemed newborn in the hospital or birthing center, even if the deemed newborn has not appeared on the PHP's roster.
   c. If the PHP receives notification of birth prior to discharge, the PHP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.
   d. The PHP shall report the deemed newborn's birth to the Department within five (5) calendar days upon learning of the birth and, at a minimum, provide the Department with the mother's name, social security number, NC FAST case number, Member identification number, residing county, and the newborn's name, sex, and date of birth.
   e. If the PHP has not received confirmation of a deemed newborn's enrollment in the PHP through an 834 eligibility file following the deemed newborn's birth, the PHP shall notify the Department and the Enrollment Broker and send notification of the birth within sixty (60) calendar days from the date of delivery.
   f. If the newborn is enrolled in Medicaid, the PHP shall send a notification of the newborn's enrollment and issue a Member identification card for the newborn to the mother within fourteen (14) calendar days of learning of the birth. This notice must include information on how the mother or caregiver can access care for the newborn.

vi. PHP auto-assignment

1. In accordance with 42 C.F.R. § 438.54, the Department developed auto-assignment algorithms for every beneficiary determined Medicaid Managed Care eligible who does not select a PHP during

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

their open enrollment period (for crossover populations only) or during the Medicaid eligibility application process. The Department may use the auto-assignment algorithm in other instances deemed appropriate by the Department and as required by North Carolina or federal law or regulation.

2. In its sole discretion, the Department may change the auto-assignment algorithm.
3. For the crossover population and for a new beneficiary enrolled into Medicaid Managed Care, the auto-assignment algorithm is defined according to the following components in this order:
   a. Beneficiary's geographic location;
   b. Whether the beneficiary is a member of a special population (e.g. member of a federally recognized tribe, or BH I/DD Tailored Plan eligible).
   c. PHP/AMH selection upon application and PCP/AMH historic relationship.
   d. Plan assignments for other family members.
   e. Previous PHP enrollment during previous twelve (12) months (for those who have "churned" on/off Medicaid managed care).
   f. Equitable plan distribution with enrollment subject to:
      i. PHP enrollment ceilings and floors, per PHP, to be used as guides.
      ii. Increases in a PHP's base formula relative to their contributions to health-related resources, as described herein.
      iii. Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment.
4. A PHP that voluntarily contributes at least one-tenth (0.1) percent of its annual capitation revenue in a Region to health-related resources and/or health equity initiative, approved by the Department may be awarded a preference in auto-assignment as defined in the Contract.
5. To promote an equitable distribution of Medicaid Managed Care enrollment among the PHPs, the Department will enforce an auto-assignment floor of ten percent (10%) and a ceiling of forty percent (40%) percent of Medicaid Managed Care Members per Region.
6. At redetermination after Medicaid Managed Care launch, the Member will be auto-assigned into the same PHP from the prior year, provided that the PHP continues to participate in Medicaid Managed Care and the Member does not request enrollment in a different PHP.
7. Auto-assignment may also be used in the following instances:
   a. For Medicaid Managed Care Members whose PHP has been discontinued. The Member will be auto-assigned using the same algorithm used for new beneficiaries.
   b. For beneficiaries who lose, but then regain, Medicaid eligibility. The beneficiary will be auto-assigned into the beneficiary's previous PHP, unless the PHP is no longer participating in Medicaid Managed Care or the beneficiary indicates that he or she wishes to enroll in another PHP. If the PHP is no longer participating in Medicaid Managed Care, the beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.
   c. For Members who have been disenrolled based upon the request of the PHP. The Member will be assigned to a new PHP based on the same auto-assignment algorithm used for new beneficiaries except that the Member will not be reassigned to the PHP that requested disenrollment.
   d. For beneficiaries who are determined Medicaid Managed Care mandatory or exempt who are discharged from a long-term stay in a nursing facility (including a state-owned Neuro-Medical Center or a DMVA-operated Veterans Home) after Medicaid Managed Care implementation. The beneficiary will be auto-assigned based on the same algorithm used for new beneficiaries.

f) **Prepaid Health Plan Disenrollment**

i. Member disenrollment from a PHP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from one PHP to be enrolled into a different PHP.

ii. Disenrollment requested by a Member

1. A Member may request disenrollment from a PHP "without cause" during the time periods specified in Section f.ii.4. or, at any time, for any of the "with cause" reason specified in Section f.ii.5.
2. A Member, or an authorized representative, may submit an oral or written request for disenrollment from the PHP to the Enrollment Broker by phone, mail, in-person, or electronically.
3. At the time of the disenrollment request, the Enrollment Broker will offer choice counseling to the Member, or his or her authorized representative, and capture the new PHP and AMH/PCP preference.
4. Without cause disenrollment requests
   a. Consistent with 42 C.F.R. § 438.56(c), a Member may change his or her PHP without cause at the following times:
      i. During the initial ninety (90) calendar days following the effective date or date of notice of new PHP enrollment (referred to as the choice period).
      ii. At least once every twelve (12) months that coincides with the Member's redetermination period.
      iii. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, during the period when the redetermination decision is delayed.
      iv. When the temporary loss of Medicaid eligibility has caused the Member to miss his or her annual disenrollment opportunity.
      v. If the Department imposes temporary management in accordance with 42 C.F.R. § 438.706, suspends new enrollment in accordance with 42 C.F.R. § 438.702(a)(4), or grants Members the right to terminate enrollment without cause in accordance with 42 § C.F.R. 438.702(a)(3) as intermediate sanctions against the PHP.[3]
   b. The following populations may disenroll from a PHP without cause at any time upon request to the Enrollment Broker:
      i. Members of federally recognized tribes.
      ii. Members receiving long-term services and supports (LTSS) in institutional or community-based settings.
   c. Unless otherwise notified by the Department of a without cause opportunity to disenroll from the PHP, to initiate a without cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.
   d. The Enrollment Broker will process without cause disenrollment requests in accordance with the following:
      i. The Enrollment Broker will evaluate the request and decide whether to approve or deny.
      ii. The Enrollment Broker will notify the Department of its decision by the next calendar day following receipt of the request.
   e. Notice of disenrollment determination
      i. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective date within seven (7) days of receipt of the request by the Enrollment Broker.

[3] If the Department imposes any of these intermediate sanctions against a PHP, the Department will notify the affected Members of their right to disenroll without cause.

ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[4]

5. With cause disenrollment requests
   a. Consistent with 42 C.F.R. § 438.56(c)(1), a Member, or an authorized representative, may request disenrollment from his or her PHP with cause at any time.
   b. The following are with cause reasons to request disenrollment from the PHP:
      i. The Member moves out of the PHP Region(s).[5]
      ii. The PHP does not, because of moral or religious objection, cover a service the Member seeks.[6]
      iii. The Member needs concurrent, related services that are not all available within a PHP's provider network, and the Member's provider determines receiving services separately would subject the member to unnecessary risk.[7]
      iv. A Member receiving LTSS would be required to change his or her residential, institutional or employment supports provider based on a change in status from in-network to out-of-network.[8]
      v. The Member's complex medical condition(s) would be better served under a different PHP, or the Medicaid Fee-For-Service/LME/MCO delivery system in the case of a Medicaid Managed Care Member who meets BH I/DD Tailored Plan eligibility (including having a qualifying event, as defined by the Department) prior to launch of the BH I/DD Tailored Plans. A Member is considered to have a complex medical condition if the condition could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
      vi. A family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the Member.
      vii. Poor performance of the PHP, as determined by the Department, after evaluation of PHP performance.
      viii. Other reasons, including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need, as defined by the Department.[9]
   c. The existence of a with cause reason for disenrollment does not automatically disenroll a Member from the PHP. To initiate a with cause disenrollment request, the Member, or the authorized representative, must contact the Enrollment Broker.
   d. The Enrollment Broker will process with cause disenrollment requests in accordance with the following:
      i. For clinical-related with cause disenrollment requests, including requests based on the need for concurrent related services, complex medical conditions, or urgent medical need, the Enrollment Broker will transmit clinical-related with cause requests to the Department

[4] 42 C.F.R. § 438.56(e).
[5] 42 C.F.R. § 438.56(d)(2)(i).
[6] 42 C.F.R. § 438.56(d)(2)(ii).
[7] *See* 42 C.F.R. § 438.56(d)(2)(iii).
[8] *See* 42 C.F.R. § 438.56(d)(2)(iv).
[9] 42 C.F.R. § 438.56(d)(2)(v).

for evaluation within twelve (12) hours of receipt. The Department will decide whether to approve or deny clinical-related disenrollment requests.

ii. For all other with cause disenrollment requests, the Enrollment Broker will evaluate the request and notify the Department of its decision to approve or deny within three (3) calendar days of receipt of the request.

e. Notice of disenrollment determination

i. The Department will notify the Member, or authorized representative, and the PHP of the denial or approval of the disenrollment request and, if approved, the disenrollment effective date within seven (7) days of receipt of the request by the Enrollment Broker.

ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the effective date that would have been established had the Enrollment Broker or the Department made a determination in the specified timeframe.[10]

6. Expedited review of with cause requests for disenrollment

a. A Member, or an authorized representative, may request an expedited review of his or her with cause disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the PHP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

b. The Enrollment Broker will process requests for expedited review in accordance with the following:

i. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.

ii. The Department will evaluate and decide whether to approve or deny the request.

c. Notice of expedited disenrollment determination. The Department will notify the Member, or authorized representative, and the PHP of the approval or denial of the expedited disenrollment request, and, if approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.

iii. Disenrollment requested by a PHP

1. In accordance with 42 C.F.R. §§ 438.56(b)(2)-(3), the PHP is prohibited from requesting disenrollment of a Member because of an adverse change in the Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Member's special needs.
2. The PHP may only submit requests for Member disenrollment if the following occurs:
   a. The Member's behavior seriously hinders the PHP's ability to care for the Member, or other Members of the PHP; and
   b. The PHP has documented efforts to resolve the Member's issues that form the basis of the request for disenrollment of the Member.
3. To initiate a disenrollment request, the PHP must contact the Enrollment Broker and provide the information required to support its request for disenrollment.
4. The Enrollment Broker will process requests for disenrollment received from the PHP in accordance with the following:
   a. The Enrollment Broker will transmit the request to Department for evaluation within three (3) calendar days of receipt of the request.
   b. The Department evaluate and decide whether to approve or deny the request.

[10] 42 C.F.R. § 438.56(e).

5. Notice of disenrollment determination
    a. If the Department denies a disenrollment requests made by the PHP, the Department will notify the PHP of the decision within seven (7) calendar days of receipt of the request by the Enrollment Broker.
    b. If the Department approves a disenrollment requests made by the PHP, the Department will notify the PHP, the Member, or authorized representative, of the decision and the effective date of the disenrollment within seven (7) calendar days of receipt of the request by the Enrollment Broker.
    c. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the PHP requests disenrollment. If the Department fails to make a disenrollment determination within the timeframes specified in this subsection, the disenrollment is considered approved for the effective date that would have been established had the Department made a determination in the specified timeframe.[11]

iv. Disenrollment required by the Department

1. The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:
    a. Loss of eligibility
        i. If the Department determines that a member is no longer be eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the PHP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.
        ii. If a Member is disenrolled from a PHP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the PHP.[12]
    b. Change in Medicaid eligibility category
    c. Nursing facility long-term stays
        i. A Member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from Medicaid Managed Care on the first day of the next month following the ninetieth (90th) day of stay and receive services through Medicaid Fee-For-Service.[13]
        ii. The PHP will have a process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) calendar days.
        iii. To monitor and report a Member's length of stay in a nursing facility the PHP must use the following process:
            i. Within thirty (30) days of admission to a nursing facility, the PHP will assess a Member's health care needs and estimate the potential length of stay. If the Member requires a stay for longer than ninety (90) calendar days, the PHP must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.
            ii. The PHP is responsible for tracking the total continuous length of stay for each Member residing in a nursing facility.

[11] Id.
[12] 42 C.F.R. § 438.56(g).
[13] Session Law 2015-245, as amended by Session Law 2018-49.

iii. The Department will send the PHP and the Member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the Member's disenrollment from the PHP.

iv. The PHP must notify the Department with an attestation of any Member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.

v. Coverage of the Member by the PHP will end on the effective date provided by the Department.

iv. Neuro-Medical Centers and Veterans Homes

i. A beneficiary, otherwise eligible for enrollment in Medicaid Managed Care, residing in a state-owned Neuro-Medical Center[14] or a DMVA-operated Veterans Home[15] when the Department implements Medicaid Managed Care are excluded and will receive care in these facilities through Medicaid Fee-For-Service.

ii. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation will be disenrolled from the PHP by the Department.

1. The Neuro-Medical Center or Veterans Home will submit the Member's information including date of admission to the Department within fourteen (14) calendar days of admission.
2. The Department will notify the Member and the PHP of the disenrollment and the disenrollment effective date.
3. Coverage of the Member by the PHP will end on the effective date provided by the Department.

g) **Appeals**

In accordance with 42 C.F.R. § 438.56(f), Members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department.

h) **Managed Care Enrollment Policy Changes**

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes.

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

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

Attachment M. POLICIES

2. First Revised and Restated Advanced Medical Home Program Policy

1. Background

The Advanced Medical Home (AMH) program refers to an initiative under which the PHP delegates care management responsibilities and functions to State-designated AMH practices to provide local care management services. Refer to *Section III.C.6. Care Management* for additional detail regarding the AMH Program. An AMH "practice" will be defined by a NPI and service location.

2. Scope

The scope of this Policy covers the agreement between the PHP and primary care providers participating in the AMH program outlined below and in the Contract.

3. Standard Terms and Conditions for PHP Contracts with All Advanced Medical Home Providers

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

4. Standard Terms and Conditions for PHP Contracts With Tier 3 AMH Providers

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements.

a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
    i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the PHP are reconciled with the practice's panel list and up to date in the clinical system of record.
    ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
    iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the PHP with clinical information to score and stratify the patient panel.
    iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.
    v. The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
    vi. The Tier 3 AMH practice must define the process and frequency of risk score review and validation.

b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
    i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
    ii. The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
        1. Patient's immediate care needs and current services;
        2. Other state or local services currently used;
        3. Physical health conditions, including dental;
        4. Current and past behavioral and mental health and substance use status and/or disorders;
        5. Physical, intellectual developmental disabilities;
        6. Medications – prescribed and taken;
        7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
        8. Available informal, caregiver, or social supports, including peer supports.
    iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.
    iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

i. The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.
ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.
iii. The Tier 3 AMH practice must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.
iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:
    1. Measurable patient (or patient and caregiver) goals
    2. Medical needs including any behavioral health and dental needs;
    3. Interventions, including medication management and adherence;
    4. Intended outcomes; and
    5. Social, educational, and other services needed by the patient.
v. The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.
vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.
vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.
viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.
ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)
    1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
    2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
    3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

d. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication management to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.
    i. The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:
        1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits

2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
3. NICU discharges;
4. Clinical complexity, severity of condition, medications, risk score.

ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

iii. The Tier 3 AMH practice must include the following elements in transitional care management:
1. Ensuring that a care manager is assigned to manage the transition
2. Facilitating clinical handoffs;
3. Obtaining a copy of the discharge plan/summary;
4. Conducting medication management;
5. Following-up by the assigned care manager rapidly following discharge;
6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
7. Developing a protocol for determining the appropriate timing and format of such outreach.

e. Tier 3 AMH practices must use electronic data to promote care management.

i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

Section VII. Attachment M.2. Table 1: Required Preventive Services

		Required for providers who serve the following age ranges (The age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes.)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					

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

Attachment M. POLICIES

6. First Revised and Restated Uniform Credentialing and Re-credentialing Policy

1. **Background**

   This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a Prepaid Health Plan (PHP) in determining whether to allow a provider to be included in the PHP's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's applicable Objective Quality Standards for participation as a Medicaid Enrolled provider.

2. **Scope**

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

3. **Policy Statement**

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

   a. **Centralized Provider Enrollment and Credentialing**

      i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

         a) The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid or NC Health Choice programs (or both).

            1. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.
            2. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

         b) The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid or NC Health Choice services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

         c) The process and information requirements shall meet the most current applicable data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.

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

d) Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid Enrolled provider, with the application serving for enrollment as a Medicaid Fee-for-Servic*e* provider as well as a Medicaid managed care provider.
   1. The Department shall not mandate Medicaid managed care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

e) Providers will be reverified and recredentialed every three years, except as otherwise specifically permitted by the NC DHHS in the Contract.

f) A PHP shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the PHP will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid Enrolled provider in accordance with the standards contained in this Policy.

g) The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers.
   1. A PHP shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

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

i. The PHP shall develop and implement, as part of its Credentialing and Re-credentialing Policy, through written policies and procedures for the selection and retention of network providers based upon the Department's Uniform Credentialing and Re-credentialing Policy. The PHP's Policy, at a minimum, must:

a) Meet the requirements specified in 42 C.F.R. § 438.214;

b) Meet the requirements specified in this Contract;

c) Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;

d) Establish that the PHP shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval;

e) Establish a documented process for determining if a provider is an active Medicaid Enrolled provider and therefore eligible for contracting;

f) Reserved.

g) Prohibit PHP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment;

h) Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

i) Prohibit PHP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;

j) Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.
k) Reserved.
l) Reserved.
m) Reserved.
n) If PHP requires a provider to submit additional information as part of its contracting process, the PHP's policy shall include a description of all such information.
    1. PHP shall make network contracting decisions based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates.
    2. Examples of valid additional information include the provider's office hours, accepting new patients, ages served, and EFT information.
o) PHP shall evaluate a provider's continued eligibility as follows:
    1. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
    2. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
p) Include a statement that the current policy and all previous versions will be published on the PHP's website and include the Policy effective dates of each version.

ii. PHP shall follow this Policy and its Provider Credentialing and Re-credentialing Policy when making a network contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state network providers.
iii. PHP shall have discretion to make network contracting decisions consistent with this Department Policy and the PHP's Provider Credentialing and Re-credentialing Policy.
iv. PHP shall publish its approved Provider Credentialing and Re-credentialing Policy, including all previous versions, on the PHP's website and include the effective date of each Policy.

Attachment M. 9. Healthy Opportunities Screening Questions

The screening questions listed below shall be incorporated into the PHP's Care Needs Screening tool in accordance with *Section V.C.6.a.iv.a) 3.* and *Section V.C.8.e.i* of the Contract.

Health Screening Questions

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		