Amendment Number 21 (22)
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 related to the following Sections of the Revised and Restated Request for Proposal #30-190029-DHB:

I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
II. Section V. Scope of Services;
III. Section VI. Contract Performance;
IV. Section VII. Attachments; and
V. Section IX. Draft Rate Book.

The Parties agree as follows:

I. 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, 40. Date of Payment* is revised and restated as follows:

40. Date of Payment: The point in time following the Claim Adjudication Date when reimbursement is generated for services. This is either the date of Electronic Funds Transfer (EFT) or the date a paper check is mailed.

b. *Section III. D. Terms and Conditions, 1. ACCESS TO PERSONS AND RECORDS* is revised and restated as follows:

1. ACCESS TO PERSONS AND RECORDS:

a. Pursuant to NCGS § 147-64.7 and NCGS § 143-49(9), the Department, the State Auditor, appropriate state or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information systems, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with Paragraph 36. **RECORDS RETENTION** of this Section III.D. of the Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such changes or additions.

b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with NCGS § 147-64.7.

c. The financial auditors of the Department shall also have full access to all financial records and other information determined by the Department to be necessary for the Department's substantiation of the

monthly payment(s). These audit rights are in addition to any audit rights any federal agency may have regarding the use of federally allocated funds.

d. The following entities may audit the records of this Contract during and after the term of the Contract to verify accounts and data affecting fees or performance:
    i. The State Auditor;
    ii. The internal auditors of the affected department or agency, to the extent authorized by law; and
    iii. The Joint Legislative Commission on Governmental Operations (Commission) and Commission staff, as defined in NCGS § 120-72(3), whose primary responsibility is to provide professional or administrative services to the Commission.
e. Nothing in this Section is intended to limit or restrict the State Auditor's rights.
f. This term shall survive termination or expiration of the Contract.

c. *Section III. D. General Terms and Conditions, 10: COMPLIANCE WITH LAWS:* is revised and restated to add the following:

f. Certifications and Representations
    i. Contractor shall certify annually pursuant to 2 C.F.R. § 200.209 Certifications and Representations that it is in compliance with federal certification and representation requirements regarding Nondiscrimination, Drug-Free Workplace Requirements, Environmental Tobacco Smoke, Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions and Lobbying.
    ii. Contractor shall certify annually that it is in compliance with state certification requirements regarding Verification of Employee Work Authorization, Ineligibility, Prior Convictions and Prior Employment.

d. *Section III. D. Terms and Conditions, 32. PAYMENT AND REIMBURSEMENT:, e. Enhanced Case Management Pilots to Address Unmet Health-Related Needs Payments, also known as the Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payments* is revised and restated as follows:

iii. Pilot Care Management Payments:
    a) The Department shall make payments to reimburse Contractor for Pilot care management payments made in accordance with *Section V.D.4. Provider Payments* to Contractor's Designated Pilot Care Management Entities.
    b) Pilot Care Management Payment Withhold
        1. The Department shall apply the Pilot Care Management Payment Withhold to the Pilot care management payments made to the PHP for Tier 3 AMH and CIN Designated Pilot Care Management Entities in a manner and frequency as specified in *Section V.D.4. Provider Payments*.
        2. If the Department determines that the performance target(s) for the Pilot Care Management Payment Withhold have been met at the end of each applicable performance period, the Department shall furnish the withheld amount to the PHP for distribution by the PHP to its Tier 3 AMH and CIN Designated Pilot Care Management Entities in a manner specified in *Section V.D.4. Provider Payments.*

e. *Section III. D. Terms and Conditions, 36. RECORDS RETENTION:, a*. is revised and restated as follows*:*

a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer period is required by federal or state law or policy. Federal record retention standards are located in 45 C.F.R. § 74.53. The State policy is mandated by the State Archives of North Carolina and is located here: https://archives.ncdcr.gov/government.

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

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

r) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions;
s) North Carolina Medicaid Withhold Program Guidance;
t) Pilot Service Delivery Index;
u) Healthy Opportunities Pilot Domain Manuals;
v) Healthy Opportunities Pilot Enrollment Roster Companion Guide – Advanced Pilot Functionality;
w) Healthy Opportunities Pilot Fee Schedule and Service Definitions;
x) Healthy Opportunities Pilot Interpersonal Violence (IPV) Protocol;
y) Healthy Opportunities Pilot 837P Invoices/Claims Companion Guide—Advanced Pilot Functionality;
z) Healthy Opportunities Pilot NCCARE360 Invoice File(s) Companion Guide—Advanced Pilot Functionality;
aa) Healthy Opportunities Pilot Guidance on Duplicative Medicaid Services;
bb) Payments Supplementary Product Guide;
cc) Pilot Member Task List Data Report Companion Guide – Advanced Pilot Functionality;
dd) Service Authorization Requests File Companion Guide – Advanced Pilot Functionality
ee) Notice of Adverse Benefit Determination Guide;
ff) DHHS Guidance: PHP Risk Stratification Communication Standardization;
gg) NCMT AMHPCP AA Requirements Document; and
hh) NC Medicaid Managed Care Billing Guidance to Health Plans.

b. *Section V. A. Administration and Management, 3. National Committee for Quality Assurance (NCQA) Accreditation* is revised to add the following*:*

e. The PHP is prohibited from requiring that entities to which it delegates care management participate in audits or monitoring activities for the purpose of meeting requirements enumerated in the National Committee for Quality Assurance (NCQA) Population Health Management (PHM) 5 complex case management standards. The PHP may continue to monitor delegated entities' care management activities against other care management or program requirements (e.g., Advanced Medical Home care management requirements) to advance performance expectations.

c. *Section V. B. Members, 3. Member Engagement, I. Member Identification Cards, ii.* 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 no charge to the Member at least once every twelve (12) months, upon request by the Member or the Member's authorized representative, upon AMH/PCP change, or upon changes to PCP provider data that is listed on the ID card (e.g., address, name, phone number).

d. *Section V. B. Members, 3. Member Engagement, m. Member Handbook, iv., a)* is revised and restated as follows:

a) Covered benefits provided by the PHP, including any approved In Lieu of Services and Value- Added Services.

e. *Section V. B. Member, 3. Member Engagement, m. Member Handbook, iv., l)* is revised and restated as follows:

l) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100, rights related to In Lieu of Services, and any other rights and responsibilities under the Contract.

f. ***Section V. B. Members, 6. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements, vii.*** **is revised and restated as follows:**

vii. The PHP shall use Department developed templates for all Member notices related to the Member grievance and appeals processes that meet applicable notification standards, including but not limited to, the notice of adverse benefit determination, the plan appeal request form, the State Fair Hearing appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii). Except as indicated in the template, the PHP shall not modify Department-developed template language provided for the purposes of notifying Members of grievance and appeal acknowledgements, extensions, and decisions without prior written approval from the Department.

g. ***Section V. B. Member, 6. Member Grievances and Appeals, b. Member Grievances and Appeals General Requirements*** **is revised to add the following:**

xii. The PHP shall apply the Member grievance, Internal Plan Appeals, and State Fair Hearing provisions outlined in this Section to any approved In Lieu of Service to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

h. ***Section V. B. Members, 6. Member Grievances and Appeals, i. Appeals and Grievances Recordkeeping and Reporting, v. Appeals and Grievance Reporting, b)*** **is revised and restated as follows:**

b) To support the Department's monitoring efforts, the PHP shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
   i. Each Notice of Adverse Benefit Determination issued by the PHP;
   ii. Each Notice of Resolution issued by the PHP;
   iii. For each Notice of Adverse Benefit Determination and Notice of Resolution issued by the PHP, both the English version and the version in the primary language of the Member as a single file with the English language version first (if the Notice is sent in a language other than English); and
   iv. Include required fields for Clearinghouse ingestion as set forth by the Notice of Adverse Benefit Determination Guide.

i. ***Section V. C. Benefits and Care Management, Fourth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services*** **is revised and restated as follows:**

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Inpatient hospital services	Services that – Are ordinarily furnished in a hospital for the care and treatment of inpatients; Are furnished under the direction of a physician or dentist; and Are furnished in an institution that - (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	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. § 440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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) 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. 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.	

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the 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
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	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

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

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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 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-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation 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

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation 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	The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	SSA, Title XIX, Section 1905(a)(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 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

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Federally qualified health center services	The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	SSA, Title XIX, Section 1905(a)(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 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
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
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1- A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-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

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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) services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Certified pediatric and family nurse practitioner services	(a) Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b) (1) or (b)(2) of this section. 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. (c) 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 - i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a family nurse practice limited to providing primary health care to individuals and families.	
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1 D, NC NEMT Policy
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Clinical Coverage Policy 15
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters Section V.C.3. Pharmacy Benefits of the Contract
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist. (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and 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.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4
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, 13e 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)

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e 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, 13e NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policy	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. Please refer to NC Clinical Coverage Policies and services listed.	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): Mobile Crisis Management Partial Hospitalization Professional Treatment Services in Facility-based Crisis Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization Substance abuse intensive outpatient program (SAIOP) Substance abuse comprehensive outpatient treatment program (SACOT) NC Clinical Coverage Policy 8A-2: Facility- based crisis services for children and adolescents

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		NC Clinical Coverage Policy 8A-5: Diagnostic assessment North Carolina Medicaid State Plan Att. 3.1-A.1, Page 15a.12: Ambulatory Withdrawal Management without Extended On-Site Monitoring North Carolina Medicaid State Plan Att. 3.1-A. 1, Page 15a. 11b: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-9: Opioid Treatment Program North Carolina Medicaid State Plan Att. 3.1-A.1., Page 15a. 12-B: Clinically Managed Residential Withdrawal Services (Social Setting Detox) North Carolina Medicaid State Plan Att. 3.1-A.1., Page 15a.12-A: Medically Monitored Inpatient Withdrawal Management Services (Non-hospital medical detoxification) NC Clinical Coverage Policy 8B: Inpatient behavioral health services NC Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F: Research-based Behavioral Health Treatment NC Clinical Coverage Policy 8G: Peer Support Services
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, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 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.	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, “is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less.”	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Optometry services	Medicaid shall cover the following optical services when provided by ophthalmologists and optometrists: (a) routine eye exams, including the determination of refractive errors; (b) prescribing corrective lenses; and dispensing approved visual aids. Opticians may dispense approved visual aids.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1- A.1, Page 10a G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		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
Private duty nursing services	Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. §440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the 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.	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

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Personal care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c. In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care 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.	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)
Hospice services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
	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 Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: (a) Total parenteral nutrition (TPN) (b) Enteral nutrition (EN) (c) Intravenous chemotherapy (d) Intravenous antibiotic therapy 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 Clinical Coverage Policy 3H-1, Home Infusion Therapy

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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. *IMD exclusion is waived for Medicaid beneficiaries receiving treatment for substance use disorders.	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 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 Clinical Coverage Policy 8B, Inpatient Behavioral Health Services
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole- body radiation therapy.	North Carolina Medicaid State Plan, Page 27, Att. 3.1- E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma 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

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 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 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

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Anesthesia	Refers to practice of medicine dealing with, but not limited to: (a) The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. (b) The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. (c) The clinical management of the patient unconscious from whatever cause. (d) The evaluation and management of acute or chronic pain. (e) The management of problems in cardiac and respiratory resuscitation. (f) The application of specific methods of respiratory therapy. The clinical management of various fluid, electrolyte, and metabolic disturbances.	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 NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device’s ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular

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SERVICE	**DESCRIPTION**	**KEY REFERENCES**
		Ultrasound
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) 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

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
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 services or in which special treatment is given.	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter- Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision
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
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	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	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Fifth Revised and Restated Section V.C. Table 1: Summary of Medicaid Services		
SERVICE	**DESCRIPTION**	**KEY REFERENCES**
Services	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 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. 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.	

j. ***Section V., C. Benefits and Care Management, First Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plan and BH I/DD Tailored Plans*** **is revised and restated as follows:**

Second Revised and Restated Section V.C. Table 3: Behavioral Health Services Covered in Standard Plan and BH I/DD Tailored Plans[1]	
BH, TBI and I/DD Services Covered by Both SPs and BH I/DD TPs	**BH, I/DD and TBI Services Covered Exclusively by BH I/DD TPs (or LME-MCOs Prior To Launch)**
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Peer Support Services • Partial hospitalization • Mobile crisis management • Facility-based crisis services for children and adolescents	**State Plan BH and I/DD Services** • Residential treatment facility services • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities (PRTFs) • Assertive community treatment (ACT) • Community support team (CST) • Psychosocial rehabilitation • Substance abuse non-medical community residential treatment

• Professional treatment services in facility-based crisis program • Outpatient opioid treatment • Ambulatory Withdrawal Management without Extended On-Site Monitoring (Ambulatory detox) • Research-based Behavioral Health Treatment • Diagnostic assessment • Medically Monitored Inpatient Withdrawal Management Services (Non-hospital medical detoxification) • Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization • Substance abuse intensive outpatient program (SAIOP) • Substance abuse comprehensive outpatient treatment program (SACOT) • Clinically Managed Residential Withdrawal Services (Social Setting Detox) **EPSDT**	• Substance abuse medically monitored residential treatment • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) • 1915(i) services **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded BH and I/DD Services** **State-Funded TBI Services**

k. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, c. Covered Services, xiii. IMD-SUD Services, b)*** **is revised and restated as follows:**

b) The PHP shall provide the Department with a report every other week on members utilizing IMD-SUD services as defined in *Section VII.J. Reporting Requirements*. The report shall be submitted to the Department every other Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

l. ***Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, e. Utilization Management, ii., f)*** **is revised and restated as follows:**

f) Reserved.

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

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

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.

d) If a PHP receives written notification from the Department that a previously approved ILOS has been determined by the Department or by CMS to no longer be medically appropriate or cost effective or if there are other compliance concerns with the ILOS requirements, including failures

to protect Member rights, the PHP shall submit a transition plan for the ILOS for current Members receiving the terminated ILOS to the Department for review and approval within the timeframe specified by the Department in the written notification. At a minimum, the transition plan shall include the following:

1. A transition of care policy to phase out the applicable ILOS in no longer than twelve (12) months from receipt of the notice from the Department terminating the ILOS while ensuring access to services required under the Contract with minimal disruption to care for Members.
2. A process to notify Members of the termination of the applicable ILOS for Members that they are currently receiving the ILOS, as expeditiously as required by the Member's health condition.

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

vi. The PHP shall ensure that ILOS are provided in a manner that preserves Member rights and protections under State and federal law, including the following:

a) Members shall not be required by the PHP to utilize an ILOS or be required to replace a Medicaid State Plan service with an ILOS.

b) The availability of an ILOS shall not be used by the PHP to reduce, discourage, or jeopardize access by the Member to covered Medicaid State Plan services/settings.

c) If a Member chooses not to receive an ILOS, the Member always retains the right to receive the covered Medicaid State Plan service or setting on the same terms as would apply if an ILOS was not available.

d) Medically appropriate Medicaid State Plan services/settings shall not be denied by the PHP on the basis that a Member was offered an ILOS, is receiving an ILOS, or has previously received an ILOS.

e) The Member shall be able to access the PHP's grievance and appeal system described in *Section V.B.6. Member Grievances and Appeals* for any ILOS offered by the PHP to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

o. *Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, g. In Lieu of Services* is revised to add the following:

viii. The PHP is required to develop and implement a consistent process that requires Network Providers requesting and/or the PHP's licensed clinical staff recommending an ILOS for a Member to utilize professional judgment to determine and document (e.g., in the Member's care plan or medical record) that the ILOS is medically appropriate for the specific Member based on the ILOS target population descriptions outlined in *First Revised and Restated Attachment M.10. Approved In Lieu of Services.*

p. *Section V. C. Benefits and Care Management, 1. Medical and Behavioral Health Benefits Package, m. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements* is revised and restated as follows:

m. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements

i. Upon notification by the Department, the PHP shall coordinate Specialized Services, as defined in the federal PASRR regulations at 42 C.F.R. § 483.120, for Members admitted to nursing facilities and coordinate transition back to the community when the Member no longer meets medical necessity criteria for skilled nursing.

ii. The PHP shall arrange for the provision of Specialized Services identified by the PASRR process for Members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this Contract.

a) The PHP shall confirm clinically appropriate Specialized Services are documented in the nursing facility's plan of care for the Member and shall coordinate with the nursing facility and other providers, as relevant, to ensure linkage to Specialized Services.

iii. Reserved.

q. ***Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, i. Dispensing Fees*** **is revised and restated as follows:**

i. Dispensing Fees

a) In accordance with Section 5.(5)a. of Session Law 2015-245, the PHP shall reimburse pharmacies a dispensing fee at a rate established by the Department.

b) The PHP shall reimburse based on a flat dispensing fee defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).

c) The Department shall perform a cost of dispensing study every five (5) years to inform the Fee-for-Service dispensing rate and notify the PHP of any changes to the pharmacy dispensing fee.

d) Reserved.

e) Reserved.

f) For 340B and Non-340B Hemophilia drugs, the dispensing fee is paid based on the quantity of units dispensed, utilizing a multiplier at $0.04 for Hemophilia Treatment Center (HTC) pharmacies and $0.025 for all other Non-Hemophilia pharmacies.

g) The PHP shall not reimburse pharmacy professional dispensing fees to drug reimbursement under the all-inclusive rate "AIR" or bundle payment.

r. ***Section V. C. Benefits and Care Management, 3. Pharmacy Benefits, h. Pharmacy Reimbursement, ii. Ingredient Costs, j) Medical Professional Drug Claims, 3. Physician Administered Drug Program (PADP), ii.*** **is revised and restated as follows*:***

ii. The PHP shall require claims to be billed by providers utilizing the HCPCS and NDC combination per the NDC: HCPCS Crosswalk file.

s. ***Section V. C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Provision of Care Management for High-Need Members, c) Care Management Services, 3., iii.*** **is revised and restated as follows:**

iii. Have a housing specialist on staff or under contract who can assist individuals experiencing housing instability, including those who are homeless, in securing housing; and

t. ***Section V. C. Benefits and Care Management, 6. Care Management, a. Care Management and Care Coordination, vi. Provision of Care Management for High-Need Members, c) Care Management Services, 9.*** **is revised and restated as follows:**

9. The PHP shall provide the Department with a report every other week on members utilizing IMD-SUD services as defined in *Section VII. Attachment J. Eighth Revised and Restated Reporting Requirements*. The report shall be submitted to the Department by every other Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

u. ***Section V. C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, iv. Advanced Medical Home Contracting, c) Required Data and Information Sharing to Support Care Management, 2., iv. Risk Stratification Information, c)*** **is revised and restated as follows:**

c. The PHP is required to provide a description of the PHP's risk stratification approach to AMH providers, following the content, format, and distribution requirements as outlined in DHHS Guidance: PHP Risk Stratification Communication Standardization.

v. ***Section V. C. Benefits and Care Management, 6. Care Management, b. Local Care Management and Related Programs, v. Local Care Management Provided by Local Health Departments, a) General Requirements, 1. is*** **revised and restated as follows:**

1. In Contract Years 1-4, the PHP shall contract with each Local Health Department (LHD) in its Region(s) to provide care management services to High-Risk Pregnant Women and At-Risk Children, to the extent that each LHD chooses to provide these services. In Contract Year 5, the PHP shall contract with each Local Health Department (LHD) in its Region(s) that meet the benchmark specifications as prescribed by the Department to provide care management services to High-Risk Pregnant Women and At-Risk Children, to the extent that each LHD chooses to provide these services. In Contract Year 5, the PHP will not be required to contract with LHDs that do not meet the benchmark specifications as prescribed by the Department to provide care management services to High-Risk Pregnant Women and At-Risk Children.

w. ***Section V. C. Benefits and Care Management, 6. Care Management, c. AMH/PCP Choice and Assignment, ii.*** **is revised and restated as follows:**

ii. The PHP shall, in instances in which a Member does not select an AMH/PCP at the time of enrollment, assign the Member to an AMH/PCP within 24 hours of effectuation date of enrollment in PHP. The PHP shall allow AMHs/PCPs to set limits on panel size and shall have a process for AMHs/PCPs to do so. The PHP shall abide by the panel limits outlined in PHP contracts with AMH and PCP providers.

x. ***Section V. C. Benefits and Care Management, 6. Care Management, c. AMH/PCP Choice and Assignment, iii.*** **is revised and restated as follows:**

iii. The PHP shall use the methodology for assigning Members to an AMH/PCP as defined by the Department and shared requirements for PCP Auto Assignment as outlined in NCMT AMHPCP AA Requirements Document.

y. ***Section V. C. Benefits and Care Management, 6. Care Management, d., i., c)*** **is revised and restated as follows:**

c) Risk scoring and stratification:
   1. Reserved.
   2. Description of risk scoring and stratification methodology;
   3. Methodology for identifying members of priority populations and other sub-populations;
   4. Number of risk strata;
   5. Translation of risk scores into the Department's risk stratification categories (i.e. high, low, medium risk);
   6. Approximate expected population and penetration rate in each stratum by priority or sub-population;
   7. Data inputs and sources for risk scoring and stratification;
   8. Differences in risk stratification by priority or sub-population;
   9. Anticipated risk stratification and alignment with Department's care management assumptions; and
   10. All other requirements outlined in DHHS Guidance: PHP Risk Stratification Communication Standardization developed by the Department.

z. ***Section V. C. Benefits and Care Management, 7. Prevention and Population Health Management Programs, i. Additional Prevention and Population Health Management Programs, i., d) Vaccines for Children (VFC) Program and NC Immunization Registry, 1.*** **is revised and restated as follows:**

1. Pursuant to Section 317(j) of Public Health Service Act, 42 U.S.C. § 247b(j), the PHP shall provide education to providers on the VFC program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.

aa. ***Section V. C. Benefits and Care Management 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, v. Pilot Periods, a)*** **is revised and restated as follows:**

a) The Pilot is divided into Pilot periods for the purposes of contracting, reporting, monitoring, evaluation, and payments. Unless the Pilot is extended, the fourth service delivery period will end on October 31, 2024.

bb. ***Section V. C. Benefits and Care Management 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, v. Pilot Periods, c)*** **is revised and restated as follows:**

c) The Department may amend the Pilot periods. The PHP shall comply with the new periods as adopted through an amendment to the Contract or as otherwise directed through formal notice from the Department, at least ninety (90) Calendar Days prior to amending the Pilot period.

cc. ***Section V. C. Benefits and Care Management 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot, v. Pilot Periods, d)*** **is revised and restated as follows:**

d) If an extension to the Pilot is approved by CMS, the Department shall have the option, in its sole discretion, to extend and/or add Pilot Service Delivery Periods. The Department shall notify the PHP in writing if it is exercising its option to extend and/or add Pilot Service Delivery Periods at least ninety (90) Calendar Days prior to amending the Pilot Service Delivery Periods .

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

i. The PHP shall follow the Department's Uniform Credentialing and Re-credentialing Policy in *Attachment M.6 Fourth Revised and Restated Uniform Credentialing and Re-credentialing Policy*.

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

a. The PHP shall make timely network contracting decisions using the process outlined in the PHP's Provider Manual.

ff. ***Section V. D. Providers, 2. Provider Network Management, h. Network Provider Systems Requirements, ii.*** **is revised and restated as follows:**

ii. Unless otherwise written in the contract, the PHP shall load contracted providers into the claim adjudication and payment system within the following time frames to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:
   a. NC Medicaid provider attached to a new contract within ten (10) Business Days after completing contract execution.
   b. NC Medicaid hospital or facility attached to a new contract within fifteen (15) Business Days after completing contract execution.
   c. Reserved.
   d. Reserved.
   e. Change in existing contract terms within fifteen (15) Business Days of the effective date after the change.
   f. Reserved.

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

i. Network Provider Credentialing and Re-credentialing Policy
   i. The PHP shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2). The PHP shall apply these criteria consistently to all providers.

hh. ***Section V. D. Providers, 2. Provider Network Management, j. Provider Disenrollment and Termination, i. Payment Suspension at Re-Credentialing*** **is revised and restated in its entirety as follows:**

i. Payment Suspension at Re-Credentialing:
   a. The PHP shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise fail to meet Department specifications.
   b. The 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 with fifty (50) days of suspension, the Department will terminate the provider from Medicaid.
   c. The PHP shall not be liable for interests or penalties for payment suspension at re-credentialing.
   d. The PHP shall address payment suspension at re-credentialing in its Provider Manual.

ii. ***Section V. D. Providers, 2. Provider Network Management, l. Provider Directory, iii.*** **Is revised and restated as follows:**

iii. The PHP shall ensure that the consumer-facing provider directory:
   a. Be in a format that is machine-readable and readily accessible;
   b. Information is placed in a location on the PHP's website that is prominent and readily accessible by Members;
   c. Includes accurate and updated provider information consistent with Contract requirements;
   d. Information is provided in an electronic form which can be electronically retained and printed; and
   e. Is available in paper form without charge upon Member request and if requested, is provided within five (5) Business Days.

jj. ***Section V. D. Providers, 2. Provider Network Management, l. Provider Directory, vi.*** **Is revised and restated as follows:**

vi. The consumer-facing provider directory must comply with 42 C.F.R. § 438.10(h)(1) and shall include the following information, at a minimum:
   a. Provider name;
   b. Provider demographics (first, middle, and last name, gender);
   c. Reserved;
   d. Provider DBA Name;
   e. Reserved;
   f. Provider mailing address;
   g. Provider type (PCP, etc.);
   h. Reserved;
   i. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
   j. Street address(as) of service location(s);
   k. County(ies) of service location(s);
   l. Telephone number(s) at each location;
   m. After hours telephone number(s) at each location;
   n. Website URL(s);

o. Provider specialty by location;
p. Whether provider is accepting new beneficiaries;
q. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
r. Whether provider has completed cultural competency training, including description of training;
s. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
t. A telephone number a Member can call to confirm the information in the directory;
u. Reserved;
v. Essential provider indicator; and
w. IHCP indicator.
x. Reserved.

kk. ***Section V. D. Providers, 2. Provider Network Management, l. Provider Directory, viii.-ix.*** **are revised and restated as follows:**

viii. The PHP shall provide the provider directory to the Department's designated vendor for inclusion in the Consolidated Provider Directory made available to the Enrollment Broker as described in *Section V. K. Technical Specifications*.
ix. Reserved.

ll. ***Section V. D. Providers, 2. Provider Network Management*** **is revised to add the following:**

m. Critical Incident Reporting
i. The PHP shall develop and submit to the Department a written policy or process for timely identification, response, reporting, and follow-up to Member incidents and for reviewing, investigating, and analyzing trends in critical incidents and deaths. The policy or process shall also include preventive action efforts to minimize the occurrence or recurrence of critical incidents. The policy or process shall be submitted by the PHP to the Department by June 30, 2025, and annually, by June 30th of each calendar year, thereafter.
ii. The PHP shall require Category A and B providers, as those terms are defined in 10A NCAC 27G .0602(8), to report Level II and Level III incidents, as those terms are defined in 10A NCAC 27G .0602(4) and (5), in the NC Incident Response Improvement System.
iii. The PHP shall monitor and respond to critical incidents in the same manner in which the requirements in 10A NCAC 27G .0608 are applicable to Local Management Entities/Managed Care Organizations to ensure the health and safety of Members enrolled in the PHP.
iv. The PHP shall ensure that Category A and Category B provider contracts are updated to include compliance with incident reporting requirements specified in *Attachment G. Eighth Revised and restated Required Standard Provisions for PHP and Provider Contracts*. If a PHP determines that a provider is not complying or there are trends in incident reporting, the PHP shall utilize processes including but not limited to provider monitoring and corrective actions to minimize occurrence of preventable incidents and to ensure health and safety of Members receiving services.
v. The PHP shall adhere to the critical event reporting requirements for Members obtaining services in DSOHF facilities.

mm. ***Section V. D. Providers, 3. Provider Relations and Engagement, c. Provider Education and Training, v.*** **is revised and restated as follows:**

v. The PHP shall develop a Provider Training Plan that outlines training topics and dates. The PHP Provider Training Plan shall reference and acknowledge the broader role the PHP has in supporting Department initiatives. Training must include:

a) Annual EPSDT, where EPSDT is relevant to the providers' area of practice:
b) PHP prevention and population health management programs;
c) Into the Mouth of Babes (IMB) program training (required before being permitted to receive reimbursement for IMB program);
d) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for Members receiving care in the home or community settings, or as Members transition across care settings;
e) How the PHP is addressing health disparities and incorporating health equity into their internal and external policies and procedures; and
f) Any other training topics required under this Contract.

nn. ***Section V. D. Providers, 3. Provider Relations and Engagement, d. Provider Manual, i., r)*** **is revised and restated as follows:**

r) Interest provisions for late or under-payment by the PHP;

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

viii. The PHP shall have fifteen (15) 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.

pp. ***Section V. D. Providers, 3. Provider Relations and Engagement*** **is revised to add the following:**

f. Provider Recruitment
   i. The Department views PHP recruitment activities as a method to help publicize Medicaid Managed Care and educate potential Providers about health plan contracting options, while ensuring the protection of Providers from coercive or misleading practices.
   ii. The PHP shall comply with all recruitment requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the PHP to ensure that Providers receive accurate oral and written information.
   iii. The PHP shall ensure that recruitment materials are accurate and does not mislead Providers or the Department.
   iv. The PHP shall establish and maintain a system of control over the content, form, and method of dissemination of all recruitment materials. All recruitment materials, regardless by whom written, produced, created, designed, or presented shall be the responsibility of the PHP.
   v. The PHP shall ensure that all recruitment materials and recruitment strategies shall abide by the PHP's Non-discrimination Policy.
   vi. The PHP shall assign a unique code to all recruitment materials distributed to Providers.

qq. ***Section V. D. Providers, 4. Provider Payment, i. Local Health Department (LHD) Payments, ii.*** **is revised and restated as follows:**

ii. For Contract Years 1-5, the PHP shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.56 PMPM for all enrolled children ages 0-5). The Department reserves the right to further prescribe the Care Management for At-Risk Children reimbursement amount or methodology or to change the methodology in Contract Years after Contract Year 1.

rr. ***Section V. D. Providers, 4. Provider Payment, i. Local Health Department (LHD) Payments, iv.*** **is revised and restated as follows:**

iv. For Contract Years 1-5, the PHP shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in the Fee-for-Service program prior to the start of the PHP contract ($4.96 PMPM for all enrolled women, ages 14 to 44). The Department reserves the right to further prescribe the Care Management for High Risk Pregnant Women reimbursement amount or methodology as allowed under 42 C.F.R. § 438.6(c) or to change the methodology in Contract Years after Contract Year 1.

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

viii. Interest and Penalties

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

tt. ***Section V.D. Providers, 4. Provider Payment, p. Advanced Medical Home Payments, iv.*** **is revised and restated as follows with no revisions to subparts a)-c):**

iv. The PHP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:

uu. ***Section V.D. Providers, 4. Provider Payment, t. Payments under Locum Tenens Arrangements, i.*** **is revised and restated as follows:**

i. The PHP shall recognize locum tenens arrangements as provided in NCGS § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 42 C.F.R. § 455.410(b).

vv. ***Section V.D. Providers, 4. Provider Payment, w., ii.*** **is revised and restated as follows:**

ii. The PHP shall implement applicable rate changes within timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest payments to the applicable provider.

ww. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, i. HSO Payments for Pilot Service Invoices, b) Invoice Requirements, 1.-5.*** **are revised and restated as follows:**

1. The PHP shall ingest invoices from NCCARE360 for Pilot services delivered by the HSO that were previously authorized by the PHP and take one of the following actions:
   i. If the invoice is accurate and the service(s) was either authorized by the PHP or was a passthrough Pilot service, the PHP shall complete the following within thirty (30) Calendar Days of receipt of the invoice from NCCARE360:
      a. The PHP shall send an invoice response file to NCCARE360 to approve the invoice in accordance with the Healthy Opportunities Pilot Payments Protocol; and
      b. The PHP shall effectuate payment, via check or direct deposit, to the HSO and send an invoice response file to NCCARE360 that includes the amount paid to the HSO.
   ii. If the invoice is inaccurate, incomplete, or invalid, the PHP shall send an invoice response file to NCCARE360 with an explanation of the basis for rejection and request the specific additional

information, if needed, to adjudicate the invoice within thirty (30) Calendar Days of receipt of the invoice from NCCARE360.

a. Upon receipt of requested additional information, the PHP shall pay or reject the invoice and send an invoice response file to NCCARE360 that includes the amount paid to the HSO within thirty (30) Calendar Days.

2. The PHP shall process invoices from NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 837P Invoice/Claims Companion Guide-Advanced Pilot Functionality.
3. The PHP shall send an invoice response file back to NCCARE360 according to the Healthy Opportunities Pilot NCCARE360 Invoice Files Companion Guide-Advanced Pilot Functionality.
4. In the event that a PHP authorized a Pilot service, the PHP shall not deny an invoice from an HSO on the basis of having subsequently retracted such authorization after the Pilot service has been provided by an HSO.
5. The PHP shall pay the HSO in the event of a payment error that requires initial, corrected or additional payment.

xx. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments, c)*** **is revised and restated as follows:**

c) The PHP shall pay a set care management payment rate, as defined by the Department in the Department's Healthy Opportunities Pilot Payment Protocol each month to its Designated Pilot Care Management Entities. As specified in this Section, the PHP shall apply the Pilot Care Management Payment Withhold to Pilot care management payments. Care management payment rates, including the amount of the Pilot Care Management Payment Withhold, may not be negotiated between the PHP and Designated Pilot Care Management Entities. The PHP cannot retain care management payments.

yy. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payment Withhold, a)*** **is revised and restated as follows:**

a) The Pilot Care Management Payment Withhold shall be set at one percent (1%) for each applicable performance period.

1. Beginning in Standard Plan Pilot Value-Based Payment Period Three (3) and upon written notification by the Department to the PHP of implementation of the Pilot Care Management Payment Withhold, the PHP shall apply the Pilot Care Management Payment Withhold and reduce the monthly Pilot care management payment made to its Tier 3 AMH and CIN Designated Pilot Care Management Entities by one percent (1%).
2. Upon implementation by the PHP of the Pilot Care Management Payment Withhold, the Department shall adjust its reimbursement of the Pilot care management payments to the PHP through the concurrent application of a one percent (1%) withhold to said payments in accordance with *Section III.D.32.* ***PAYMENT AND REIMBURSEMENT****.*

zz. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payment Withhold, d)*** **is revised and restated as follows:**

d) Prior to the PHP's implementation of the Pilot Care Management Payment Withhold Program the Department shall provide the PHP with written notice detailing the performance measure subject to the withhold, the performance period, the percentage of the monthly payment being withheld, the effective date in which the PHP should begin applying the withhold, and the effective date in which the Department will implement its withhold and adjust its reimbursement of the Pilot care management to the PHP. Within fifteen (15) Calendar Days of the receipt of the written notice from the Department, the PHP shall notify its Tier 3 AMH and CIN Delegated Pilot Care Management Entities of the applicable withhold(s), the performance targets and applicable performance period, the percentage of the monthly payment being

withheld, and the effective date in which the PHP will begin applying the withhold.

aaa. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payment Withhold, e) Performance Targets for Pilot Care Management Payment Withhold, 1.*** **is revised and restated as follows:**

1. For the PHP's Tier 3 AMH and CIN Designated Pilot Care Management Entities to receive the amounts retained under the Pilot Care Management Payment Withhold, the PHP, in partnership with its Tier 3 AMH and CIN Designated Pilot Care Management Entities, shall meet the performance target(s) during the applicable performance period as defined in the Healthy Opportunities Pilot Standard Plan Value-Based Payment Guide and Healthy Opportunities Pilot Value-Based Payment Technical Specifications Manual.

bbb. ***Section V.D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payment Withhold, e) Performance Targets for Pilot Care Management Payment Withhold, 3.–5.*** **are revised and restated as follows:**

3. Following the end of the applicable performance period, the Department shall issue a written Notice of HOP Withhold Determination to the PHP detailing the Department's determination of whether the PHP, in partnership with its Tier 3 AMH and CIN Designated Pilot Care Management Entities, met the applicable performance target(s) during the performance period. Within thirty (30) Calendar Days of receipt of the Department's Notice of HOP Withhold Determination, the PHP shall notify each of its Tier 3 AMH and CIN Designated Pilot Care Management Entities of the Department's determination.
4. If the Department determines that the performance target(s) have been met by the end of the applicable performance period, the Department shall, within sixty (60) Calendar Days of the date of the written Notice of HOP Withhold Determination, furnish the withheld amount to the PHP for distribution to its Tier 3 AMH and CIN Designated Care Management Entities. Once received from the Department, the PHP shall distribute the applicable portion of the withheld amounts owed to each of its Tier 3 AMH and CIN Designated Pilot Care Management Entities within sixty (60) Calendar Days of receipt of the funds from the Department.
5. If the Department determines that the performance target(s) have not been met by the end of the applicable performance period, the Department shall not be required to make any additional payments to the PHP for distribution to the Designated Pilot Care Management Entities subject to the Pilot Care Management Payment Withhold.

ccc. ***Section V. D. Providers, 4. Provider Payment, aa. Healthy Opportunities Pilot Payments, iii. Pilot Care Management Payment Withhold*** **is revised to add the following:**

f) Designated Pilot Care Management Entities that are Local Health Departments are excluded from participation in the Pilot Care Management Payment Withhold.

ddd. ***Section V. D. Providers, 4. Provider Payment, cc. InCK Alternative Payment Model (APM), i.*** **is revised and restated as follows:**

i. Beginning in Contract Year 2 and continuing for the duration of the InCK APM, the PHP shall pay incentive payments to AMHs participating in InCK. Such payments shall be exclusively based on each AMH's performance on the InCK APM measure set forth in the InCK Performance Measure Technical Specifications Manual.

eee. ***Section V. D. Providers, 4. Provider Payment, nn.*** **revised and restated as follows:**

nn. Payment for Substance Use Disorder (SUD) Services

i. For dates of service on or after October 1, 2024, the PHP shall reimburse in-network providers of

substance use disorder (SUD) services at no less than one hundred percent (100%) of the Enhanced Mental Health Medicaid Fee-for-Service Fee Schedule rate, as set by the Department, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement established on or after October 1, 2024. For any claims that the PHP is required to reprocess to comply with this Section, the PHP shall reprocess the claims and pay, as applicable, any interest consistent with the requirements of *Section V.H.1.d.iv).*

fff. ***Section V. D. Providers, 5. Provider Grievances and Appeals, d. Grievances, iii.*** **is revised and restated as follows:**

iii. The PHP shall have a method of allowing providers to submit grievances through the PHP provider web portal.

ggg. ***Section V. D. Providers, 5. Provider Grievances and Appeals, e. Appeals, iii.*** **is revised and restated as follows:**

iii. The PHP shall have a method of allowing providers to submit appeals through the PHP provider web portal.

hhh. ***Section V. D. Providers, 5. Provider Grievances and Appeals, g. Appeals of Suspension or Withhold of Provider Payment, v.*** **is revised and restated as follows:**

v. The PHP shall pay interest and penalties, if applicable in accordance with *Section V.H.1.d.iv.* or *Section V.D.4.l.viii.*, for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

iii. ***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 with no revisions to subparts a)-g):**

v. The PHP shall conduct at least two (2) clinical performance improvement projects annually that align with the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy and must be related to the following areas:

jjj. ***Section V. E. Quality and Value, 2. Value-Based Payment/Alternative Payment Models, a.*** **is revised and restated as follows:**

a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value, the Department is encouraging accelerated adoption of value-based payment (VBP) or Alternative Payment Model (APM) arrangements between PHPs and providers, and requiring that PHPs' Provider Incentive Programs be aligned with the Quality Strategy and related measures. Use of VBP and Provider Incentive Programs will align financial incentives and accountability around the total cost of care and overall health outcomes and ensure that PHPs and providers are recognized and rewarded for quality gains.

kkk. ***Section V. E. Quality and Value, 2. Value-Based Payment/Alternative Payment Models*** **is revised to add the following:**

m. AMH Quality Measures for Measurement Year 2024

i. With the launch of Medicaid Expansion, the Department aims to ensure continued participation in the Medicaid program by AMHs; encourage engagement by AMHs with Medicaid Expansion Members to close care gaps; and minimize the impact of VBP/APM arrangements entered into prior to the launch of Medicaid Expansion from disincentivizing AMHs from serving Medicaid Expansion Members who may have gaps in care that potentially impact performance on certain quality measures.

ii. To achieve the Department's goals, the Department has identified eight (8) quality measures outlined in *Attachment E. Fourth Revised and Restated Required PHP Quality Metrics* where performance on the

quality measures by the AMH (or its designated CIN) may be impacted in quality measurement year 2024 by the launch of Medicaid Expansion:

a) Cervical Cancer Screening (CCS/CCS-E);
b) Chlamydia Screening in Women (CHL);
c) Colorectal Cancer Screening (COL-E);
d) Controlling High Blood Pressure (CBP);
e) Glycemic Status Assessment (GSD) (previously titled Hemoglobin A1c Control for Patients with Diabetes (HBD);
f) Plan All-Cause Readmissions (PCR);
g) Screening for Depression and Follow-Up Plan (CDF); and
h) Total Cost of Care.

iii. For purposes of determining incentive-related performance for any VBP/APM arrangements with an AMH (or its designated CIN) for quality measurement year 2024 related to any of the eight (8) quality measures identified in this Section, the PHP is prohibited from refusing to make any applicable incentive payments otherwise owed to the AMH (or its designated CIN), if the sole basis for the AMH (or its designated CIN) failing to meet the performance targets established under the VBP/APM arrangement is caused by the inclusion of Medicaid Expansion Members in the performance assessment.

iv. The requirements specified in this Section are solely for determining AMH (or its designated CIN) performance for purposes of the PHP's VBP/APM arrangements with its AMH (or its designated CIN) for quality measurement year 2024.

v. As necessary, the PHP shall ensure it makes any required changes to any applicable AMH (or its designated CIN) agreements to ensure compliance with this Section.

vi. By no later than December 1, 2024, the PHP shall submit a plan to the Department that includes the following:

a) Describes how the PHP is operationalizing the requirements outlined in this Section with its AMHs (or their designated CIN); and
b) Provides a summary of any changes to any applicable AMH (or its designated CIN) agreements being pursued by the PHP to implement this Section.

lll. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, i.*** **is revised to add the following:**

e) For purposes of claims payment, the PHP shall be deemed to have paid the claim as of the Date of Payment, and the PHP shall be deemed to have denied the claim as of the date the remittance advice is sent.

mmm. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. Claim Submission Timeframes, a) For any claims with a date of services on or before June 30, 2023, 1.*** **is revised to add the following:**

iii. When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date the patient monthly liability (PML) is determined.

nnn. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. Claim Submission Timeframes, b) For any claims with a date of service on or after July 1, 2023, 1.*** **is revised to add the following:**

ii. When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined.

ooo. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iii. Claim Submission Timeframes*** **is revised to add the following:**

c) For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, the PHP shall allow the Provider one hundred eighty (180) Calendar Days from the primary insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to the Member's assigned PHP. The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment.

ppp. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, a)*** **is revised and restated as follows:**

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

qqq. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, b)*** **is revised and restated as follows:**

b) Reserved.

rrr. ***Section V. H. Claims and Encounter Management, 1. Claims, d. Prompt Payment Standards, iv. Interest and Penalties, c)*** **is revised and restated as follows:**

c) The PHP shall not be subject to interest payments under circumstances specified in NCGS § 58-3-225(k).

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

e) All references to a penalty related to late payments to Providers are hereby stricken as of July 1, 2024.

ttt. ***Section V. H. Claims and Encounter Management, 1. Claims, f. Overpayment or Underpayment Recovery, ii.*** **is revised and restated as follows:**

ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with NCGS § 58-3-225(h), except that not less than sixty (60) Calendar Days before the PHP seeks to recover any overpayments or offsets any future payments from the provider, the PHP shall provide the written notice required under NCGS § 58-3-225(h).

uuu. ***Section V. H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., a)., 3., i.*** **is revised and restated as follows:**

i. Medical: for purposes of determining if the PHP has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC, Healthy Opportunities, and Integrated Care for Kids per member per month payments.

vvv. ***Section V. H. Claims and Encounter Management, 2. Encounters, e. Submission Standards and Frequency, ix., c) Accuracy., 1., i.*** **is revised and restated as follows:**

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

home and care management fees, and CMHRP, CMARC, Healthy Opportunities, and Integrated Care for Kids per member per month payments.

www. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, b., iv.*** **is revised and restated as follows:**

iv. The PHP shall calculate the Department-defined MLR experienced for all Non-Expansion Medicaid populations in a MLR reporting year as the ratio of the numerator and denominator.

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

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.
   iii. Comply with the requirements under 42 C.F.R. § 438.8(e)(3).
   iv. Are not expenditures made to any non-profit entity that is a subsidiary of, or otherwise legally affiliated with, the PHP. Any PHP expenditure to a non-profit entity that funds ongoing PHP operations is ineligible for inclusion in the Medical Loss Ratio under this subsection.
2. The PHP is prohibited from including in the MLR numerator any of the following expenditures:
   i. Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.
   ii. Payments to related providers that violate the Payment Limitations as required in the Contract.
3. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:
   i. Payments from the Department to reimburse for required additional directed or wrap payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

xxx. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, c., ii., b)-d)*** **is revised and restated as follows:**

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

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

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

yyy. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, c., ii.*** **is revised to add the following:**

e) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of remittance paid to Department if the PHP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Section V.I.4.a.xi.i)* and *Section V.I.4.b.iii.j).*

zzz. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, c., iii.*** **is revised and restated as follows:**

iii. The PHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating the CMS-defined MLR and aggregate data for all Non-Expansion Medicaid populations for purposes of calculating the Department-defined MLR.

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

d. If the PHP's Department-defined MLR for the non-Expansion Medicaid population 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.C.8. 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; and
   iv. Allocate a portion of the total obligation to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

bbbb. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, i. Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population, i.*** **is revised and restated as follows with no revisions to subparts 1-6:**

i. The PHP shall calculate and report a distinct aggregate Department-defined MLR for Medicaid Expansion Eligible Member population on an annual basis aligned to the rating year (from the start of Medicaid Expansion through June 30, 2024, and annually for each rating period beginning on July 1 through June 30 thereafter).

cccc. ***Section V. I. Financial Requirements, 2. Medical Loss Ratio, i. Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population, iii., 2.*** **is revised and restated as follows:**

2. 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.C.8. Opportunities for Health*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;

dddd. ***Section V. I. Financial Requirements, 4. Risk Corridor, a.*** **is revised and restated as follows with revisions to subparts only as identified within this Amendment:**

a. A risk corridor arrangement between the PHP and the Department will apply to share in gains and losses associated with the PHP Non-Expansion Medicaid Member populations 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 Services Ratio") for each 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").

eeee. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., i.*** **is revised to add the following:**

d) For rating year four as July 1, 2024 to June 30, 2025.

ffff. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., iv.*** **is revised and restated as follows:**

iv. 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 and wrap payments).

gggg. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., v., a)*** **is revised and restated as follows**:

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

hhhh. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., vi., f)*** **is revised and restated as follows:**

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

iiii. ***Section V. I. Financial Requirements, 4. Risk Corridor, a., vi.*** **Is revised to add the following:**

g) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of rebates paid to the Department if the PHP's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Section V.I.2.d.* and *Section V.I.2.i.iii.*

h) Voluntary contributions to health-related resources or initiatives that advance public health and Health Equity made in lieu of remittance paid to Department if the PHP's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Section V.I.4.a.xi.i)* and *Section V.I.4.b.iii.j).*

jjjj. ***Section V. I. Financial Requirements, 4. Risk Corridor, b. Risk Corridor for Medicaid Expansion Eligible Member Populations, i.*** **is revised and restated as follows**:

i. A distinct risk corridor arrangement between the PHP and the Department will apply to share in gains and losses of the PHP for Medicaid Expansion Eligible Member populations 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 Services Ratio") for each 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").

kkkk. ***Section V. I. Financial Requirements, 4. Risk Corridor, b. Risk Corridor for Medicaid Expansion Eligible Member Populations, ii., a) is*** **revised to add the following:**

ii. For Period 2: July 1, 2024 to June 30, 2025.

llll. ***Section V. I. Financial Requirements, 4. Risk Corridor, b. Risk Corridor for Medicaid Expansion Eligible Member Populations, ii., d)*** **is revised and restated as follows**:

d) The PHP Target Services Ratio for Expansion populations shall be calculated using the Target Services Ratio for each applicable 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 and wrap payments).

mmmm. ***Section V. I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, c., ii.*** **is revised and restated as follows:**

ii. FQHC/RHC, excluding any applicable wrap payments

nnnn. ***Section V. I. Financial Requirements, 5. Minimum Primary Care Provider (PCP) Expenditure Requirement, e., iii.*** **is revised and restated as follows**:

iii. For the Risk Corridor Measurement Period for rating years three and four: ninety-five percent (95%) 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).

oooo. ***Section V. I. Financial Requirements, 6. Healthy Opportunities Pilot Payments, g., iii.*** **is revised and restated as follows:**

iii. Standard Plan Pilot Value-Based Payment Period Three (3): April 1, 2024 – October 31, 2024.

pppp. ***Section V. I. Financial Requirements, 6. Healthy Opportunities Pilot Payments, h. Pilot Administrative Payment Withhold, i.*** **is revised and restated as follows:**

i. The Department shall retain one percent (1%) of the PHP's Pilot administrative funds for each Pilot Service Delivery Period beginning in Pilot Service Delivery IV in accordance with *Section III.D.32. PAYMENT AND REIMBURSEMENT*. Actions taken by the Department to withhold a portion of the PHP's Pilot administrative funds shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a).

qqqq. ***Section V. J. Compliance, 4. Third Party Liability (TPL)*** **is revised to add the following:**

n. To support the insurance come-behind billing effort and protect the PHP's recovery rights on billed claims, the PHP shall submit to the Department a listing of the claims previously billed to insurance carriers or recovered by other means. This listing is referred to as a match-off file. After the initial match-off file is delivered, the subsequent frequency will be monthly.

i. To support the match-off process, the match-off file is required to contain the following data elements and be submitted using a Department-developed template:
   a) DHB Recognized Medicaid Identification number;
   b) From Date of Service;
   c) To Date of Service;
   d) Charge Amount;
   e) Paid Amount;
   f) Paid Date;
   g) Date Billed to Carrier or Claim Recouped from Provider; and
   h) Deposit date of recovery or date claim recouped from Provider.

ii. The initial match-off file is required to be a cumulative list of claims billed or recovered from July 1, 2021 to October 31, 2024. The PHP shall deliver the initial match-off file to the Department by no later than December 1, 2024.

iii. The PHP shall deliver the monthly match-off files to the Department by the fifteenth (15th) day of each month and include the claims billed or recovered in the previous calendar month.

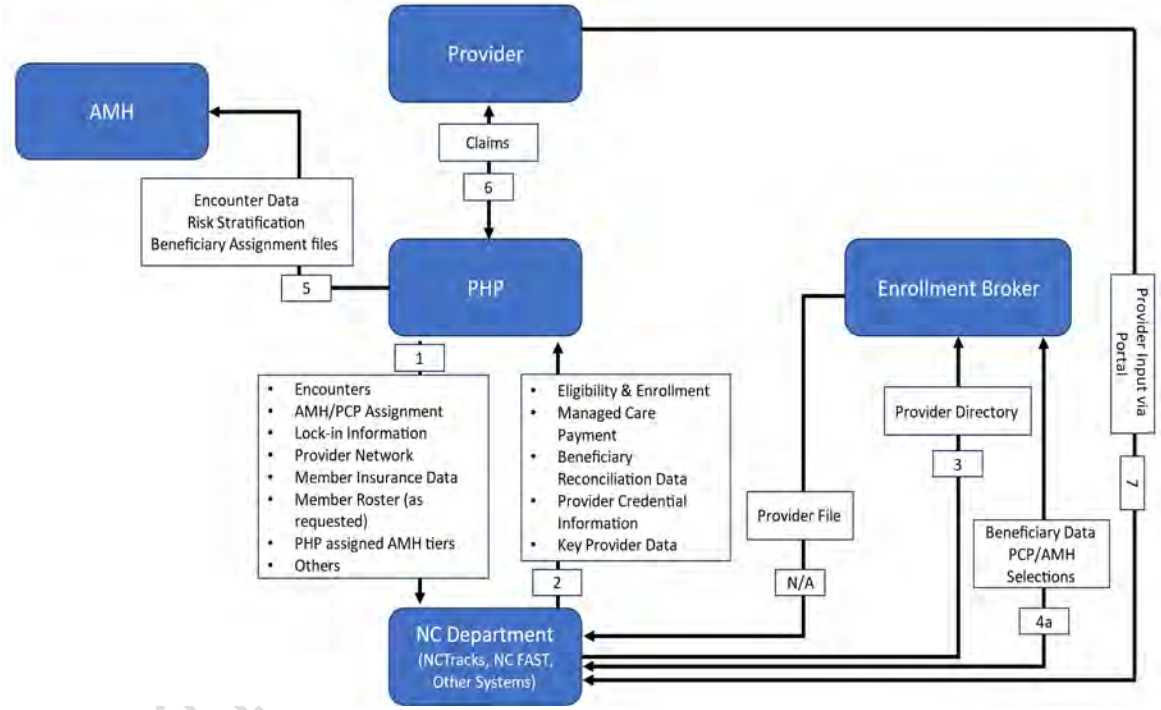
iv. If the PHP does not provide a match-off file or delivers it late to the Department, any resulting refunds requested by carriers will be refunded to the carrier by the PHP.

rrrr. ***Section V. J. Compliance, 5. Recipient Explanation of Medical Benefit (REOMB), a.*** **is revised and restated as follows:**

a. The PHP shall submit a REOMB report quarterly, or upon the request of the Department, on a template provided by the Department.

ssss. ***Section V. K. Technical Specifications, 1. Data Exchange Model, First Revised and Restated Diagram and Accompanying Matrix*** **is revised and restated as follows:**

Second Revised and Restated Diagram and Accompanying Matrix



tttt. ***Section V. K. Technical Specifications, 1. Data Exchange Model, Second Revised and Restated Data Exchange Description—For Informational Purposes*** **is revised and restated as follows:**

No.	Third Revised and Restated Data Exchange Description – For Informational Purposes
1.	The PHP will send the Department or its Vendors the following data: a) Encounter Data – Medical and pharmacy encounter data; b) AMH/PCP Assignment – The PHP will submit to the Department the Member's assigned AMH/PCP; c) Lock-in Data – Member lock-in data (including pharmacy and prescriber); d) Provider Network Data File; e) PHP Network File; f) Member Insurance Data; g) Member Enrollment – On request the PHP will send the Department its current, complete roster of Medicaid Managed Care Members; and h) PHP Assigned AMH Tiers – The Provider and updated AMH Tier assignment anytime the PHP changes the Provider Attested AMH tier including the reason for the change.
2.	The Department will send the PHP the following data: a) Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated Member records; b) Managed Care Payments; c) Member Reconciliation Date – The Department will send weekly 834 files to be used by the PHP for reconciliation purposes; and d) The Department will send a daily provider enrollment file.
3.	The Department will send the Enrollment Broker the following data: a) The Department will send the Enrollment Broker a full list of all active and enrolled providers, including the Medicaid provider roster for inclusion in the Provider Directory; b) The Department will send the Enrollment Broker the provider affiliation file that includes all group practices and their affiliated doctors for a given location for the organization; and c) The Department will send to the Enrollment Broker the PHP and Tribal Option network providers.
4a.	Real-time webservices between NC FAST and EB will be used to share beneficiary data from NC FAST to the EB and will also be used for the EB to send member PHP and PCP/AMH selections through that interface back to NC FAST.
5.	The PHP will send the following data to the AMH's: a) Member Assignments; b) Encounter / Claims Data; and c) Member Risk Stratification Data.
6.	The PHP and the Provider will exchange the following data: a) Claims Data – the contracted Providers will send claims data for payment to the PHP; and b) Payment Data – The PHP will send payments to the provider.
7.	The Provider enrolls in Medicaid and maintains provider data via the NCTracks Provider Portal.

uuuu. ***Section V. K. Technical Specifications, 3. Enrollment and Reconciliation, c. Provider Enrollment and Credentialing, ii.*** **is revised and restated as follows:**

ii. The PHP shall reconcile provider data with the Department, or designated vendor, at least daily.

vvvv. ***Section V. K. Technical Specifications, 5. Provider Directory, a.*** **is revised and restated as follows*:***

a. The Department's designated vendor is responsible for integrating the Provider Directory information to supply with a Consolidated Provider Directory to support PHP choice counseling and selection.
   i. The PHP should use the National Provider Identifier (NPI) issued by NPPES plus the Department's specified key as the unique provider identifier for the location. For those providers who do not qualify

for NPI's, the Atypical Provider ID issued by the Department's designated vendor system should be used.

wwww. ***Section V. K. Technical Specifications, 5. Provider Directory, b. Consolidated Provider Directory Data Transmissions, i.-iii.*** **is revised and restated as follows:**

i. The Department's designated vendor creates a Consolidated Provider Directory which will include all Managed Care and Medicaid Fee for Service providers.

ii. The PHP will create a successfully processed full Provider Network File (PNF) including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The PHP will deliver the file to the Department's designated vendor every Calendar Day by 5:00 p.m. A successfully processed full PNF means that for each submission of the PNF by the PHP to the Department's designated vendor, the PHP has included all provider records from the PHP's network in the file submission and the PHP receives a Provider Network Response File (PNrF) from the Department's designated vendor in response to the PNF submission.

iii. The final file format will be determined by the Department's designated vendor or the Department's PDM; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).

xxxx. ***Section V. K. Technical Specifications, 5. Provider Directory, b. Consolidated Provider Directory Data Transmissions, v.*** **is revised and restated as follows:**

v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the Department's designated vendor.

III. <u>Modifications to Section VI. Contract Performance</u>

Specific subsections are modified as stated herein.

a. ***Section VI. Contract Performance, B. Service Level Agreements, Sixth Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2023)*** **is revised and restated as follows:**

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
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.	Monthly	$1,000 per eligibility file that does not meet the submission guidelines of the eligibility file.
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

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
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 PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$100,000 per quarter
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 by a live operator within thirty (30) seconds and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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	Monthly	$10,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			answered by a live voice divided by the total number of calls received by the service line during open hours of operation.		
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 and the number of calls abandoned 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 PHP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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 by a live operator within thirty (30) seconds and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	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	Monthly	$10,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			answered by a live voice divided by the total number of calls received by the service line during open hours of operation.		
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 by a live operator within thirty (30) seconds and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
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 by a live operator within thirty (30) seconds and the number of calls abandoned 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 PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
21.	Call Abandonment Rate – Pharmacy	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or	Monthly	$10,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Line		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.		
22.	Encounter Data Timeliness – Medical	The PHP shall submit ninety- eight percent (98%) of medical encounters within thirty (30) Calendar Days after payment whether paid or denied. *For purposes of this standard, medical encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x.* *Effective October 1, 2023, this includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.* *Effective July 1, 2024, this includes encounter data for Integrated Care for Kids per member per month care management payments.*	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per encounter per Calendar Day
23.	Encounter Data Timeliness – Pharmacy	The PHP shall submit ninety-eight percent (98%) of pharmacy encounters within seven (7) Calendar Days after payment whether paid or denied. *For purposes of this standard, pharmacy encounters only include 837- P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.*	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 encounter per Calendar Day
24.	Encounter Data Accuracy – Medical	The PHP shall meet or exceed a ninety-eight percent (98%)	A paid claim submitted as an encounter which passes all	Monthly	$25,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		approval acceptance rate for Medical claims. *For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters.* *Effective October 1, 2023 this includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, CMARC and Healthy Opportunities per member per month payments.* *Effective July 1, 2024, this includes encounter data for Integrated Care for Kids per member per month care management payments.*	validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.		
25.	Encounter Data Accuracy – Pharmacy	The PHP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. *For purposes of this standard, pharmacy encounters only include NCPDP encounters.*	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
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 sixty (60) Calendar Days or at least ninety-nine percent (99%) 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	$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

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. *For purposes of this standard, medical encounters only include 837- P encounters and 837-I encounters.*	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
31.	Call Response Time/Call Answer Timeliness – NEMT Member Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned 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
32.	Call Wait/Hold Times – NEMT Member Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
33.	Call Abandonment Rate – NEMT Member Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
34.	Call Response Time/Call Answer Timeliness – NEMT Provider Line	The PHP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and the number of calls abandoned 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
35.	Call Wait/Hold Times – NEMT Provider Line	The PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes and the number of calls abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
36.	Call Abandonment Rate – NEMT Provider Line	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
37.	Non-Emergency Transportation – Hospital Discharge	The PHP shall ensure that at least ninety-eight percent (98%) of Medicaid Members discharged from hospitals or emergency departments are picked up within three (3) hours of receipt of the request from the Member, the Member's authorized representative, or hospital staff, or within (3) hours of the Member's scheduled discharge, whichever is later, as specified in the *NC Non-Emergency Medical Transportation Managed Care Policy*.	The number of trips per month that Contractor fails to pick up at least ninety-eight percent (98%) of Medicaid Members being discharged from a hospital or emergency department within the established timeframes after receipt of a request from the Member, the Member's authorized representative, or hospital staff for NEMT.	Monthly	$3,000 per trip for any delay beyond the three (3) hour pick-up requirement for any trip above the 2% threshold
38.	Member Welcome Packet Timeliness – Single Mailing of	The PHP shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets	The number of Member Welcome Packets (single mailing of entire welcome	Monthly	98.99% - 95%: $5,000 per month

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Entire Welcome Packet *Applies if the PHP utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	(single mailing of entire welcome packet) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	packet) mailed by the PHP within the required timeframe divided by the total number of new Members enrolled in the PHP during the measurement period.		94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
39.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	The PHP shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *Section V.B.3. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the PHP within the required timeframe divided by the total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
40.	Member Welcome Packet Timeliness – Separate Mailing for Identification Card *Applies if the PHP utilizes separate mailings to send components of the Welcome Packet*	The PHP shall meet or exceed ninety-nine percent (99%) of identification cards (mailed separately from welcome letters and Member handbooks) mailed within the timeframes specified in *Section V.B.3.Member Engagement.*	The number of identification cards (mailed separately from welcome letters and Member handbooks) mailed by the PHP within the required timeframe divided by total number of new Members enrolled in the PHP during the measurement period.	Monthly	98.99% - 95%: $5,000 per month 94.99% - 80%: $7,500 per month 79.99% or less: $10,000 per month
41.	Provider Welcome Packet Timeliness	The PHP shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in *Section V.D.3. Provider Relations and Engagement.*	The number of Provider Welcome Packet sent by the PHP within the required timeframe divided by the total number of new providers who have executed a contract with the PHP during the measurement period.	Quarterly	97.99% - 95%: $5,000 per quarter 94.99% - 80%: $7,500 per quarter 79.99% or less: $10,000 per quarter

Seventh Revised and Restated Section VI.A. Table 2: PHP Service Level Agreements (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
42.	Non-Emergency Medical Transportation – Approved Trips	The PHP shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the PHP minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-J-SP operational report, divided by the total number of NEMT trips approved by the PHP. *NEMT trips for hospital discharges will not be included in determining compliance with this SLA.*	Monthly	99.25%-99.49% = $15,000 per month 99.01%-99.24% = $20,000 per month 99% or less = $25,000 per month

IV. <u>Modifications to Section VII. Attachments A-N</u>

Specific Attachments are modified as stated herein.

a. ***Section VII. Attachments A – N* is renamed to *Section VII. Attachments.***

b. ***Attachment A. Second Revised and Restated PHP Organization Roles and Positions is revised and restated in its entirety as Attachment A. Third Revised and Restated PHP Organization Roles and Positions and attached to this Amendment.***

c. ***Attachment E. Third Revised and Restated Required PHP Quality Metrics is revised and restated in its entirety as Attachment E. Fourth Revised and Restated Required PHP Quality Metrics and attached to this Amendment.***

d. ***Attachment F. Fifth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards is revised and restated in its entirety as Attachment F. Sixth Revised and Restated North Carolina Medicaid Managed Care Network Adequacy Standards and attached to this Amendment.***

e. ***Attachment G. Seventh Revised and restated Required Standard Provisions for PHP and Provider Contracts is revised and restated in its entirety as Attachment G. Eight Revised and restated Required Standard Provisions for PHP and Provider Contracts and attached to this Amendment.***

f. ***Attachment J. Seventh Revised and Restated Reporting Requirements is revised and restated in its entirety as Attachment J. Eighth Revised and Restated Reporting Requirements and attached to this Amendment.***

g. ***Attachment M.2. First Revised and Restated Advanced Medical Home Program Policy is revised and restated in its entirety as Attachment M.2. Second Revised and Restated Advanced Medical Home Program Policy and attached to this Amendment.***

h. ***Attachment M.4 Care Management for High-Risk Pregnancy Policy is revised and restated in its entirety as Attachment M.4 First Revised and Restated Care Management for High-Risk Pregnancy Policy and attached to this Amendment.***

i. ***Attachment M.5 Care Management for At-Risk Pregnancy Policy is revised and restated in its entirety as Attachment M.5 First Revised and Restated Care Management for At-Risk Pregnancy Policy and attached to this Amendment.***

j. ***Attachment M.6. Fourth Revised and Restated Uniform Credentialing and Re-credentialing Policy is revised and restated in its entirety as Attachment M. 6. Fifth Revised and Restated Uniform Credentialing and Re-credentialing Policy and attached to this Amendment.***

k. ***Attachment M.10. First Revised and Restated Approved PHP Name In Lieu of Services is revised and restated in its entirety as Attachment M.10. Second Revised and Restated Approved PHP Name In Lieu of Services and attached to this Amendment.***

l. ***Section VIII. Attachment O. 7. Second Revised and Restated Offeror's Proposal and Response: Contractor's Contract Administrators is revised and restated in its entirety as Attachment O. 7. Third Revised and Restated Offeror's Proposal and Response: Contractor's Contract Administrators and attached to this Amendment.*** BCBS Only

V. Modifications to Section IX. Draft Rate Book

Section IX. Draft Rate Book is renamed to ***Section IX. Standard Plan Rate Book*** and revised and restated in its entirety to incorporate *Standard Plan Rate Book State Fiscal Year 2025,* which is attached to this Amendment.

VI. Effective Date

This Amendment is effective July 1, 2024, unless otherwise explicitly stated herein, subject to approval by CMS.

VII. 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.

Department of Health and Human Services

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

Plan Name

_____ Date: _____

Plan Signature Authority

Attachment A. Third Revised and Restated PHP Organization Roles and Positions

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

Third Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff	These individuals will carry out the implementation and readiness review terms of the contract.	• N/A
2. Full-Time Member Services Staff	These individuals will coordinate communication with Members.	• Must reside in North Carolina
3. Member Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates Member complaints, grievances and appeals in a timely manner.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program
4. Full-Time Member Complaint, Grievance, and Appeal Staff	These individuals will work to resolve Member complaints, grievances and appeals in accordance with state and federal laws and this Contract.	• Must have appropriate clinical expertise in treating the Member's condition or disease for which they will be reviewing appeals for
5. Full-Time Utilization Management Staff	These individuals will conduct utilization management activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Shall be NC-licensed nurses and/or licensed behavioral health professionals in good standing • Pharmacists must be registered, with current NC Pharmacist license
6. PBM Liaison	If the PHP partners with a third-party PBM, this individual will serve as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	• N/A
7. Care Management Supervisor	This individual shall be responsible for all staff and activities related to the care management program, and shall be responsible for ensuring the functioning of care management activities across the continuum of care.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program • Care Manager for behavioral health services is NC-licensed LCSW in good standing • Care Manager for medical services is a NC-licensed registered nurse in good- standing
8. Full-Time Care Managers	This individual shall be responsible for conducting all functions and activities of the care management program and serve as the lead for each care management teams.	• Must reside in North Carolina • Must be licensed practitioners • Must be supervised by an RN, LCSW, or psychologist with trauma-based experience and training provider

Third Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
9. Care Management Staff	As part of the care management team, these individuals shall be responsible for conducting all functions and activities of the care management program.	• Must reside in North Carolina • Care management staff may include social workers, community health workers and peers
10. Behavioral Health (BH) Managers and Full-Time BH Staff	These individuals shall be responsible for integrating into the clinical and care management teams to ensure Member's behavioral health needs are fully integrated into the service delivery system.	• Must reside in North Carolina • Experience working in behavioral health managed care and clinical setting • Licensed behavioral health professional practicing within their scope
11. Full-Time Care Management Housing Specialist	This individual(s) can assist Members who are experiencing housing instability, including those homeless in securing housing.	• Must reside in North Carolina
12. Full-Time Care Management Transition Staff	These individuals will assist Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.	• Must reside in North Carolina
13. Provider Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must reside in North Carolina • Fully dedicated to the North Carolina Medicaid Managed Care program
14. Provider Relations and Call Center Staff	These individuals will coordinate communications between the PHP and providers.	• Must reside in North Carolina
15. Pharmacy Director for the Pharmacy Service Line	This individual will oversee all Pharmacy Service Line staff management and ensure the team meets the requirements of the Contract.	• NC registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
16. Pharmacy Technician Supervisor for the Pharmacy Service Line	This individual will ensure Pharmacy Service Line staff are trained on and compliant with pharmacy clinical coverage policies, prior authorization (PA) requirements, and drug formularies/preferred drug lists.	• Certified Pharmacy Technician registered with the NC Board of Pharmacy • Minimum of three (3) years of pharmacy benefits call center experience
17. Liaison between the Department and the North Carolina Attorney General's Medicaid Investigation Division	This individual will serve as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must reside in North Carolina

Third Revised and Restated Section VII. Attachment A. Table 1: PHP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
18. Special Investigations Unit (SIU) Lead	This individual shall lead the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate the Department and OCPI, as well as ensure timely resolution of investigation.	• Fully dedicated to the North Carolina Medicaid Managed Care Program Funded from the North Carolina Medicaid budget
19. Special Investigations Unit (SIU)	These individuals will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice or have at least three (3) years of relevant experience.
20. Tribal Provider Contracting Specialists	These individuals shall be trained in IHCP requirements and accountable to developing necessary tribal networks.	• Must reside in North Carolina
21. Liaison to the Division of Social Services	This individual will serve as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serve as a primary contact to triage and escalate Member specific or PHP questions.	• Must reside in North Carolina
22. InCK Integration Consultant	This individual will support care teams in implementing InCK by providing consultations to support Family Navigators on topics including but not limited to resource navigation across core child service areas, trainings, and connections to help InCK participant meet goals of Shared Action Plan. The Integration Consultant also advises InCK leadership on key components of the model.	• Must reside in North Carolina • 1.0 FTE required per PHP • Must have clinical experience (e.g. Care Manager, RN, BSW, LPN, MSW). • Must be selected through collaborative process with NC InCK Managing Director and Operations and Strategy Director
23. InCK Family Navigator	This individual will be a designated care team member assigned to support an InCK member's (assigned to SIL 2 and SIL 3) care integration needs.	• Must reside in North Carolina • Must have clinical experience (e.g. Care Manager, RN, MSW, LPN, BSW)

Attachment E. Fourth Revised and Restated Required PHP Quality Metrics

Section VII. Fourth Revised and Restated Attachment E. Table 1: Survey Measures and General Measures lists the Department's quality and administrative measures that are meant to provide the Department with a complete picture of the 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.

1. The PHP shall track all measures listed in *Section VII. Fourth Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*. The Department will monitor other measures that are not included in the table below and may engage with the PHPs around these performance measures. An asterisk (*) indicates that the measure is calculated by the Department.

Section VII. Fourth Revised and Restated Attachment E. Table 1. Survey and General Measures				
Reference #	Measure Steward	*CBE #*	*Measure Name*	*AMH Measure*
1.	NCQA	1516	Child and Adolescent Well-Care Visit (WCV)	x
2.	NCQA		Well-Child Visits in the First 30 Months of Life (W30)	x
3.			Reserved.	
4.	NCQA	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
5.	NCQA	0032	Cervical Cancer Screening (CCS/CCS-E)	x
6.	NCQA	0038	Childhood Immunization Status (Combination 10) (CIS 10) (CIS/CIS-E) ^Ù	x
7.	NCQA	0033	Chlamydia Screening in Women (CHL)	x
8.	NCQA	0059/0575	Glycemic Status Assessment for Patients with Diabetes (GSD) ^ÙÙ	x
9.	NCQA	0018	Controlling High Blood Pressure (CBP)	x
10.			Reserved.	
11.	NCQA	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	

^ This measure is a 2024 Standard Plan Withhold measure.

^^ The Department requires both administrative and hybrid reporting for this measure.

12.	NCQA	1517	Prenatal and Postpartum Care (PPC)ÙÙÙÙ	x
13.	NCQA	1407	Immunizations for Adolescents (Combination 2) (IMA /IMA-E)	x
14.	NCQA	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	
15.	DHHS	N/A	Low Birth weight	
16.			Reserved.	
17.	PQA	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	
18.	DHHS	N/A	Rate of Screening for Pregnancy Risk* Ù^^^^	
19.	DHHS	N/A	Screening for Health-Related Resource Needs (HRRN)* ÙÙÙÙÙÙ	
20.	CMS	8F/0418e	Screening for Depression and Follow-Up Plan (CDF) Ù^^^^^^	x
21.			Reserved.	
22.	NCQA	1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	x
23.	Health Partners	N/A	Total Cost of Care*	x
24.	NCQA	1800	Asthma Medication Ratio (AMR)	
25.	NCQA	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	
26.	NCQA	0034	Colorectal Cancer Screening (COL-E)	x
27.	NCQA	0108	Follow-Up Care for Children Prescribed Attention- Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	
28.			Reserved.	
29.	NCQA	3620	Adult Immunization Status (AIS-E)	
30.	NCQA	N/A	Antibiotic Utilization for Respiratory Conditions (AXR)	
31.	NCQA	2372	Breast Cancer Screening (BCS-E)	
32.	NCQA	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	

^^^^ This measure is a 2024 Standard Plan Withhold measure. The Department requires both administrative and hybrid reporting for this measure.

^^^^^ The Department will work jointly with the PHP and CCNC to collect pregnancy risk screening data and report this measure.

^^^^^^ This measure is a 2024 Standard Plan Withhold measure.

^^^^^^^ The PHP must report to the Department whether they are using the standard or electronic measure.

2. Updates to PHP Quality Metrics
    a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website and subsequently amend *Section VII. Fourth Revised and Restated Attachment E. Table 1: Survey Measures and General Measures*, as necessary, to align with the annual January.
    b. The PHP shall adopt the updated measures posted annually in January for the upcoming measurements year with reporting to be provided to the Department in June of the subsequent year.
    c. The PHP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Section VII. Sixth Revised and Restated Attachment J. Table 1: Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2024, the PHP would report the results in June 2025).

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

At a minimum, Contractor'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.

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, Contractor 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. Third 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
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	

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

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 atleast 95% of Members
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. Third Revised and Restated Table 1: PHP Time/Distance Standards* and *Section VII. Attachment F. Sixth Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards*.

Section VII. Attachment F. Sixth 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) • Diagnostic Assessment • 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) • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program

Section VII. Attachment F. Sixth Revised and Restated Table 2: Definition of Service Category for Behavioral Health Time/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 withdrawal management, without extended on-site monitoring • Ambulatory withdrawal management, with extended on-site monitoring • Medically Monitored Inpatient Withdrawal Services • Clinically Managed Residential Withdrawal Services (Social Setting Detox) • Mobile Crisis Management
4.	Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Withdrawal Management Services beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Services beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent/child Medically Managed Intensive Inpatient Services beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

PHP 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. Third 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 of 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}
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

Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
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.: First Revised and Restated Behavioral Health Service Definition Policy	Within two (2) hours
10	Urgent Care Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within twenty-four (24) hours
11	Urgent Care Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within twenty-four (24) hours
12	Routine Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within fourteen (14) Calendar Days
13	Routine Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Within forty-eight (48) hours
14	Emergency Services for Mental Health	Refer to Attachment M. 8.: First Revised and Restated Behavioral Health Service Definition Policy	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. Attachment F. Third Revised and Restated Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
15	Emergency Services for SUDs	Refer to Attachment M. 8.: First Revised and Restated 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. Second Revised and Restated 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
8a.	Gynecology[2]
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

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

Attachment G. Ninth 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 must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the 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 State's Credentialing and Re-credentialing Policy and to notify the Department 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. Third 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 or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).

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.

cc. Designated Pilot Care Management Entities: For all contracts with Designated Pilot Care Management Entities, provisions that indicate:
    i. The Designated Pilot Care Management Entity shall:
        a) Utilize NCCARE360 for functions outlined in *PHP Contract Sections V.C.8.e.ii.a. and V.C.8.g.xiv.*
        b) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, v.b.*
        c) Manage transitions of care for Pilot-enrolled Members as outlined in *PHP Contract Section V.C. Benefits and Management, 6. Care Management, a.v.c. Transitional Care Management* for Members that change health plans.
        d) Perform Pilot-related care management responsibilities as outlined in *PHP Contract Section V.C. Benefits and Management, 8. Opportunities for Health, g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs, also known as Healthy Opportunities Pilot*.
        e) Abide by the Pilot provider complaint process described in *PHP Contract Section V.D.5 Provider Grievances and Appeals, j. HSO Grievances related to the Healthy Opportunities Pilot.*
        f) Adhere to the technology requirements described in *PHP Contract Section V.K. Technical Specifications, 8. Healthy Opportunities Pilot Technology Specifications.*
        g) If the Designated Pilot Care Management Entity is a Tier 3 AMH or CIN, it must participate in the Healthy Opportunities Pilot Care Management Payment Withhold outlined in this Contract and described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments***.** Designated Pilot Care Management Entities that are Local Health Departments are excluded from participation in the Healthy Opportunities Pilot Care Management Payment Withhold.
    ii. The PHP shall:
        a) Make Pilot care management payments including, as applicable, any amounts withheld as part of the Pilot Care Management Payment Withhold, to Designated Pilot Care Management Entities for Pilot-enrolled members as outlined in *Section III.D.32.e.iii. Pilot Care Management Payments*.
        b) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, PHP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.
    iii. The PHP shall include Department-developed standard contract language included in the Advanced Medical Home (AMH) Manual in its contracts with Designated Pilot Care Management Entities.
    iv. Healthy Opportunities Pilot Care Management Payment Withhold (Pilot Care Management Payment Withhold)
        a) The Pilot Care Management Payment Withhold is defined as a set

percentage of the monthly care management payment for which the Tier 3 AMH or CIN Delegated Pilot Care Management Entity, in partnership with the PHP and its PHP(s)' other Tier 3 AMH or CIN Delegated Pilot Care Management Entities, is required to meet specific performance target(s) described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* as a condition to receive the retained portion of the payment from the PHP.

b) The amount of the Pilot Care Management Payment Withhold shall be set at one percent (1%) of the monthly fixed Pilot care management payments made to the Tier 3 AMH or CIN Designated Pilot Care Management Entity by the PHP.

c) Within fifteen (15) Calendar Days of the PHP's receipt of the written notice of withhold from the Department described in PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* in advance of each performance period subject to a Pilot Care Management Payment Withhold, the PHP shall provide written notification to the Tier 3 AMH or CIN Designated Care Management Entity of the applicable performance period, details of the associated performance target(s) that is required to earn the retained funds, and the effective date that funds will start being withheld.

d) For the Tier 3 AMH or CIN Delegated Pilot Care Management Entity to receive the retained Pilot Care Management Payments, the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, shall meet the target during the applicable performance period subject to the withhold, in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments*.

e) Following the end of the applicable performance period and within thirty (30) Calendar Days of receipt of the notification of the determination of whether the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, met the performance target(s) during the performance period, the PHP shall notify the Tier 3 AMH or CIN Delegated Pilot Care Management Entity of the determination.

f) If a determination is made in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* that the targets have been met by the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, by the end of the applicable performance period, the PHP shall make a single, lump sum payment to the Tier 3 AMH or CIN Delegated Pilot Care Management Entity of the retained funds within sixty (60) Calendar Days of receipt of the funds from the Department.

g) If a determination is made in accordance with PHP Contract *Section V.D. Providers 4. Provider Payments, aa. Healthy Opportunities Pilot Payments, ii. Pilot Care Management Payments* that the performance

target(s) have not been met by the PHP, in partnership with its Tier 3 AMH or CIN Designated Pilot Care Management Entities, by the end of the applicable performance period, the Tier 3 AMH or CIN Delegated Pilot Care Management Entity is not entitled to the retained funds.

dd. Healthy Opportunities Network Leads: The PHP must contract with any Healthy Opportunities Network Lead operating in the PHP's Region(s), as noted in Section V.D.1.c.vi, using a Department-standardized PHP-Network Lead model contract, to access the Network Lead's network of Pilot providers, also referred to as Human Service Organizations (HSOs).

ee. Advanced Medical Home InCK: For all Advanced Medical Homes participating in the InCK program, a provision that outlines the InCK model and requirements that is consistent with the Advanced Medical Home Manual. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's InCK Program.

ff. Category A and Category B Providers (as those terms are defined in 10A NCAC 27G .0602(8)): For all contracts with Category A or Category B providers, provisions that require compliance with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

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

a. Attachment M. 2. First Revised and Restated 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
e. Advanced Medical Home Manual

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; and*
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 for a date of service on or before June 30, 2023, 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), except for pharmacy point of sale claims which shall be submitted within three-hundred sixty-five (365) Calendar Days of the date of the provision of care. When a Member is retroactively enrolled, the [Company] shall not limit the time in which claims may be submitted by the [Provider] to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

The [Provider] shall submit all claims with a date of service on or after July 1, 2023, to the [Company] for processing and payments within three hundred sixty-five (365) Calendar Days from the date of covered service or discharge (whichever is later). When a Member is retroactively enrolled, the [Company] shall not limit the time in which claims may be submitted by the [Provider] to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims.

However, the [Provider's] failure to submit a claim within these timeframes will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i. *For Medical claims (including 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. The [Company] shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The [Company] shall implement the capability for EDI 277 and electronic method (portal or email) January 1, 2024, or later date if approved by the Department.*
    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.*

ii. *For Pharmacy Claims:*

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

iii. *If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) Calendar 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 if applicable).*

iv. *If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid.*

v. *The [Company] shall pay the interest as provided in this section and shall not require the [Provider] to request the interest.*

vii. *For purposes of claims payment, the [Company] shall be deemed to have paid the claim as of the Date of Payment, and the [Company] shall be deemed to have denied the claim as of the date the remittance advice is sent to the [Provider]. The [Company] defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the [Provider] or the date a paper check is mailed to the [Provider].*

h. Contract Effective Date.

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

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

i. Tobacco-Free Policy.

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

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

ii. Providers Subject to a Partial Tobacco-Free Policy

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

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

1. *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.*
2. *Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:*
    a. *Ensure access to common outdoor space(s) free from exposure to tobacco use.*
    b. *Prohibit staff/employees from using tobacco products anywhere on the property.*

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

iii. Providers subject to Full Tobacco-Free Policy

Beginning on the date that the BH I/DD Tailored Plans launch, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

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

Attachment J. Eighth 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.

Eighth 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. Reserved.	[redacted]
e. Reserved.	
f. Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
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 weekly 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.
n. Reserved.	
3. ***Benefits and Care Management***	
a. Institute of Mental Disease (IMD) Report	Every other week summary of members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.
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 ad hoc 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.

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
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. Reserved.	[redacted]
n. Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.
o. Reserved.	[redacted]
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. Reserved.	[redacted]
s. Reserved.	
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.
y. UM and Clinical Coverage Report	Ad Hoc report outlining analysis of compliance with attestation upon request.

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
z. PCP Assignment Monitoring Report	Biweekly report on PCP assignment, changes and panel limits.
4. ***Providers***	
a. Network Data Details Extract	Quarterly and ad hoc report containing demographic information on network providers.
b. Reserved.	[redacted]
c. Reserved.	
d. Reserved.	
e. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for key provider contracting and service functions, provider welcome packets, time to load provider or a provider contract's administrative changes to PHP's claim adjudication and payment systems during the reporting period, including break down of data by provider type and by specified turn-around time periods.
f. Reserved.	[redacted]
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. Reserved.	[redacted]
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. Reserved	[redacted]
n. Provider Grievances, and 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	Quarterly report to capture claims data, calculations, and summary report for Local Health Dept directed payments.

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
Report	
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. Reserved.	
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. Reserved.	
y. Reserved.	
z. Reserved.	
5. ***Quality and Value***	
a. Reserved.	
b. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.
c. Reserved	
d. Reserved	
e. Reserved	
f. Annual Quality Measures Report	Annual PHP performance on quality measures to track.
g. Eligible Mothers for Low Birth Weight Extract	Quarterly update on eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
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	Monthly 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).
d. Reserved.	
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. Reserved.	

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
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. (Section IV.4.d.)
i. Recipient Explanation of Medical Benefit (REOMB) Report	The PHP is responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The PHP sends REOMBs to a random sample of Members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the Member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The PHP is required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.
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. Audited Financial Statements submitted as part of this reporting packet must comply with 42 C.F.R. § 438.3(m).
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.
d. NC PHP Claims Monitoring Report	Monthly summary of the volume and dollar amount of claims that were paid, denied, and rejected during the reporting period, and current inventory of pended claims by professional, institutional, and pharmacy. Top 10 denial reasons by volume and dollar amount.
e. TPL Recovery Match Report	A monthly report detailing those claims upon which the PHP has been unable to effectuate recovery within one (1) year of the date of service.
10. *Healthy Opportunities Pilot*	
a. Reserved.	
b. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the PHP may submit if the Department notifies the PHP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the PHP's anticipated spending through the remainder of the Pilot service delivery year.
c. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.

Eighth Revised and Restated Section VII. Attachment J. Table 1: Reporting Requirements	
PHP Report Name	**PHP Report Description**
d. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of PHP Pilot administrative fund spending.
e. Healthy Opportunities Pilot Care Management Assignment Report	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Pilot Enrolled Beneficiaries.
f. Healthy Opportunities Pilot High-Priority Populations Report	Report that the PHP will submit in dual parts: (a) annually, the PHP will submit the Priority Populations Report outlining the PHP's plan for enrolling priority populations, to understand the PHP's enrollment plans and ensure inclusive representation of priority populations. (b) quarterly, the PHP will submit the report outlining aggregate enrollment data for these priority populations, to understand the PHP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a).

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Attachment M.2. Second 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. The PHP shall maintain a contractual relationship with the AMH (not the CIN).

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 reconciliation 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 reconciliation;
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. First Revised and Restated 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 -5**	**6 to -21**	**22 to 121**
1	Adult Preventative and Ancillary Health Assessment			Y
2	Blood Lead Level Screening	Y	Y	
3	Cervical Cancer Screening (applicable to Females only)		As Needed	Y
4	Vaccines per ACIP recommendations https://www.cdc.gov/vaccines/hcp/acip-recs/index.html	Y	Y	Y
5	Reserved			
6	Health Check Screening Assessment	*	*	
7	Hearing	*	*	
8 & 9	Hemoglobin or Hematocrit	*	*	As Needed
10	Reserved			
11	Reserved			
12	Reserved			
13	Reserved			
14	Reserved			
15	Standardized Written Developmental	*		
16	Reserved			
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	*	*	Y
18	Urinalysis		*	Y
19	Reserved			

Section VII. Attachment M.2. First Revised and Restated 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 -5**	**6 to -21**	**22 to 121**
20	Vision Assessment	*	*	Y

* Please refer to the American Academy of Pediatrics: Bright Futures Periodicity Schedule for information on when preventive services should be delivered to children under the age of 21. The AAP Bright Futures Periodicity Schedule can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

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Attachment M.4. First Revised and Restated Care Management for High-Risk Pregnancy Policy

1. **Background**
   Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments. Refer to the Contract for additional detail regarding Care Management for High-Risk Pregnancy.

2. **Scope**
   The scope of this Policy covers the agreement between the PHP and LHD providers offering Care Management for High-Risk Pregnancy, as outlined below and in the Contract.

3. **General Contracting Requirement**
   a. LHDs shall accept referrals from the PHP for Care Management for High-Risk Pregnancy Services.

4. **Care Management for High-Risk Pregnancy: Outreach**
   a. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
   b. LHD shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

5. **Care Management for High-Risk Pregnancy: Population Identification and Engagement**
   a. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) calendar days of receipt of risk screening forms.
   b. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome.
   c. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.
   d. LHD shall review available PHP data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.
   e. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

6. **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**
   a. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support
   b. LHD shall utilize assessment findings, including those conducted by the PHP to determine level of need for care management support.

c. LHD shall document assessment findings in the care management documentation system.
d. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained.
e. LHD shall assign case status based on level of patient need.

7. Care Management for High-Risk Pregnancy: Interventions

a. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.
b. LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
c. LHD shall develop patient-centered care plans, including appropriate goals, interventions and tasks.
d. LHD shall utilize NC Resource Platform and identify additional community resources once the Department has certified it as fully functional.
e. LHD shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Member 's PHP network.
f. LHD shall document all care management activity in the care management documentation system.

8. Care Management for High-Risk Pregnancy: Integration with the PHP and Healthcare Providers

a. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
b. LHD shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
c. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county.
d. LHD shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
e. LHD shall ensure awareness of PHP Members' "in network" status with providers when organizing referrals.
f. LHD shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

9. Care Management for High-Risk Pregnancy: Collaboration with PHP

a. LHD shall work with the PHP to ensure program goals are met.
b. LHD shall review and monitor PHP reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk.
c. LHD shall communicate with PHP regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.
d. LHD shall participate in pregnancy care management and other relevant meetings hosted by the PHP.

10. Care Management for High-Risk Pregnancy: Training

a. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by PHP and/or the Department, including webinars, new hire orientation or other programmatic training.

b. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by PHP and/or the Department.
c. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
d. LHD shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

11. Care Management for High-Risk Pregnancy: Staffing

a. LHD shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:
    i. Registered nurses;
    ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program.
    iii. Bachelor's degree in a human service field with five (5) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5.
    iv. Bachelor's degree in a human service field with three (3) or more years of care management/case management experience working with the specific population of (low-income, pregnant individuals and/or children ages 0-5) and has certification as a Case Manager (Commission for Case Manager (CCM) Certification preferred).
    v. Program staff hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.
b. LHD shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
c. LHD shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team.
d. If the LHD only has a single Care Manager for High-Risk Pregnancy, the LHD shall ensure access to individual (s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
e. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
f. LHD shall ensure that Pregnancy Care Managers must demonstrate:
    i. A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
    ii. Proficiency with the technologies required to perform care management functions
    iii. Motivational interviewing skills and knowledge of adult teaching and learning principles;
    iv. Ability to effectively communicate with families and providers; and
    iii. Critical thinking skills, clinical judgment and problem-solving abilities.
g. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    i. Provision of program updates to care managers.
    ii. Daily availability for case consultation and caseload oversight.
    iii. Regular meetings with direct service care management staff.

iv. Utilization of reports to actively assess individual care manager performance.
v. Compliance with all supervisory expectations delineated in the Care Management for High- Risk Pregnancy Program Manual.

h. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following PHP/Department guidance about communication with PHP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
i. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by PHPs.

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Attachment M. 5. First Revised and Restated Care Management for At-Risk Children Policy

1. **Background**
   Care Management for At-Risk Children are care management services provided by Local Health Departments to a subset of the Medicaid population ages 0-5 identified as being "high-risk." Refer to the Contract for additional detail regarding the Care Management for At-Risk Children Program.

2. **Scope**
   The scope of this Policy covers the required terms that must be in agreements between the PHP and Local Health Department providers offering Care Management for At-Risk Children outlined below and in the Contract.

3. **Care Management for At-Risk Children: General Requirements**
   LHD shall accept referrals from the PHP for children identified as requiring Care Management for At-Risk Children.

4. **Care Management for At-Risk Children: Outreach**
   a. LHD shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources.
   b. LHD shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At- Risk Children services.
   c. LHD shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross- county partnerships to optimize care for patients who receive services from outside their resident county.
   d. LHD shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population.
   e. LHD shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the Department.

5. **Care Management for At-Risk Children: Population Identification**
   a. LHD shall use any claims-based reports and other information provided by PHPs, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations.
   b. LHD shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.
   c. LHD shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

6. **Care Management for At-Risk Children: Family Engagement**
   a. LHD shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
   b. LHD shall foster self-management skill building when working with families of children.
   c. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

7. **Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level**
    a. LHD shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description.
    b. LHD shall review and monitor PHP reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
    c. LHD shall use the information gained from the assessment to determine the need for and the level of service to be provided.

8. **Care Management for At-Risk Children: Plan of Care**
    a. LHD shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.
    b. LHD shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home.
    c. LHD shall provide care management services in accordance with program guidelines, including condition- specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals.
    d. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need.
    e. LHD shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

9. **Care Management for At-Risk Children: Integration with PHPs and Health Providers**
    a. LHD shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient- centered plans and goals targeted to meet individual child's needs.
    b. LHD shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team.
    c. Where care management is being provided by a PHP and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the PHP/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services
    d. LHD shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical home PCP and/or care team and to the PHP.
    e. LHD shall ensure awareness of PHP Member's "in network" status with providers when organizing referrals.
    f. LHD shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

10. **Care Management for At-Risk Children: Service Provision**
    a. LHD shall document all care management activities in the care management documentation system in a timely manner.
    b. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

11. Care Management for At-Risk Children: Training

a. LHD shall participate in Department/PHP-sponsored webinars, trainings and continuing education opportunities as provided.
b. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

12. Care Management for At-Risk Children: Staffing

a. LHD shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications:
    i. Registered nurses;
    ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program.
        1. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines.
    iii. Bachelor's degree in a human service field with five (5) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5.
    iv. Bachelor's degree in a human service field with three (3) or more years of care management/case management experience working with the specific population of (low-income, pregnant individuals and/or children ages 0-5) and has certification as a Case Manager (Commission for Case Manager (CCM) Certification preferred).
    v. Program staff hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.
b. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.
c. LHD shall ensure that Care Management for At-Risk Children Care Managers must demonstrate:
    i. Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system;
    ii. Ability to effectively communicate with families and providers; and
    iii. Critical thinking skills, clinical judgment and problem-solving abilities.
    iv. Motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles
d. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.
e. If the LHD has only has a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
f. LHD shall maintain services during the event of an extended vacancy.
g. In the event of an extended vacancy, LHD shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.
h. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency

planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.

i. LHD shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

j. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    i. Provision of program updates to care managers.
    ii. Daily availability for case consultation and caseload oversight.
    iii. Regular meetings with direct service care management staff.
    iv. Utilization of monthly and on-demand reports to actively assess individual care manager performance.

k. LHD shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

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Attachment M. 6. Fifth 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 program.

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 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-Service 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 the PHP Provider Manual 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 the PHP Provider Manual 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 policies and procedures, 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 the Department's Uniform Credentialing and Re-credentialing 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) Reserved.

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.

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) Reserved.

ii. PHP shall follow the Department's Unform 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.

iv. Reserved.

The remainder of this page is intentionally left blank.

Second Revised and Restated Attachment M.10. Approved PHP Name In Lieu of Services

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

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

1. The Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute based on documentation provided to the Department by the PHP demonstrating such cost effectiveness and clinical effectiveness;
2. The PHP shall ensure that Members are provided the rights outlined in *Section V.C.1.g. In Lieu of Services* for all approved In Lieu of Services;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the PHP; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise. In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process.

In accordance with *Section V.C. Benefits and Care Management*, the following In Lieu of Services have been approved by the Department:

Second Revised and Restated Attachment M.10. Approved PHP NAME In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.						
2.						
3.						

Second Revised and Restated Attachment M.10. Approved AmeriHealth Caritas of North Carolina In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.	Institute for Mental Disease (IMD) for Mental Health Services for Members 22-64	0160	7/1/2021	Use of IMD settings for Members in need of psychiatric care provides the needed level of care and supervision for these adults while avoiding a more costly admission in an inpatient psychiatric unit. The added benefit is leaving the inpatient psychiatric bed open for individuals who need that level of care, and thereby reducing the incidence of Members in need of an inpatient psychiatric admission waiting for prolonged periods in the emergency room.	Target population includes Members age 21- 64 who need mental health inpatient admission.	Emergency Department-Acute Inpatient Hospital
2.	Behavioral Health Urgent Care (BHUC)	T2016 U5	07/01/2021	A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Members receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.	Target population includes members age 4 and older experiencing a behavioral health crisis. The scope of the service does not violate federal requirements prohibiting room and board.	Emergency Department-Acute Inpatient Hospital

Second Revised and Restated Attachment M.10. Approved Blue Cross and Blue Shield of North Carolina, Inc. In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	IMD 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 alternative placement for treatment for beneficiaries with acute psychiatric for no more than fifteen (15) Calendar Days within a calendar month.	Target population includes Members with acute psychiatric or substance use problems for no more than fifteen (15) Calendar Days within a calendar month.	Inpatient Psychiatric bed Facility
2.	Behavioral Health (BH) Urgent Care	T2016 U5	7/1/2021	Diversion from Inpatient hospitalizations and long wait times/observation in emergency rooms for placement. Stabilization of condition and ability to return to community.	Target Population includes beneficiary presents behavioral, psychological, or biological dysfunction and functional impairment, which are consistent and associated with DSM-5 diagnosis. The scope of the service does not violate federal requirements prohibiting room and board.	Emergency Room Observation Inpatient Acute Hospitalization
3.	Reserved.					
4.	Reserved.					
5.	Environmental Modifications	S5165	7/1/2021	This service will avoid costly institutional placement, emergency room, and inpatient readmissions by modifying or adapting the home to maintain the Member's health, safety, and welfare.	Target population includes Members who are LTSS Members currently residing in their own home or other private residence and Members currently receiving LTSS Medicaid State Plan benefits.	Nursing Home Placement
6.	Reserved.					
7.	Reserved.					

Second Revised and Restated Attachment M.10. Approved Carolina Complete Health, Inc. In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.	Massage Therapy	97124, 97140	7/1/2021	Reduction in chronic pain and back pain without the use of opiate therapies.	Target population includes adult Members that have documented history of chronic pain	Injection, Hydromorphone Injection, Methadone HCl Injection, Meperidine Hydrochloride Injection, Fentanyl Citrate Codeine Phosphate
2.	Inpatient psychiatric care/treatment in Institutes for Mental Disease (IMD)	0160	7/1/2021	Reduction in inappropriate emergency department stays, reduction in inpatient medical stays awaiting placement in inpatient behavioral health beds, increase in appropriate psychiatric utilization and placement.	Target population includes adult Members that have a mental health or substance use diagnosis.	Inpatient Hospital
3.	Behavioral Health Urgent Care (BHUC)	T2016 U5 (without Observation) T2016 U8 (with Observation)	7/01/2021	BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of Members experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning with the goal to reduce inappropriate utilization of the Emergency Department for BH specific needs and assisting Members by linking them to more clinically appropriate community based services and decreasing the recurrence of crisis needs.	Target population includes Members experiencing a behavioral health crisis related to a substance use disorder, mental health disorder, and/or I/DD diagnosis or any combination of the above.	Emergency Care Inpatient Hospital

Second Revised and Restated Attachment M.10. Approved UnitedHealthcare of North Carolina, Inc. In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.	Behavioral Health Urgent Care (BHUC)	T2016 U5	7/1/2021	A designated intervention/treatment location, known as a BHUC, that is an alternative to any community hospital emergency department where members with urgent primary behavioral health needs will receive triage and referral. The behavioral health urgent care location must include the ability to initiate the involuntary commitment petition via first-level evaluations (Clinician Petition), medical screening, case management and referrals.	Target population includes children aged 4 to 20 and adults with mental health, substance use disorder, or co-occurring disorders. Also, people experiencing behavioral health crisis meeting urgent triage standards.	Inpatient Hospital
2.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	Increasing access to IMD acute beds for Members in behavioral health crisis can lead to better outcomes and fewer exacerbations of serious behavioral health crises. Use of IMD beds, in conjunction with other diversion-based length of stay (BHUC where available), along with robust Care Management and ancillary supports such as Peer Support will help to ensure Members have access to the right care at the right time for their specific needs – as well as for well-managed lengths of stay.	Target population includes Members who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered settings.	Inpatient Hospital

Second Revised and Restated Attachment M.10. Approved WellCare of North Carolina, Inc. In Lieu of Services						
No.	**ILOS Service Name**	**Revenue/ Procedure Code**	**Approved**	**Description/Definition of ILOS**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
1.	Intensive Outpatient (IOP) for Mental Health	S9480 with Rev Code 905	7/1/2021	IOPs are more cost effective than hospitalization while delivering invaluable group therapy in a setting of supportive professional care, including peer support by those with lived experience to support positive change. Group-based therapy offers Members an opportunity to participate in a community setting to witness the success of those around them and inspire others within the group as they further their own therapy, knowledge of their psychiatric conditions and steps toward sustained recovery. IOPs for treatment of mental health conditions offer services and support programs that operate on a small scale and do not require the intensity associated with hospitalization or residential services characteristic of larger, broader-based treatment centers.	Target population includes Members with a behavioral health diagnosis needing more intensive care, but not inpatient treatment; Members discharging from inpatient care who need more than outpatient support.	Partial Hospitalization
2.	Institute for Mental Disease (IMD) for Acute Psychiatric care	0160	7/1/2021	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to fifteen (15) Calendar Days per calendar month in an IMD.	Target population includes Members with mental health and substance use disorders who require inpatient behavioral health treatment.	Inpatient Stay-Initial Hospital Care
3.	Behavioral Health Urgent Care (BHUC)	T2016 U5	7/1/2021	Provide crisis stabilization for Members experiencing acute mental health episodes in an urgent care setting in order to decreased crisis/emergency department utilization, decrease inpatient hospital stays, and improve crisis stabilization.	Target population includes Members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	Emergency Room Visit Inpatient Stay-Initial Hospital Care
4.	Programs for High Risk Populations	H0046 HK	7/1/2021	Specialized therapeutic in-home service is a flexible in-home support service designed for children at risk of foster care, ages 5 through 17, who are at risk for or stepping down from inpatient services. Services are delivered by a team led by a licensed clinician and, a Master's-level therapist, and a psychiatric nurse as a means to decreased inpatient and crisis utilization and decrease crisis/emergency department utilization.	Target population includes Members with complex medical and behavioral health conditions and unmet social needs.	Inpatient Hospital Stay

Attachment O. Offeror's Proposal and Response: 7. Fourth Revised and Restated Contractor's Contract Administrators – Blue Cross and Blue Shielf of North Carolina

7. Fourth Revised and Restated Contractor's Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	Angela Boykin, Chief Executive Officer, Healthy Blue
Address 1 Physical Address	4613 University Drive Durham, NC 27707
Telephone Number	919-765-4684
Email Address	angela.boykin@bcbsnc.com

Contract Administrator regarding day to day activities herein:

Name & Title	Carole Slocum, Chief Compliance Officer, Healthy Blue
Address 1 Physical Address	4613 University Drive Durham, NC 27707
Telephone Number	312-805-1224
Email Address	Carole.Slocum@bcbsnc.com

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	Carole Slocum, Chief Compliance Officer, Healthy Blue
Address 1 Physical Address	4613 University Drive Durham, NC 27707
Telephone Number	312-805-1224
Email Address	Carole.Slocum@bcbsnc.com

Section IX. Standard Plan Rate Book

Standard Plan Rate Book State Fiscal Year 2025 Contract Rates is attached to this Section IX. and effective for the period of July 1, 2024 – June 30, 2025, upon CMS approval.